Deadlock:
A Political Economy Perspective on the
Massachusetts Health Policy Reform Experience

A dissertation presented

by

Kaitlyn Kenney Walsh

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ABSTRACT OF DISSERTATION
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ABSTRACT

The issue of health care reform has persisted on both the state and national political agenda for decades. State involvement in health policy reform has grown considerably since the enactment of Medicaid in 1965 and the states have increasingly served as “laboratories of democracy” testing different health reform initiatives and approaches. Massachusetts has been identified in numerous instances as a pioneer among those states experimenting with reform, particularly with respect to its efforts to promote comprehensive health coverage. In a sense, the Massachusetts experience has positioned this state at the vanguard of the national health reform debate. Since the failure of its first attempt to provide universal insurance coverage in the late 1980s, efforts to reform the state's health care system have persisted, routinely surfacing on the state political agenda.

Using a political economy framework, this dissertation analyzes four discrete policy reform episodes in Massachusetts over a two decade period beginning in the late 1980s and concluding in 2008. Based on in-depth interviews and a review of archival documents and news reports, this study illustrates how the course of reform has been influenced by such issues as the allocation for public and private responsibilities for health care coverage and cost control, the evolution and functioning of the employer based health insurance system, and the role played by dominant structural interests of the health care industry. In addition, attention is given to the way that political rhetoric and previous policy action or inaction have shaped reform opportunities at any point in time.

The completion of this study comes at an interesting time, as the nation recently elected a president dedicated to health care reform. In that context, the 2006
Massachusetts model may be considered as a useful template for constructing a reform plan. This study provides insight into the process that shaped its development and the factors that enabled its passage.
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Appendix A
CHAPTER ONE
THE PROBLEM OF HEALTH CARE REFORM:
APPROACHING THE MASSACHUSETTS EXPERIENCE

I. Introduction

This study explores the development of health reform in Massachusetts over a two-decade period beginning in 1985 and culminating in the fall of 2008. This presentation of the Massachusetts experience with health reform will be told in terms of four primary episodes. The first episode took place in 1988 when Massachusetts enacted chapter 23 of the acts of 1988, a universal health care bill that relied upon an employer mandate according to which employers would provide health insurance for employees or contribute towards a state fund to cover workers’ health care benefits (Ascuaga 1992). The second episode occurred eight years later, in 1996, with passage of chapter 203 of the acts of 1996. This legislation repealed the universal health care law enacted in 1988 and expanded Medicaid coverage for children, disabled adults, and long-term unemployed adults (Greenberg & Zuckerman 1997). The third episode took place in 2000, when the public defeated Ballot Question 5, An Act to Protect the Rights of Patients and to Promote Access to Quality Health Care for All Residents of the Commonwealth. This initiative, placed on the November 7, 2000 ballot, sought to ensure the provision of comprehensive, high quality care and health coverage for all residents of the Commonwealth (Altman et al. 2000). Finally, the fourth episode considers a contemporary reform, as implementation of the recently enacted chapter 58 of the acts of 2006, An Act Providing Access to Affordable, Quality, Accountable Health Care unfolds. Despite general agreement on the need to expand access to health insurance coverage, policymakers endorsed different
mechanisms to achieve this end (Rowland 2005, November 1). By focusing on a series of discrete policy reform attempts in this way, the latter three dependent to some extent on what had come before, it is possible to examine the key factors that have both animated and blocked the process of health policy change while giving a continuous sense of the state’s health policy history in a crucial period.

As will be described in more detail below, other scholars have written about Massachusetts health policymaking (for example, Bergthold 1987, 1988, 1990; Goldberger 1990; Hackey 1998; McDonough 2000, 2004). Their research has generally addressed one reform episode and focused on such factors or processes as the role of specific actors in the policymaking process, and the way in which political circumstances or behavioral norms impact policy development and passage. These studies have illuminated the subject in numerous ways; however, none of these researchers has sufficiently explained policy developments in Massachusetts in terms of a framework that integrates political, economic, and institutional developments. Nor has any scholar previewed this study over the full twenty year period. The approach in this work will be to provide a theoretically informed narrative that shows the way that the possibilities and limitations for policy change in Massachusetts were affected by the interplay of economic interests and the objectives of political actors. An especially interesting feature is the role of political discourse in mobilizing support or opposition to reform efforts, thereby shaping the direction of the debate.

A. Analytic Framework

The framework employed for this case study is a political economy approach. As
Armstrong et al. (2001) explain, this approach considers politics and economics as integrally related. They assert that the use of political economy as an analytic framework makes health care reforms more transparent. Reinforcing this claim, Clark (1998) argues that for a particular outcome to be fully understood, it is necessary to gain an understanding of the political and economic context shaping the reform movement. Therefore, each episode reviewed in this project will be discussed in light of the broad set of economic and political factors that influence its shape, content, and outcome (McKinlay 1984).

Political economy is an interdisciplinary approach used to analyze the way in which politics and economics interact with each other to achieve both individual and community goals (Clark 1998). The fundamental premise underlying utilization of this approach as an analytical framework is that politics and economics are distinct but interrelated concepts that must both be examined in order to gain a complete understanding of the social and political system (Caporaso & Levine 1992).

Within the field of political economy, there are contending perspectives - the classical liberal, the radical, the conservative, and the modern liberal - that differ based on normative assumptions as to the proper roles of government and the private market in society. For example, classical liberal political economists generally support a laissez-faire government that defers to free markets for organizing society. Conversely, radical political economists emphasize the value of an egalitarian society and argue that government intervention is necessary in order to ensure this principle is upheld and that individuals work together to “collectively direct their social existence” (Clark 1998, p. 26). These more narrowly refined approaches to political economy dominated the field in its early years.
Recent scholars seem to be distancing themselves from explicitly normative approaches that focus solely on the role of the market and government and shifting towards more expansive interpretations of this paradigm. As Caporaso and Levine (1992) illustrate, the diverse interpretations and applications of political economy as a theoretical perspective are largely attributed to the broad ways in which both politics and economics can be conceptualized. In their words:

Politics has meant “who gets what, when and how” (Laswell, 1936), “the struggle for power” (Morgenthau, [1948] 1960), “the art and science of government,” “the socialization of conflict” (Schattschneider, 1960), “patterns of power, rule, and authority” (Dahl, 1956), “the science of the state”… “pure conflict, as in us against them” (Schmitt, 1976), and “the conciliation of conflicting interests through public policy” (Crick [1962] 1964). Power, authority, public life, government, the state, conflict, and conflict resolution are all bound up with our understanding of politics. (p. 8)

Additionally, they explain the term economics has several different nuances which are all related, but emphasize slightly different aspects of this term. For example, this term might refer to the economic calculation behind given actions as well as explain an allocation method within a society. Additionally, economics considers the role of the economy itself, as a separate market that prompts us to move in a certain direction.

A brief review of the applications of the political economy framework in numerous substantive areas ranging from trade policy to education policy to health policy, among others, helps illustrate the expansive applications of this approach. For example, Gawande and Krishna (2003) review the literature on the development of protectionist trade policies; their review suggests that generally, when used in this field, the political economy framework includes an assessment of the implications of trade options on the economy and consideration of the political ramifications of policy options for policymakers. In his
book chronicling education policy in the twentieth century, Franciosi (2004) uses a political economy approach to review numerous reform movements and to explain how schools have reached their current status in light of this reform history. Under his framework, the political aspect of this approach involves an assessment of the struggle over the features of education policy and control of schools (such as between parents, teachers, and reformers, and between local authorities and state or federal governments, etc.) while the economic aspect includes an assessment of the allocation of resources (such as per pupil spending, equitable funding among schools, teacher salaries, the availability or shortage of teachers, etc.). Franciosi (2004) considers how these political and economic variables have interacted over time in order to influence reform movements and position American public schools as they stand today.

Within the health policy field, the political economy approach has been adopted to explain health care status, the organization of the health care system, and health care reforms (see for example Doyal 1979; Reisman 1993; McKinlay 1984; Zhou 2001; and Armstrong, Armstrong, & Coburn 2001). Again, the way in which the political economy approach is incorporated to explain each of these health policy issues provides a glimpse into the variety of ways in which this approach has been interpreted and applied. In her book, The Political Economy of Health, Doyal (1979) argues that different economic systems (in developed vs. undeveloped countries) and different levels of activism on behalf of the state in promoting public health jointly explain patterns of health and illness. In The Political Economy of Health Care, Reisman’s (1993) goal is to explain different methods of promoting health and overall well being through the organization of health care. He argues that since health is a matter of both public and private concern, the multidisciplinary
approach of political economy is useful because it considers the potential role of both the
date and the market in promoting health. His book is organized according to three
primary headings, equality, economy, and efficiency, and within each of these sections he
provides an explanation as to the way in which the respective objectives of equality in
access to health care, control of health care costs, and cost-effective allocation of health
care spending and services might be met when left to either the public or private domain.

In addition to these applications of a political economy approach within the health
policy field, this framework is relied upon with increasing frequency as a heuristic device
for analyzing health care reforms. As Zhou (2001) asserts, “the political economy
approach puts the discussion of health care reforms in the proper perspective, since health
care involves many stakeholders and its reforms inevitably have political as well as
economic repercussions” (p. 1). Oliver (1998) adopts this framework in a fashion similar
to the one which will be employed here, as a guide for a case study on the evolution of
Maryland’s Medicaid managed care program, while the authors contributing to Zhou’s
other very different issues and aspects of health care reform.

As Mykhalovskiy (2001) explains, the research questions addressed by political
economy approaches to health care reform are numerous and diverse, ranging from studies
of the relationship between the pharmaceutical industry and government, to the re-
organization of long-term care services and the individualization of responsibility for health
and health care. Still, when used in the context of health policy reform, Mykhalovskiy
(2001) argues that political economy generally explores restructuring of health care in terms
that focus primarily on the shifting and contested boundaries between the state and the
market. However, he argues that to improve the explanatory power of political economy, this focus needs to be expanded to consider the role of ruling discourse, as this greatly impacts the way in which “things get done” in health care reform (p. 148). In his study, Mykhalovskiy (2001) purports that intricate relationships between social scientists and existing ruling structures seem to direct the subject of health care research and obfuscate research that might be positioned otherwise. Moreover, he argues that the types of information produced from this research and its accompanying narrative have a profound impact on the way in which health care and reform is conceptualized and considered. Mykhaolovky’s (2001) preliminary analysis regarding the way in which research within the health care arena is focused and how this impacts reform movements is very poignant. But it is the culminating point he reaches, the need to emphasize not only the relationship between government and the market, but also the discourse surrounding health care and health reform when utilizing the political economy approach to study reforms, which is the important finding for this study.

While this review has highlighted the varied applications of political economy, it has also demonstrated that there are some basic assumptions that distinguish this theoretical perspective and underlie all its applications. The first of these is that it is not possible to isolate individual parts of a particular context in order to gain a firm understanding of the whole picture; it is the relations between and interaction of what constitutes both economics and politics that shape a system; “states, markets, ideas,

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1 This section relies heavily on the introduction provided in Armstrong et al. (2001). They provide a thorough explanation regarding the expanding interpretations and applications of the political economy framework. Additionally, they provide the basis of the discussion which follows regarding the fundamental components of this approach which distinguish it from other theoretical perspectives.
discourses and civil society are not independent variables but interrelated parts of the same whole” (Armstrong et al. 2001, p. vii). Additionally, Armstrong et al. (2001) argue that both the mode of production for social needs and the existing relations of ruling are social constructs that are not immutable. In fact, ideas, discourse, and ways of seeing can play an active role in reinforcing or disrupting these existing arrangements.

This case study of the Massachusetts experience with health care reform will also employ a broad interpretation of the political economy perspective in its use of an approach that will be analytical, not normative. Rather, politics and economics will be considered according to the expansive conceptualizations reviewed by Caporaso and Levine (1992). With respect to politics, this study will place emphasis on how key political factors come into play during episodes of reform (Skocpol & Keenan 2005). This study will consider: how problems are defined and how they emerge on the political agenda (Rochefort & Cobb 1994; Majone 1989; Baumgartner & Jones 1993), how conflicts are expanded or constrained and the role of different stakeholders in shaping this scope (Schattschneider 1975), and the role of participants and institutions, both inside and outside of government, that are actively involved during a movement (Kingdon 2003; Baumgartner & Jones 1993).

The economic perspective will include consideration of the economic motivations shaping the actions of prominent players in each reform episode (Lindblom 1977; Schattschneider 1975). Additionally, attention will be given to the way in which reform episodes might alter the existing mode of providing health care. Finally, this study will appraise the role of the economy as an external market that prompts us to move in a specific policy direction (Baumgartner & Jones 1993; Sturzenegger & Tommasi 1998).
Although employing a broad conceptualization, the application of this framework will place emphasis on the two primary tenets underlying this approach as described above. For each episode, it is the interaction between the political and the economic, the public and the private, and the state and the market that will be highlighted (Mykhalovskiy 2001; Przeworski 2003). In studying these interactions, each episode will also emphasize the way in which ideas and discourse have impacted the way particular issues are viewed and how this has served to reinforce the status quo or enable change.

B. Case Selection

State involvement in health policy reform has grown considerably since the enactment of Medicaid in 1965 (Sparer 1996). Among the states, Massachusetts is an ideal place to study health policy reform for a number of different reasons. First, since that time, Massachusetts has been identified in numerous instances as a pioneer among the states in its efforts to promote comprehensive health coverage (see for example Holahan et. al. 1998; McDonough 2004; Bovbjerg & Ullman 2002). In a sense, the Massachusetts experience has positioned this state at the vanguard of the national debate. Since the failure of that first attempt to expand insurance coverage in the late 1980s, efforts to reform the current health care system have persisted. Still, despite the persistence of this issue and its fascinating evolution, there has been no long-term solution to the problem of implementing comprehensive reform. This issue has not been resolved but it will not go away; again in 2006 health reform resurfaced and acquired a dominant spot on the state political agenda (Greenberger 2005, May 26). It is too soon to determine if this reform will be maintained and serve as a long-term solution to the issue of the uninsured.
To date, there are a few studies that focus on health care reform in Massachusetts, and some that review episodes considered in this study, but there has not yet been a longitudinal case study of comparable depth that reviews this series of health reform movements over time. Perhaps the portion of this dissertation that has been most widely studied is the episode considered in 1988. However, these publications still leave room for further analysis as will be conducted in this study. None of these publications, while useful, offers an integrated and comprehensive analysis of the Massachusetts reform experience over a twenty year time period. Moreover, while many studies on Massachusetts reform efforts have relied upon a single theoretical framework, this study will incorporate a multi-theoretical perspective, synthesizing several theories and illustrating their applicability in the course of chronicling four policy reform episodes.

For example, Oliver & Paul-Shaheen (1997) included the Massachusetts experience with health care reform in 1988 in their case study of six states that enacted comprehensive health reforms. Paul-Shaheen (1998) later included Massachusetts in a study of seven states that had “taken the lead” in health policy reform in the late 1980s. Some of the findings from these studies regarding the feasibility of policy change at the state level have been helpful in conceptualizing themes and patterns to consider in this study. However, while these studies adopt a comparative case study approach in an effort to discern trends and commonalities regarding affable conditions for health policy reform by studying health reform movements across different states at a given time, my study will adopt a single longitudinal case study approach that will allow identification of affable conditions for reform, but will also provide some further insight into how past reform experiences shape the process, politics, and content of subsequent efforts. Focusing on a single state also
allows a number of contextual variables to be held constant (Stoessel 1998). In addition to these comparative case studies, Dukakis (2001) has also authored a chapter on the health care reform experience in five different states, including Massachusetts in 1988. However, he provides only a brief overview of the process surrounding this reform movement, as the primary tenet of his chapter is centered on the role of the governor in initiating health policymaking.

In his chapter on Massachusetts in *Rethinking Health Care Policy: The New Politics of State Regulation*, Hackey (1998) also reviews the passage of chapter 23 in 1988. However, his analysis is conducted within the context of how the process of enacting this legislation is illustrative of the “negotiated policy regime” that characterized hospital cost containment in Massachusetts during the 1980s. Though his study also reviews how the interactions among and between key players in this reform movement impacted the process and substance of this reform episode, his focus is on the hospital cost containment aspect of this debate. This is also true of Kronick’s (1990) article on health care policy in Massachusetts during this same time period and of McDonough’s (1997) book entitled, *Interests, Ideas and Deregulation: The Fate of Hospital Rate Setting*. Conversely, the primary focus of my study is on the universal access provision of this reform episode. However, these scholars have highlighted the importance of considering the role that linking hospital financing legislation to broader health care reform had on the outcome of this reform movement.

Two sociologists have conducted analyses of the health policy process in Massachusetts as the subject of their Ph.D. theses. Bergthold’s (1987) dissertation focused on the health policy process in Massachusetts from 1982-1985, during the time period prior to passage of
the Health Security Act. The emphasis in her dissertation and in subsequent articles she has published on this topic (see for example Bergthold 1988 and Bergthold 1990) is the role of the business community in the policy process. Cumulatively, her studies on health policy change in Massachusetts cover the time period from 1982-1988 and lead her to argue that business is a powerful player that is able to control the policy process. Moreover, she contends that there is particular potency in a business/state alliance; if business and the state are able to form an alliance that can be maintained throughout the legislative decision-making process, it is possible for substantial policy change to occur.

Byrnes’s (1993) dissertation also centered on passage of the Health Security Act of 1988 in Massachusetts. As I will do, Byrnes utilized a political economy framework to explore the process that led to passage of this legislation. Using this framework, Byrnes argued that health care systems and policy are a part of, and a reflection of, dominant political and economic structures, and that these structures are ever changing. In contrast, Goldberger (1990) draws on her personal experience and involvement in this reform movement to argue that it was the involvement of consumers, rather than traditional dominant health care powers that initiated the possibility of health policy change. The suppositions purported by these authors regarding the process and players that led to policy change will be further explored in my study. The role of business and the state specifically, and economic and political players considered more generally, as well as consideration of the role of the public in shaping the outcome of this reform episode will all be considered. These claims will be investigated along with a number of additional themes, highlighted below, that I have derived for consideration based on the political economy framework.
Furthermore, these arguments will be considered not just for the health reform case in 1988, but across a series of three additional reform movements.

Finally, Ascuaga (1992) has written an overview chapter chronicling the development of the Health Security Act, the challenges of implementing the legislation, the factors that led to the unraveling of this law, and the lessons learned from this experience regarding health care reform at the state level. Ascuaga’s chapter provides an initial glimpse into numerous different aspects of this reform episode; I hope to build on this initial glance and provide a more detailed account of this legislation’s development and therefore provide further insight into lessons that can be learned from this experience. This study will also consider how the experience in this reform episode impacted subsequent reform movements.

There are considerably fewer studies on the subsequent reform movements that will be considered as part of this project. For example, the articles by Greenberg & Zuckerman (1997), and McDonough et. al. (1997) on passage of chapter 203 in 1996, An Act to Improve Access to Care, are brief and provide a general summary of the legislation’s content and a brief discussion of factors that the authors’ in both articles identified as precursors to successful passage of this reform legislation. An article by Bovbjerg & Ullman (2002) on this same reform episode focuses on more technical aspects of the legislation, rather than the politics associated with its formation and adoption. Perhaps the most detailed description of the process leading up to passage of chapter 203 is McDonough’s (2000) chapter “Agendas and Children’s Health Care in Experiencing politics: A legislator’s stories of government and health care;” however, this review is a subjective account of McDonough’s efforts to facilitate passage of this reform during his
tenure as a state legislator. Therefore, it represents just one of many perspectives and data sources that will be considered in my study. There is a dearth of research analyzing the third reform episode considered here, the 2000 ballot initiative. Again, the literature on this topic has been more technical, focusing on the stipulations included in the original initiative petition (see Altman et al. 2000). Given that the last reform episode is only just now unfolding, scholarly studies that provide a detailed assessment of this reform movement are just emerging (see for example McDonough et. al. 2006 and Holahan & Blumberg 2006).

There is only one article to date (McDonough 2004) that longitudinally reviews a series of health reform episodes in Massachusetts. However, McDonough’s (2004) article is designed to serve as a brief legislative overview that provides a glimpse into the major health reforms of 1988 and 1996 in order to discern what general lessons from these two experiences might inform the current reform movement. My study of the Massachusetts health care reform experience will update and expand greatly upon McDonough’s (2004) reform review. In addition to providing a rich, in depth, description and analysis of the 1988 Health Security Act and the 1996 Act to Expand Access to Care, this research project will also include coverage of the 2000 ballot initiative that sought to expand access to health care, and the 2005-2006 reform movement which culminated with passage of the 2006 Act Providing Access to Affordable, Quality, Accountable Health Care. Moreover, this study will review each of these reform episodes according to a consistent approach that has proven effective in explaining as well as assessing health care reforms. Consequently, the political economy framework will be incorporated in order to highlight recurring themes throughout these episodes and identify persistent obstacles that have
allowed health reform to be eluded. In addition, by conducting a longitudinal case study, it will be possible to review how previous policy action or inaction, and involvement of particular interests, has shaped subsequent reform opportunities. Again, while the focus will be on Massachusetts, I hope to glean insight into what factors have facilitated or impeded health care reform initiatives on the broader spectrum.

C. Analysis: Illustrating Recurring Themes in the Political Economy Approach to Health Care Reform

In reviewing the political economy literature, some recurring themes have emerged that seem especially relevant to consider in applying the political economy approach to studies of health reform. These themes will be referred to and illustrated, as applicable, in reviewing the reform episodes considered in this case study.

Public-private boundary setting

As previously explained, one of the central components of the political economy approach is the interaction of the political and economic, or the public and the private (Mykhalovskiy 2001; Przeworski 2003). Interestingly, it is often resolving this issue of interaction, or deciding where the line should be drawn in dividing the responsibilities of the public and private sector, that is one of the most contentious aspects of policy debates (Caporoso & Levine 1992). Darman & Lynn (1980) write about the “business-government problem” which they define as, “the destructive effects generated by repeated collisions between these two [business and government]” (p. 42). They argue that this tension, compounded by the very different interests and views of each sector, make progress
difficult to achieve. In Armstrong et al. (2001), the authors suggest that this is the very theme of three of the first four chapters of their book on the health care system in Canada; although discussing different health policy issues, the fundamental debate inherent in each of these chapters revolves around determining whether the government or the private market is the most efficient producer of goods and services. My study will also consider this recurring theme of the tension between the public and the private, and the difficulties of discerning where to draw the line dividing the responsibilities of each sector.

Recurring plot line

Perhaps one of the most pervasive trends characterizing health policy reform movements is the pattern of a recurring plot line. According to this pattern, generally, reformers as well as the general public exhibit strong enthusiasm for reform, but this is ultimately followed by a gradual decline of support (Rochefort 1997; Rochefort 2002). Interestingly, this trend might emanate from the theme highlighted above; as the debate regarding the role of government and the private sector becomes more inflamed and contentious, the public can be swayed by one side or the other, resulting in a loss of confidence in their previous convictions. This trend has characterized numerous health policy reform movements. One of the most recent widely known examples of this is the Clinton’s launch of the Health Security Plan in 1992. Clinton touted his commitment to pass health reform legislation throughout his campaign for the presidency and this was heavily supported by most Americans. However, in the first year of his presidency, support for his plan markedly declined and he was unable to pass the reform promise on which he had campaigned. In Boomerang, Skocpol (1996) sets out to explain this theme in
the context of the Clinton reform; her goal is to explain what led to a turnaround in U.S. politics and how such strong enthusiasm for reform became dismantled. In reviewing the episodes included in this investigation, evidence of this same pattern will be analyzed.

Dominant structural interests

Another recurring theme in the political economy literature on health reform is the ability of political and economic power elites to obfuscate or control the direction of reform initiatives. Alford (1975) refers to these political and economic elites as “dominant structural interests,” arguing that in a market economy their power has become buttressed through institutional mechanisms which guarantee their control (p. 14). In a recent book investigating health care reform initiatives throughout the twentieth century, Gordon (2003) reaches a similar conclusion and discusses the impact this has on reform opportunities. He argues,

The federal system [of government in the United States] exaggerates the clout of economic interests, which are able to play political jurisdictions off against one another. Over time, the political status of economic interests has yielded considerable cultural clout as well. All of this has had a direct political effect: powerful economic interests throttle popular reform efforts that might otherwise threaten them. It has had a chilling effect: legislators narrow debate to ensure that important patrons are not displeased. And it has had an administrative effect: economic interests capture public policy in order to minimize the costs of state intervention or turn it to their advantage.....In a polity in which economic interests enjoy profound political advantages, innovations in social policy have always been difficult - and often succeeded only when they promised to even out competitive disparities, ensure social stability, or socialize private costs. (p. 210-211)

In each of the reform periods reviewed here, evidence of this theme will also be examined. When applicable, the description of a reform episode will highlight the role of political and economic elites in blocking reform initiatives or shaping them to reflect their own interests.
Dilemma of employment-based reform

This discussion brings us to the final insistent theme which will be explored in this application of the political economy perspective on the health care reform experience in Massachusetts. Again, in light of the economic and political power of entrenched interests, new reform proposals which threaten existing structures and power relationships are strongly resisted. Therefore, as Gordon (2003) explains, expanding the private employment based health insurance system as a mechanism to expand health coverage appears to be one of the few politically viable options that politicians can endorse. Despite all its flaws, this approach appeals to many entrenched interests who “demonize” the prospect of a public system in light of their desire to maintain the existing structure and power relationships inherent in the private health care system (Gordon 2003, p. 299). However, this situation poses an interesting conundrum, or “catch 22,” because while Gordon (2003) and others (see for example Gleckman 2003; Kahn & Pollack 2001; Meyer & Silow-Carroll 2003) argue that the most likely mechanism to expand health coverage is to build upon the existing structure, efforts to do so – particularly through employer mandates - have generally been unsuccessful (Schoeff 2005; Silow-Carroll & Alteras 2004). In reviewing the reform episodes which characterized the Massachusetts experience over the past two decades, evidence illustrative of this very conundrum, or the “catch 22” of the employer based system, will be highlighted.

Language as a mode of political conflict

Another important element included in the analysis of these reform episodes is the role of discourse in political conflicts and agenda setting. Rochefort & Cobb (1994) and
Kingdon (2003) argue that issues or problems can be interpreted in many different ways. In *The Politics of Problem Definition*, Rochefort & Cobb (1994) illustrate that the way in which a problem is defined impacts public perception of an issue and also the likelihood of agenda access. In addition, they identify common rhetorical strategies employed by actors in political debates to define problems and they illustrate how these strategies can be used by opposing sides to gain advantage in political contests.

Stone (2002) highlights that in policy discourse, there are many modes used for defining problems. For example, symbols and numbers are often used as political devices to influence public perception of an issue. In policy debates, symbols and stories are often relied upon to conjure concerns that a problem is worsening. Since numbers can be manipulated, they are often incorporated to paint a specific picture of a problem or to support specific claims.

Political discourse is critical to convincing the public and government that there is a legitimate problem that requires government attention. Therefore, skillful use of rhetoric is a crucial part of the policymaking process. As Kingdon (2003) highlights, the problem stream is one of the critical elements in determining the decision agenda, and political discourse is used by issue advocates to help prioritize an issue among others floating in the problem stream.

In each of the reform episodes considered as part of this study, attention will be paid to the way in which problems were defined and presented in the effort to earn a spot on the governmental agenda. In addition, this analysis will consider the rhetorical strategies employed by actors involved in political conflicts and illustrate how these were used to influence the outcome of the debate.
II. Research Design

A. Research Methodology

This study employs a qualitative case study approach. The objective of this project is to provide an in depth, rich description of health policy reform episodes in Massachusetts between 1985 through 2006 in order to describe how and why particular reform outcomes resulted (Yin 1994). A longitudinal case study is valuable as it considers how the nature of policy and the politics of reform have changed over time. Additionally, a historical account allows us to examine the role past reform initiatives have had in shaping future reform movements. In his book *The Democratic Wish*, Morone (1990) argues, “politics cannot be understood outside their historical context - past patterns illuminate present policies; and not just as ‘background’ but as explanations for why things happen. In my view, students of public affairs should spend more time looking back” (p. xii). Expanding on a point originally developed by Skocpol (1992) Morone and Belkin (1994) maintain,

…rich historical legacy offers us far more than a series of morality tales about successes to emulate and failures to heed. Each reform campaign - whether it wins new policies or not – creates new political conditions; each effort shapes the next generation of proposals and their fate. Even defeated reforms shake up government agencies, revise conventional wisdom, renegotiate political rules, and reorganize the constellation of interest groups primed for the next debate. (p. 2)

Thus, by conducting a case study that focuses on a series of reform initiatives, it will be possible to consider how previous reform movements impact subsequent efforts.

Moreover, in asserting the utility of a case study approach, Yin (1994) explains that by conducting a descriptive case study, it is possible to develop some general explanations for the events under consideration and to indicate how such explanations may apply to other situations. Consistent with this objective, this study will focus on the Massachusetts
experience with health care reform, but the intent of this study is also to provide insight into the broader problem of why attempts to pass comprehensive health policy reform have generally been unsuccessful.

B. Data

As detailed, the political economy approach contends that both political and economic factors are integrally related, powerful forces that help structure social and political life in this country. Adopting the political economy approach will require a firm understanding of the political and economic factors, as well as the discourse and ideas that shaped the development and outcomes of these health policy reform episodes in Massachusetts during the 1985-2008 time period reviewed in this study.

In order to assess each of these variables, I consulted a wide array of data sources. According to Yin (1984), this, the ability to deal with a full variety of evidence including documents, artifacts, interviews and observations, is one of the unique strengths of the case study approach. To begin, I first reviewed existing scholarly literature on health care reform initiatives in Massachusetts during the proposed study time period. Additionally, I reviewed popular press coverage of reform episodes in Massachusetts from 1985-2006. Northeastern University’s NewsBank Inc., America’s Newspapers electronic database includes access to Massachusetts newspapers’ archives. Within this database access to the following primary newspapers and years are available: The Boston Globe (1980-present) and the Boston Herald (July 1991-present). The microfiche system was utilized in order to search for relevant articles published in the Boston Herald previous to 1991. In total, over 2,600 articles related to each of these reform movements were reviewed.
I also searched the Massachusetts State House Library catalog and retrieved and reviewed relevant public documents, government reports, bills, testimony, and original memoranda. The library catalog holds state publications dating back to the early 1800s. Additionally, records of public hearings from 1975 to the present were available and organized by subject matter of the legislation. Finally, some committee hearings related to the aforementioned reform movements were available for review through videotapes.

Last, I conducted nearly 40 interviews with key players and stakeholders involved during the different reform episodes reviewed in this project. A purposive or judgment sampling technique was employed to develop a preliminary list of interview participants based on the initial literature and document review (Bernard 1988). However, recommendations from these interviewees prompted additional interviews when an interviewee suggested an individual, not previously identified, who might also be able to shed additional light on the events surrounding a reform period. This technique is known as snowball sampling, because, as Babbie (1992) explains, “in studying a loosely structured political group, you might ask one of the participants who he or she believes to be the most influential members of the group. You might interview those people, and in the course of the interviews, ask who they believe to be the most influential. In each of these examples, your sample would ‘snowball’ as each of your interviewees suggested others” (p. 292).

The purpose of these interviews was to reconstruct the events and exchanges that occurred among key participants in the policy process (Hogarty 2002). While each interview was organized to include a set list of questions (see Appendix A for sample protocol), overall, a semi-structured interview technique was utilized in an effort to facilitate and encourage dialogue with interviewees (Hacker 1997). Based on my experience
in a previous research project (Rochefort et al. 2003), this technique has proven effective in ensuring that previously formulated questions are answered and also in encouraging interviewees to share stories or anecdotes that might prove useful or interesting (and may not have been captured utilizing a more formal technique).

C. Limitations of the Study

It is important to acknowledge some of the concerns that might be raised with respect to the selection of Massachusetts for this study and with the case study approach more generally. First, some might argue that selecting Massachusetts as a case for this study limits the utility of the study’s findings. Those with this concern might suggest that Massachusetts is an outlier in the U.S. political scene, making it difficult to generalize findings from a study of this state to the broader political spectrum. However, others such as Goldberger (1990) counter that this notion of “Massachusetts exceptionalism” is unfounded. She states, “Despite its reputation for social liberalism, Massachusetts has also been on the forefront of the tax revolts of the 1980s. In 1980, voters approved a referendum which cut local property taxes; six years later voters approved a referendum limiting growth in state taxes to the rate of increase in wage and salary income” (p. 858).

Still, if one remains convinced that Massachusetts is an extreme or unique case, operating on this premise actually reinforces the explanatory power of this study’s findings (Yin 1994). If comprehensive reform remains elusive even in a state committed to reform with a climate that seems ripe for such policy innovation, what factors are so strong as to resist these inclinations for success? Thus, Massachusetts serves as a useful laboratory for studying health care reform movements (Stoessel 1998).
The sources consulted for this project will provide valuable insights into the concerns and perceptions of those who were involved during different reform episodes. Although every effort will be made to verify substantive information provided in interviews, “as is the case with most scholarly studies that rely on interviews as a primary source of data, the impossibility of screening all relevant facts and the need to rely on what participants choose to reveal means that some critical data are often overlooked” (Hogarty 2002, p. xi). Still, this approach offers the best method for re-enacting different events, and reviewing the way in which central actors saw their role and a particular issue.

III. Conclusion

This study will be presented in the following five chapters. Chapter two begins with a detailed description of the political and economic climate that characterized Massachusetts just prior to and during passage of chapter 23 of the acts of 1988, the Health Security Act. Then, this chapter reviews the process by which the Health Security Act arrived on the agenda and was subsequently enacted. As this event represents a major shift in policy, the conceptual model developed by Baumgartner and Jones (1993) known as “punctuated equilibrium” is relied upon to help describe this episode. Included in the description of this episode is a focus on identifying the political and economic factors and conditions that enabled comprehensive policy change to occur.

Chapter three explores the unraveling of the Health Security Act enacted in 1988 and the passage of chapter 203 of the acts of 1996, which increased access to health insurance coverage by expanding Medicaid. This account carefully considers how political and economic circumstances changed since 1988. I place emphasis on highlighting the
way in which changes among political and economic variables impacted the shape and content of policy during this reform episode. My objective is that, through a study of these changes, it is possible to better understand and explain why Massachusetts ultimately adopted a policy reform for expanding health care coverage that was very different than that which was previously passed.

Chapter four begins with an account of the climate in which the 2000 ballot initiative reform movement developed. Then, an analysis of the struggle between those supporting and those opposing Massachusetts Ballot Question 5 of 2000, which included a provision to guarantee health care coverage to all citizens of the Commonwealth, is presented. Attention is paid to the tactics employed by all involved stakeholders to influence the outcome of this initiative. Through a detailed study of the way in which this reform initially developed, and subsequently marketed to the public, this analysis elucidates what factors contributed to the demise of this reform initiative despite initial popular support that garnered the public’s attention and earned it a spot on the ballot.

In chapter five I turn to the most recent health care reform episode in Massachusetts that culminated with passage of “landmark” health care legislation in April of 2006 (Kowalczyk 2006, June 4). Despite agreement in the abstract on the need to increase health care coverage in the Commonwealth, policymakers have had great difficulty reaching consensus on the best plan for accomplishing this objective. The study of this episode relies upon the Kingdon (2003) model of policymaking, as the convergence of the problem, political, and policy streams prompted passage of chapter 58 of the acts of 2006. This chapter also places considerable emphasis on the role of political and economic elites, and how they shaped the debate surrounding the reform process and the outcome of this
reform initiative. Chapter five finishes with an implementation analysis, identifying the political and economic challenges the state has encountered, and will continue to grapple with, as it carries out and seeks to sustain this health reform initiative.

Chapter six is the concluding chapter of this study. Here, the recurring themes and obstacles that have pervaded the reform episodes reviewed in this study are synthesized. I provide a summative illustration of the ways in which the political economy themes highlighted at the outset of this study have played out in the reform episodes considered. Additionally, this chapter identifies those barriers that have frequently presented themselves in reform episodes and describes the way in which these barriers have consistently impeded reform. Derived from a thoughtful review of the political economy approach as applied to each of these episodes, the culminating themes reiterated in this chapter provide some further insight into explaining the deadlock that has characterized comprehensive health policy reform in Massachusetts.
CHAPTER TWO
A TEMPORARY VICTORY: THE HEALTH SECURITY ACT OF 1988

Massachusetts Governor Michael Dukakis signed the Health Security Act, chapter 23 of the acts of 1988, into law on April 21, 1988. Passage of this legislation, colloquially referred to as the universal health care bill, marked a dramatic change in health care policy for the state of Massachusetts. This analysis reviews the environment, with attention on political and economic variables, that precipitated the development of this reform; describes the process by which this issue emerged on the agenda; illustrates the struggle between those seeking to alter and those seeking to maintain the status quo; and finally, explains how these collective processes and activities enabled dramatic policy change to occur.

I. Identification of the Issue: The Uninsured in Massachusetts

Historically, health care policy has been a fundamental concern on the Massachusetts political agenda. In the early 1980s, cost concerns were the primary driver of attention to this issue, primarily because hospital rates in Massachusetts far exceeded those of the rest of the nation (Byrnes 1993). However, in the mid to late 1980s, concerns associated with the health care system expanded to include access, as high costs of health care led to increasing numbers of individuals who were unable to afford health insurance coverage. Over time, initiatives and proposals seeking to address quality concerns have also been the focus of a number of health care bills and debates. However, it is beyond the scope of this dissertation to consider the full range of health care policies and proposals that have sought to address all three features of the unholy triangle (i.e., cost, quality, and
access) that characterize the health care system. Rather, as outlined in chapter one, this dissertation will focus on four health care reform initiatives in Massachusetts, enacted between 1988 and 2006, that have sought to address the issue of inadequate access.

In the fall of 1985, the Study Commission on Health Care Finance and Delivery Reform was instituted by Governor Michael Dukakis. This Commission was charged with evaluating the state hospital cost control program; reporting on how this program was impacting access to care for the poor; and proposing a system that would allow access improvements by October of 1987. In the spring of 1987, the members reported that the hospital cost containment law did not appear to have adversely impacted hospital access for the poor, but that evidence indicated access to in-patient care for the uninsured was considerably worse than access for the insured. Their report estimated that 520,000 or more Massachusetts residents lacked health insurance (Knox 1986, May 6). Though there was agreement regarding the need to address this problem, Dukakis and the commission members were not able to immediately settle on a plan to do so (Health Care for All 1987, January 29). In the spring of 1987, Patricia McGovern, Senate Chair of Ways and Means of the Massachusetts General Court, filed S. 1690, a health care bill designed to provide universal access to health insurance in Massachusetts. It is here that this chapter begins the chronicle of the process that ultimately led to passage of chapter 23, the Health Security Act, in 1988.
II. Problem Definition

A. Scope and Severity of the Problem

In policy debates, numbers are commonly incorporated to tell a story, especially to illustrate that a problem is getting bigger or worsening (Stone 2002). A review of news articles during the mid to late 1980s in Massachusetts reveals how numbers were invoked to document this trend. For example, in September of 1985 a *Boston Globe* article reported that approximately 530,000 residents of the Commonwealth lacked health insurance (Knox 1985, September 12). By the spring of 1987, reports suggested that over 600,000 Massachusetts residents were without health insurance. Stone (2002) also asserts that by counting or measuring something, people tend to heed more attention to the issue or item being quantified. These numbers prompted initial attention to this issue, and the increased frequency with which numbers relative to the problem of the uninsured were incorporated in press documents garnered more attention to this issue and influenced perception as to its urgency. The headline of *The Boston Globe* on June 30, 1987 read “Hub Study: 15% have no health insurance.” The first paragraph of that article went on to explain “Fifteen percent of Boston’s residents – one out of seven – have no health insurance” and later cited a recent statewide survey suggesting “660,000 people – or one in 10 [in Massachusetts] – lack health insurance” (Tye 1987, June 30). These same figures were then routinely incorporated throughout the press covering this issue. Finally, consistent with Stone’s (2002) assertion

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2 See for example, “Making health care universal” (1987, March, 30); Kuttner (1987, June 22); HCFA (1986, October); and Friedman & Swartz (1986).

3 See for example, “The health care gap” (1987, July 3) which refers to the 660,000 people in MA without health insurance, 1/10 statewide and 1/7 in Boston; “A health care goal” (1987, July 18), which references 660,000 persons in state with no health insurance; and Knox (1987, August 6) which references 660,000 MA citizens without health insurance.
that numbers are explicitly evaluative, discourse utilized in conveying these numbers reinforced the normative implications of these findings. For example, one article in the *Boston Globe* stated “…660,000 people in Massachusetts have no health insurance – an astonishing [emphasis added] one in ten statewide and one in seven Bostonians” (“The health-care gap” 1987, July 3).

Use of numbers emphasized the high incidence of this problem and focused people’s attention on the notion that this problem was severe because it appeared to be intensifying rather than improving. At the same time, profiles of individuals and families facing extreme hardships as a result of their lack of health insurance increased the proximity of this issue to many Massachusetts residents. In March of 1987, the *Boston Globe* featured a story on Linda Goss, a 34 year old working single mother of three that included a picture of her with her young daughter. The article lamented,

> ‘As I get older, I’m finding my situation more difficult to deal with,’ says Goss, a single mother. ‘It’s so rough. Why can’t it be easy? Why can’t there be something out there for people like me?’

The Goss family, like nearly 35 million Americans, has no health insurance. While state and national legislators wrangle over initiatives to provide health insurance to the uninsured, people like Goss wait, taking one wortisome day at a time, living in constant fear of serious accident or illness…..For a while Goss tried to pay for family [health insurance] coverage on her own, but after two years she gave up… ‘I had to give up,’ she says. It was either paying for that or putting food into my kids’ mouths’. (Reynolds 1987, March 2)

Later, the *Boston Globe* published a story entitled *It's a Tough Road for the Uninsured* that profiled the struggles of the Wests and other families who lacked health insurance coverage. The article stated,

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4 See for example, Reynolds (1987, March); and Dezell (1987, June 19-25).
The Wests – hardworking, solid citizens who pay their own bills – have no coverage for medical expenses. They, and nearly 600,000 other uninsured Massachusetts residents, are at the mercy of fate and the willingness of hospitals and other health providers to grant them charity status. The uninsured are also at the vortex of one of the most turbulent legislative debates in memory…At its center, the debate involves a simple, human matter: Access to the kind of care that 88% of the Commonwealth’s population can already take for granted.

‘There’s an awful lot of need for something like this,’ Andrew West said, referring to the legislation. ‘People further down the ladder are taken care of. But there are lots of people in the middle, people trying to make it, people trying to pay their bills. You shouldn’t have to be penalized for getting sick’. (Knox 1987, October 4)

Again, this article not only provided a written profile of the Wests and three other families, it also included pictures of them with their families. As Rochefort & Cobb (1994) explain, by personalizing an issue, the public is better able to relate to those affected by the problem and this increases the likelihood of categorizing this issue as a legitimate societal predicament. The article goes on to explain the tragic situation of Jim Steuert:

This is what happened to Jim Steuert, a computer engineer from Maynard, who thinks the death of his 6-year old disabled daughter, Jessica, might have been avoided if he hadn’t changed jobs – and thereby lost insurance coverage for round-the-clock home nursing care.
Jessica, who suffered from cerebral palsy and a severe respiratory defect, suffocated in her sleep on August 30th because Jim, exhausted by caring for her, slept through the alarm that sounded when she stopped breathing. (Knox 1987, October 4)

Highly emotional stories also serve to mobilize people (Baumgartner & Jones 1993).

When asked about the press coverage during this time, one interview participant recalled,

there was a general backdrop of a lot of hardship cases of people again in distinct population groups who would have horror stories about their inability to get care – or wouldn’t due to their finances - to pay for that care. So, there were anecdotical case studies that were put out there…you couldn’t write anything as bad as these people telling me what their personal stories were. (Interview 2)
Though numbers initially intimated the broad scope of this problem, these personalized and highly emotional stories —suggesting the death of a child may have resulted from a lack of health insurance —reinforced the notion of how severe this issue could become if left unresolved.

B. Problem Population

In their book on problem definition, Rochefort & Cobb (1994) explain that the way in which an issue is defined is critically important in determining its chances of reaching the political agenda and the probability of a policy outcome favorable to issue advocates. There are numerous different components that comprise how a problem is defined and consequently how an issue is perceived. Who constitutes the “problem populations” or the groups most commonly afflicted by this problem, greatly influences both public and governmental attitudes towards intervention (Rochefort & Cobb 1994, p. 22). In this case, advocates were strategic in their descriptions of the “problem population.”

The emphasis on explaining that many of these individuals were in working families was pervasive. Advocates used this as one way to connote that the affected population was one worthy of a solution to their plight. In a report profiling the uninsured, the consumer advocacy organization Health Care for All (1988, May) explained that three-quarters of the uninsured were working people and their dependents. Their report included a profile of six individuals or families who were all working, but lacking health insurance. Speaking with advocates involved during this reform episode confirmed that there was a conscious effort to depict the affected population as one the public could relate
to – a population that was hard-working and deserving of assistance. One advocate explained,

We had this, we had a communication strategy which linked this issue to real people - people who were either working people without health insurance who were getting screwed…Excuse my language, but you know, basically getting the short end of the stick. You know, these are the people, again, emphasizing the point that these are not people who are on welfare, because if you’re on welfare you have health insurance because you’re on Medicaid. But these are the people who are working hard and yet they are not provided health insurance by their employers. And so there was a fairness issue here that we wanted the public, that we wanted the voters to understand – Dukakis wanted them to understand this. (Interview 25)

Another advocate explained,

We had about 400,000 people uncovered at the time, 400 plus, and what I found out is obviously that they’re the working poor; that’s the cohort you’re talking about. The really poor get Medicaid, which is interesting. And you’ve got these working people there, and they’re mainly for the services entity – they’re the waiters and waitresses, they’re the people who do this kind of work and they don’t get any health insurance but they go to work every day! And there seemed to be such an awful disconnect. (Interview 35)

Press coverage also reinforced the image of a worthy population, reiterating that these uninsured people are generally employed. One editorial stated, “Nearly half of those without health insurance in Massachusetts are not the elderly or impoverished; they have health care coverage through federal and state programs. Rather, the uninsured are the working poor” (“Making health care universal” 1987, March 30). Another article referred to this population as, “…the thousands of non-welfare, working persons, who now have little [health insurance] or none” (Turner 1987, May 5). And again referring to the Boston Globe article on the West family, they were described as, “The Wests – hardworking, solid citizens who pay their own bills [emphasis added]– have no coverage for medical expenses” (Knox 1987, October 4). As Cook (1979) explains, there is a correlation between the
favorability of attitudes toward a group and popular support for providing aid to them (as cited in Rochefort & Cobb 1994, p.23). By describing the “problem population” in this way, advocates encouraged the public to see this group as a hard working population, deserving of assistance. These stories fostered a sensitive tone, and laid the foundation for a positive policy image (Sabatier 1999).

Nonetheless, Baumgartner and Jones (1993) argue that social conditions alone do not prompt government action; in order for policymakers to embrace a problem and place it on the agenda, it is necessary to illustrate a link between these private problems and possible public solutions. The following excerpts exemplify how participants advocating for policy change removed any culpability for this problem from the affected groups and argued explicitly that resolution of this problem required government intervention. A member of the Mayor’s Committee on Access to Health Care who was one of the primary authors of a study on insurance coverage in Massachusetts was quoted as stating, “The study shows no one is to blame if they are not insured, it is pretty arbitrary who gets insurance” (Tye 1987, June 30). Another article asserted,

About 530,000 residents of the commonwealth are currently uninsured for health costs. More than half of those who are chronically uninsured hold jobs, the private study group noted, but they work in fast-growing sectors such as retailing or service industries where employers often do not provide health benefits. Another large segment of the uninsured is dependents of workers who may have some insurance but not family coverage. This picture runs counter to popular conceptions of the uninsured as largely a “welfare” population, the authors said, and it challenges both employers and government to do something [emphasis added] about the worsening trend. (Knox 1985, September 12)

These depictions of the problem suggested that this issue was not only amenable to government solutions, but required governmental attention for resolution.
Political scientist John Kingdon (2003), whose model for agenda setting will be discussed more fully in chapter five, emphasizes the importance of the problem stream in the policymaking process. According to his theory, a “window of opportunity” for policy change occurs when the problem, political, and policy streams align. However, in order for this window to open, government must first be convinced that there is a legitimate problem that needs to be fixed. Therefore, as Kingdon (2003) highlights, the problem stream is one of the critical elements in sharpening attention to an issue and determining the decision agenda.

III. Emergence on the Agenda

Skillfully depicting and defining this problem as one that was growing, affecting a “worthy” population that people could relate to, and arguing it was rectifiable through government intervention were critical factors in enabling its emergence on the governmental agenda in 1987-1988. In addition, there were other critical variables that help to explain what prompted governmental attention to and consideration of this issue.

A. Political Leadership and Personal Commitment

After the Study Commission on Health Care Finance and Delivery Reform announced the results of its survey, including the finding that the timing was right for the state to expand insurance coverage, Senate Chair of the Ways and Means Committee, Patricia McGovern, announced her plans to file a bill in the spring of 1987 (Knox 1986, May 6). Senator McGovern was frustrated that so many working people lacked access to health insurance while many who were not working received insurance through Medicaid.
Senator McGovern was raised in the city of Lawrence, a lower income community in which many workers held low-wage jobs that did not provide health insurance benefits. These roots personalized this issue for Senator McGovern, and enabled her to sympathize with many of the individuals struggling to acquire health insurance. As the state senator representing this community, Senator McGovern felt she represented many of the constituents who fit the image of the uninsured that had been profiled (Personal Interview, also see Goldberger 1990). McGovern’s personal attachment to this issue and her commitment to finding a solution were instrumental in initiating agenda access for this issue and also played a key role in shepherding policy proposals through the complicated legislative process.

Shortly after Chairwoman McGovern filed her bill, Governor Michael Dukakis made two important announcements. First, he announced his candidacy for the Presidency (HCFA 1988, May; Kuttner 1987, June 22). Second, he announced his intent to sponsor a health care bill, since the Commission he had sponsored had not yet developed a plan (Knox 1987, June 29). Like McGovern, he had strong personal convictions that “it is unacceptable in this country for people, especially working people, not to be guaranteed basic health security” (Personal Interview).

The political leadership and personal commitment of these leaders to health care reform were fundamental to its emergence on the agenda. Baumgartner and Jones explain (1993) that speeches by public officials are seen to cause issues to shoot high on the agenda. Chairwoman McGovern and Governor Dukakis certainly used public forums and speeches to draw attention to the importance of this issue; examples will be discussed in
later sections of this chapter. In addition, there were a number of other political and economic factors that aided emergence of the issue of health care reform on the agenda.

B. Political Factors Prompting Agenda Access

The pending expiration of chapter 574 in September, the legislation dealing with cost containment and the state’s hospital reimbursement system, provided the political imperative to assess the state’s existing health care system. This legislation had created the uncompensated care pool, a funding system that provided hospitals reimbursement for bad debt or free care by imposing a uniform surcharge into regulated hospital rates paid by all private-payers. Hospitals that collected surcharge revenue exceeding the cost of uncompensated care forwarded these excess funds to the pool. Then, funds were redistributed to hospitals whose surcharges fell short of the cost of uncompensated care they had provided (Holahan et. al. 1998). Initially, one of the goals of this system was to reduce incentives on behalf of hospitals to avoid the treatment of uninsured patients. Consequently, renewal of this legislation or introduction of new policy was necessary to ensure financing mechanisms that would support the ability of the uninsured to receive necessary medical care (which practically meant guaranteeing that providers and facilities were reimbursed for care provided). When asked what prompted the 1988 Health Security Act, one interview participant who was a policymaker at the time stated, “We were coming out of a hospital financing law. I can’t remember the details...it was expiring, and that was part of the leverage that was used to push this through” (Interview 2). Former Governor Dukakis also asserted, when asked what prompted him to push for universal health care and the employer mandate,
…it was basically, what are we going to do about this large and growing burden on employers… And this is, by the way, a time when we were regulating hospital costs. And that was very much, as you know, part and parcel with this [the universal health care reform in 1988]. (Personal Interview with Governor Dukakis)

Thus, the pending expiration of existing health policy legislation provided the impetus to evaluate the current health care financing and delivery system.

Another political variable that some have suggested factored prominently into agenda access for health care reform was Governor Dukakis’s presidential candidacy and political power. Baumgartner and Jones (1993) argue that presidential involvement in a policy issue can be key to pushing issues high on the agenda. Though not the president, as a potential presidential candidate Governor Dukakis became a well-known governor, and his personal involvement in this issue became especially important. Many suggested that the governor’s presidential candidacy motivated both him and the legislature to demonstrate their dedication and ability to resolve this issue, giving it priority agenda status. For Dukakis, it was important to consider the implications that addressing or failing to address the problem of the uninsured might have on his presidential campaign and platform. When asked what factors prompted this reform episode, an interviewee who was working as a Ways and Means staff person during the latter part of the 1980s replied, “You had a governor running for president…It provided the political imperatives for both the legislature and the governor; the governor first and then the legislature to do something on reform. He was running for president. The uninsured was an issue, the democratic legislature certainly wanted to see a Democratic president” (Interview 13). One legislator during this reform episode suggested that Governor Dukakis’s presidential campaign was
one of the “biggest” influences on prompting legislative consideration of health care reform. He suggested,

If you read the timeline and some of the history on it [the Health Security Act], it was really Pat McGovern who kind of launched this idea. And at the time, Dukakis and Phil Johnston were opposed to it saying it goes too far, too big. As they started tapping, as we started getting into the issue and then healthcare started to be identified as a major concern, I suspect the governors’ advisors found that health insurance might be a wedge issue or a latent issue that candidates weren’t really focusing on and would be a very important tool for him going into the presidential race. So, it was important for him. Mike Dukakis controlled the state in the late eighties. He controlled bureaucracy with just incredible discipline and skill. He controlled the party and for practical purposes was the party. He had tremendous sway over the media coverage and the framing of political issues so if you did not have his support for an initiative as aggressive or bold as this, it probably would have been stillborn. And I think the presidential race got him interested in it. (Interview 2)

Timing was critical; this issue began to emerge as an existing health care policy was expiring, and as the governor announced his intentions to wage a presidential campaign. These conditions provided a political environment that impelled this issue to the forefront of the agenda.

C. Economic Factors and Vested Interests: Business and Hospitals

Certain economic variables also aided this issue in acquiring a position on the political agenda. Advocates eager for this issue to gain agenda access were skillful in promoting a new understanding of the issue to encourage business support for legislative action (Baumgartner & Jones 1993). The issue became one not just of equity and fairness for the uninsured, but also for the business community. Nelson Gifford, Chairman of the Health Care Task Force for the Massachusetts Business Roundtable, was an outspoken supporter of health care reform for this reason. As a representative of the Massachusetts Business
Roundtable, he argued vociferously that universal health insurance would ultimately minimize costs for business by decreasing business liability through the uncompensated care pool. Moreover, Gifford argued that it was not fair for employers who did offer health insurance to pick up the costs of those employers unwilling to do so (indirectly – through financing of the uncompensated care pool) (Goldberger 1990; Interview 27).

Another advocate who promoted the 1988 health care reform explained,

If someone is paying for something then, they’re going to be more likely to, their going to see it as in their own self interest. Essentially, they [business] bought into the argument that they were paying for the workers of people who weren’t paying for health insurance. (Interview 8)

The comments of many interview participants echoed these same or similar sentiments. One participant who was a state bureaucrat at the time explained, “Because the state had set up the uncompensated care pool a few years before…I think the kind of inequities that [the surcharge used to fund the uncompensated care pool] was beginning to create for employers who provided coverage, were paying twice. So they paid for the coverage and then paid again through the pool” (Interview 9), while another leader of a business organization stated, “the rest of the business community was picking up what those who should have been doing something about [providing health insurance to their employees] wouldn’t voluntarily do” (Interview 3). The press also presented this issue in terms of economic fairness to business. As one article in the Boston Globe explained,

…Massachusetts companies that offer their employees health insurance are already paying $325 million in a hidden “payroll” tax. It is masked as a 13% surtax on their health insurance premiums, which is pooled and used to cover hospital bills of the uninsured…These companies are subsidizing other companies – largely those in the building trades, fast-food chains, and retail and grocery businesses – that do not offer their workers health insurance.” (“A health care benchmark” 1987, August 10)
In studying the process of health policy change in Massachusetts, Bergthold (1990) concluded that economic problems for business led to their political mobilization. Indeed, concerns regarding the economic impact of rising health insurance premiums and the equity or fairness of the current financing system encouraged business to become supportive of governmental attention to this issue. For example, Tom Davidson, comptroller for Shawmut Design and Construction company, argued that the system imposed an unfair economic burden on his company and put them at a competitive disadvantage. As a small company, Shawmut paid approximately $250,000 per year in order to provide health insurance for its employees, but Davidson estimated about $32,000 of that was funneled to the uncompensated care pool to provide reimbursement for the care of workers whose employers did not provide insurance. Consequently, he was a vocal proponent of health care reform options that would alleviate this economic burden and address these inequities (DiNardo 1987, November 30). An advocate for health care reform in 1988 explained in an interview,

they [the business community] had an interest at the time because the uncompensated care costs were going up so much and those costs were being built into hospital costs and therefore to premiums, and I think the uncompensated care costs was something like 18% at the time so there was a direct interest in the part of the business community to do something about that. (Interview 5)

In the end, businesses that were providing health insurance began to feel increasingly burdened by the economic implications of the existing health care system, and this prompted them to encourage the emergence of this issue on the legislative agenda.

Similarly, hospitals had an economic incentive that prompted them to promote governmental discussion of health care finance and delivery issues. Hospitals had become
dependent upon the uncompensated care pool and the resources it dispensed. With chapter 574 expiring and the continuation of the pool uncertain, hospitals became increasingly concerned as to how they would be reimbursed for free care and bad debt care they provided. As one news article explained, “the expiration of the state’s hospital financing law…has increased pressure for legislative action, since it removed the mechanism for transferring about $800,000 a day from hospitals with below-average levels of ‘bad debt and free care’ to the 30 institutions that provide the bulk of care to the uninsured” (Knox 1987, October 20). Though hospitals were most concerned about their economic viability as a result of the expiration of this law, their push for consideration of this issue was linked ideologically (and later legislatively) to the broader issue of discerning a mechanism to provide coverage for the uninsured, many of whom relied on uncompensated care pool funds to cover their care.

IV. Politics, Economics and the Policy Struggle

A. Developing Policy Options: The Introduction of Plans to Insure the Uninsured

In February of 1987, Senator McGovern filed bill S. 1690 in an effort to address the Commonwealth’s problem of uninsured residents. The plan included: a 2% payroll tax on employers who did not provide health insurance to their employees, a 1% percent tax on their employees, a .5% payroll tax on all employers, and money from general revenues to fund a state insurance program (Goldberger 1990; Office of the House Minority Leader 1988, February; HCFA 1988; Winston 1987, February 26). Following the unveiling of Senator McGovern’s plan, representatives from the gubernatorial administration commented that they intended to work with the Senator on the issue of health care reform.
Their goal was to design a plan that would address the problem of the uninsured but avoided the imposition of any new taxes in the Commonwealth (Winston 1987, February 26; Knox 1987, June 29). Over time, debate and discussion regarding the McGovern plan and the need for reform soared and anticipation for the administration plan grew.

Finally, in August, Governor Dukakis responded with a basic outline of the health reform plan he intended to file. The Governor’s proposal hinged on acquiring Congressional exemption from the 1974 Employee Retirement Income Security Act (ERISA) legislation that prohibits states from requiring employers to provide health insurance coverage (Knox & Winston 1987, August 14). According to his proposal, employers would be required to provide health insurance to their employees and families directly, which would circumvent the need for a new state tax to fund health insurance for the uninsured. Additionally, state funds currently used to underwrite uncompensated hospital care would be utilized to purchase health insurance for the unemployed and disabled.

If the state were unable to attain the ERISA exemption that would allow them to implement this plan, the Administration would alternatively impose a surcharge on the unemployment insurance all businesses were required to purchase. Employers would have the option of choosing to provide insurance or paying a 12% surcharge on the unemployment insurance they must buy for each employee (Knox 1987, September 10). All businesses would be required to pay an unemployment insurance surcharge of 0.13 percent (approximately $18 a year for every employee) to fund health insurance for unemployed Massachusetts residents (Knox 1987, October 4). The revenues from these surcharges would be administered by a new state agency, the Health Partnership, which
would combine these proceeds with the hospital surcharge revenue collected to fund the uncompensated care pool. The prospective state agency would utilize these aggregate funds to purchase health insurance for the uninsured (Knox & Winston 1987, August 14). Additionally, in an effort to impose some cost controls on the health care system, Dukakis included a provision that would limit the amount hospitals would be able to increase their charges for 1988.5 As Phillip Johnston explained just after Senator McGovern announced her plan, “I’m not going to speculate on what the [Dukakis’s] bill will look like. But I don’t believe the Governor is anxious to impose any new tax on the people of the Commonwealth” (Knox 1987, June 29). In the end as Johnston suggested, the plan presented by Dukakis included a politically savvy policy alternative to new taxes. Since payments to cover unemployment compensation are technically defined as contributions rather than insurance premiums or taxes, the governor and his team had devised a revenue raising strategy that did not rely on new taxes (“A health-care bench mark” 1987, August 10). At a time when the governor was considering a presidential run, this distinction was critical. In September, the governor formally introduced his bill, S. 6000.

The decision of these two policymakers, Governor Dukakis and Senator McGovern, to address the issue of the uninsured reflected that what had previously been considered a “private problem” had reached a threshold that required a public response. In fact, some of the media coverage after Dukakis’s announcement of his plan suggested that the problem of the uninsured was due to a structural flaw and that government had

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5 Dukakis’s plan included a provision that would limit the amount hospitals could increase their charges by to the overall rate of inflation in medical care plus two percent. As will be discussed later in this chapter, this became one of the most contentious aspects of the legislation See for example, Foreman (1987, September 13); Winston (1987, September 17); and Phillips (1987, September 29).
the ability to “fix” this problem (Baumgartner and Jones 1993, p. 28). As one editorial stated, “It [Dukakis’s plan] lays the groundwork for straightening out much that is wrong with the patchwork of health-care services, the mismatch of state and insurance funding, the hodgepodge of rates for reimbursement and the unfair payment by companies stuck with paying the whole tab for hospital losses on unpaid bills” (“A visionary health bill” 1987, Sept. 12). Nonetheless, this acknowledgement – that the current problem of the uninsured required a public response and that the governor’s plan laid the groundwork for a solution – generated a new round of debate, controversy, and power struggles between the state and vested interests in the private market as to how responsibilities should be divided in order to resolve this issue. Hospitals and businesses, which had an economic stake in the outcome of this legislation, became greatly involved in trying to influence policymakers to ensure that the plan that ultimately emerged divided these responsibilities according to their preferences. Policymakers wrangled with these interests in an effort to balance the preferences of industry stakeholders with their own personal and political goals.

B. Policy Evolution

At the outset, many expected that the health care bill Governor Dukakis proposed would sail through the legislative process quickly (Black 1987, September 9). However, as seems to be the case with most major reform proposals, when various interests scrutinized the details of the plan, stakeholders who had previously supported reform became increasingly critical of certain elements in the proposal and the initial overarching support began to wane.
In explaining the nature of political conflict, Schattschneider (1975) argued that the outcome of all conflict is determined by the scope of its contagion; that is, the number of participants that become involved in a problem affects the results. Consequently, he argued that for policy proponents to “win” it is in their best interest to define a problem in such a way so as to maximize the number of participants involved and to increase the intensity of the debate on this issue. Considering Schattschneider’s (1975) explanation of the process of political conflict, Cobb and Ross (1997) sought to explain why, if all issues have the potential to be expanded, some are expanded but others are restricted. While Schattschneider (1975) focused on the perspective of proponents who seek agenda access for a new issue or policy, Cobb and Ross (1997) provide insight into the tactics and strategies used by those opposed to consideration of a new issue or policy. They highlight the numerous issue attack strategies that opponents can use in their efforts to restrict the scope of an issue and deny it agenda access. 6 As the sections below will illustrate, in this case, opponents used both fear and negative spillover strategies to restrict this issue. In their efforts to reach their desired outcome - retention of the status quo - opponents used these strategies to define the proposed policy as one that would actually make the situation worse.

Nonetheless, chapter 23 of the acts of 1988 was officially passed nearly 8 months after the formal announcement of Dukakis’s plan. In the end, though the final legislation had pieces of both the McGovern and Dukakis proposals, it had clearly evolved as a result of the influence of numerous vested interests.

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6 For more on this topic see Cobb & Ross (1997), p. 25-45.
Round 1: The influence of dominant structural interests

Not surprisingly, bills of this magnitude, designed to radically alter the health care system in Massachusetts, are sure to acquire much attention from those who might be impacted by any change to the existing system. This was certainly the case in 1987 and 1988. According to one account, the health industry spent about $2.2 million on lobbying activities in 1987; this constituted about one-fifth of the total spent by all special interest groups for lobbying purposes in Massachusetts. By way of contrast, in 1986, the same health-related groups spent $1.6 million (Phillips 1988, May 3). Hospitals were estimated to have spent nearly $500,000 on lobbying activities related to the health care reform bills, while Blue Cross and Blue Shield spent nearly $200,000 (Phillips & Mohl 1988, January 16).

As described in the previous chapter, one recurring theme in political economy literature is the ability of political and economic elites to control the direction of reform initiatives. According to Alford’s (1975) “structural interest” perspective “powerful interests benefit from the health care system precisely as it is…these interests do not have to exert ‘power’ to influence ‘decisions’ except to block proposals for change” (p. 6). Gordon (2003) argued economic interests have a profound impact and advantage in influencing the outcome of health reform efforts, often by simply outspending reformers. Though these spending patterns provide a glimpse into the involvement of certain vested interests in influencing the health care policy process, a qualitative review of the process leading up to the enactment of chapter 23 reveals how powerfully certain dominant political and economic interests were able to influence policy outcomes and block any policy changes that adversely impacted their economic circumstances.
The hospital industry

With the existing hospital financing legislation expiring imminently and the inclusion of a hospital financing element in Governor Dukakis’s policy proposal, the hospital industry became increasingly active in voicing and demonstrating their concerns with this legislation. The administration did try to preemptively alleviate pressure that it anticipated from the hospitals; in order to offset level funding in reimbursements from the federal Medicare program and cutbacks in state funding of Medicaid, the rate limits proposed by the administration would enable hospitals to receive up to $190 million more in revenue (than in 1987) in the upcoming year. Nonetheless, the hospital industry still felt this proposition was insufficient.

Different tactics were employed to make certain that the hospitals’ voice was heard and that policymakers respected their strength and clout. Consistent with the strategies of agenda denial described by Cobb and Ross (1997), the Massachusetts Hospital Association (MHA), an organization with high group legitimacy, utilized fear strategies to convince members of the adverse implications that would result from a hospital revenue cap. Hospital workers were told that without millions of dollars in additional funding, programs would be cut, salary freezes would be put in place, and layoffs would certainly result. One hospital employee, who had worked for two and a half years at Massachusetts General Hospital in the supply department, was profiled in a news article. He explained that management held a series of meetings with employees about the bill’s effects. He stated, “they [hospital managers] said if the cap is on, they would have to cut back on jobs, freeze salaries and close some departments. I don’t want that to happen. I have a family”

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7 See for example, Winston (1987, September 17); and Knox (1987, Sept. 15).
In order to increase their numbers and therefore impact, the hospitals convinced their staff and employees to support their cause by making them fearful of the impact on their economic livelihood if the current proposal passed. Using this issue attack strategy, the MHA was able to discredit arguments that their funding was sufficient and redefine the way this issue was perceived to increase the likelihood of an outcome favorable to their economic interest.

On September 16, 1987, to increase public pressure on policymakers to respond to demands for increased funding for the hospital industry, the MHA bused nurses and hospital workers from all over the state to rally in front of the State House (Knox 1987, September 10; Winston 1987, September 17). Some suggested that to encourage participation, hospitals allowed workers to leave their shifts at the hospital and paid them for their time away from work. Many came dressed in their hospital uniforms and carried signs with slogans such as, “Gov’s Bill Hazardous to Health” (Winston 1987, September 17). Estimates at the time suggested anywhere from 6,500 to 10,000 workers participated in the rally (Winston 1987, September 17). Indicative of the powerful impact this event had, one interview participant who was actively involved in drafting the gubernatorial health policy reform proposal was able to vividly recall this incident nearly twenty years later. He explained,

In ’87 and ’88 the hospitals and the nurses were actually quite, as I recall it, unified around some things and I remember when the hospitals decided that the version of the bill that we originally filed did not include enough in the way of rate growth for them they put what I remember as 10,000 nurses on Boston Common for a rally. Maybe it wasn’t 10,000, but it felt like 10,000 and I remember being able to hear them…And you know, I walked down to the rally, it was a very impressive rally…I think I kind of got at that time, as much as I still did have to learn, if nurses are worried that’s not a good, that’s you know, usually a sign that there may be a substantive
problem and certainly there could also be a political problem. So we ended up, I ended up having to win some arguments internal to the administration around wanting to put more money on the table for the hospitals because we needed the hospitals and the nurses. (Interview 34)

As this member of the administration highlighted, the intense lobbying and rallying activities of the hospitals did impact the substance of the health reform proposals. Fearing hospital resistance to the rate caps and projected hospital revenues in the Dukakis proposal would result in the demise of the universal health care bill in its entirety, legislators felt compelled to make some changes to the bill. In October, in an effort to make some political compromises which will be discussed in more detail below, the House Ways and Means committee re-worked the governor's bill to include a number of different revenue raising provisions for hospitals including a stipulation that would allow hospital rates to increase up to medical inflation plus an additional three percent, enabling hospitals to earn up to $348 million in hospital revenues in 1988. Clearly, the voice of the hospitals was heard. Still, the hospital industry continued to lobby around the universal health care bill and insisted on the need for additional revenue.

*The business community*

As highlighted above, the impetus for involvement in this issue on behalf of the business community was cost. Under the existing arrangement, the costs imposed on businesses that provided health insurance via hospital surcharges were becomingly increasingly burdensome. Consequently, many businesses that were providing health insurance were initial supporters of health care reform because they felt reform might address their cost concerns. However, as the details of reform proposals emerged and the
political activity surrounding the proposals intensified, the potential economic implications of the Dukakis health care reform prompted not only businesses previously involved to reconsider their stance on health care reform, but also precipitated the involvement of the small business community – which was not previously as involved - in the health care debate discussion.

Bergthold (1988) explained in analyzing the role of business in the 1988 health care reform episode that business “couldn’t afford not to get involved” (p. 428). Though this was clearly important for larger businesses in their quest to put health care reform on the agenda, this attitude prevailed among both large and small businesses following the introduction of actual legislative proposals designed to reform the health care system. After learning of the inclusion of an employer mandate in the Dukakis health care bill, small organizations felt threatened by the possibility of legislation requiring them to provide health insurance to their workers. Comments from active participants involved in this reform, newspaper articles from this time, and excerpts from the legislative floor debates on this bill highlight how prominently economic arguments shaped the lobbying efforts of the small business community and the discourse surrounding the Dukakis reform proposal. While the hospital industry used fear tactics to influence the public and policymakers, business used what Cobb and Ross (1997) categorize as a “negative spillover” strategy (Cobb & Ross 1997, p. 42). The message from business was not just that this bill was bad for small business, but rather, would spillover and have devastating impacts on the Massachusetts economy as a whole.

One Republican policymaker who was actively opposed to the reform explained in an interview that,
pragmatically, a bunch of us felt that the underpinnings of this things were a little soft and that there was an enormous potential for an enormous resentment out there from the business community at the time, particularly the smaller businessmen…but all in all, in a place that had a lot of small businessmen, you know – landscapers, restaurants, stuff like that – it was perceived as you know, an economic kind of disaster for them. (Interview 6)

Another interviewee who worked at a small business industry group at the time of the 1988 reform was asked what concerns her organization had with the Dukakis proposal. She responded,

it [the reform] was more hurting existing companies that couldn’t afford it, it was also the potential of discouraging people from starting new companies because that would be another…be a benefit or an expense they would have to factor into their area and this is a particular concern for those mom and pop type companies. You know what I mean, a pizza joint. You’d have to sell a lot of pizzas to add that benefit – so there was that. (Interview 12)

Later, when asked how these concerns were conveyed to policymakers, she stated, “we [the small business community] talked about lost jobs, slow down in the economy, slow down in job creation, people being laid off” (Interview 12).

“Six months ago, David Arvedon was a small business owner. Now, thanks to Gov. Dukakis’s universal health insurance proposal, Arvedon says he’s a ‘small business activist’” (Bailey 1987, September 15). This is the preamble to an article featured in the Boston Globe following the introduction of Dukakis’s reform proposal. It goes on to state,

Arvedon worries that, in trying to shape a workable health insurance program, the Dukakis administration has ignored the interests of small business. And by small business, Arvedon does not mean the budding Reeboks or Bildners, he means the hundreds of mom and pop business owners who can’t afford membership in the Small Business Association and wouldn’t have time to attend the meetings if they could. “This bill is dynamite for small business…I know at least two of my commercial tenants would be willing to go out of business and move out of state should
the law pass. How many more tenants are like that’ he asks. (Bailey 1987, September 15)

The testimony of various representatives from a House session focused predominantly on this bill echoed many of the same themes highlighted above and also revealed how heavily opposition rested on arguments regarding the adverse economic repercussions of this bill. In his testimony, Representative Morin argued,

the most important concern and fear I have is how this bill is going to affect the Massachusetts miracle. I am concerned about my constituents on Cape Cod who work in small businesses that are going to have to cope with the mandates in this bill…I can’t support this. I’d rather have employed, uninsured people in Massachusetts than I would unemployed insured people in Massachusetts. And until I am sure this bill will not do that, I cannot support it. (SHNS 1988, February)

Later, Representative Pierce asked, “what do we gain if we mandate that happy objective [universal health insurance] in Massachusetts, only to cause small businesses to fail, potential businesses not to be created, or small businesses to be driven out of Massachusetts? I think that is a foolish policy” (SHNS 1988, February). Just before the House adjourned from this session, Representative Marsh argued,

what will this bill do to the Massachusetts economy? What we don’t realize is times are coming right now that are going to cause problems. Not only is the budget way out of whack, but the growth in jobs has slowed….if you talk to any economists looking at Massachusetts, where is this mandate going to effect? In the service industry. All it’s going to add to is our unemployment rate. (SHNS 1988, February)

These accounts help depict how the details of the Dukakis health care plan, specifically the inclusion of an employer mandate, propelled the small business community into the health care reform debate. Just as the small business community began actively voicing concerns with the universal health care bill, the big business community reneged on their previous position and joined in opposing the reform. This transition in stance was
largely provoked by the realization that the influence of other vested interests resulted in the inclusion of some elements in the health care reform bill that would not provide business with an economic reprieve from rising health care costs. Cost containment had been the motivating factor behind the initial support of reform by big business.

Interestingly, as policymakers wrestled with the details of health care reform, it became apparent that they would have to deal with the difficult predicament of balancing the contrasting preferences of two powerful vested interests. The hospital industry was focused on ensuring any new legislation would enable them to collect what they foresaw as adequate revenues in the upcoming years. Simultaneously, business was focused on encouraging legislation that would curtail its liability for rising health care costs. Since increases in hospital charges would likely result in increases in the costs of providing health insurance for employers, as well as potential increases in what employers would be forced to contribute to the uncompensated care pool, the primary objectives of these two vested and powerful interests were clearly at odds.

The previous section detailing the hospital industry influence on policy evolution highlighted how policymakers, in their efforts to appease the interests of the hospital industry, began toying with legislative provisions within the universal health care bill that would allow increases in hospital revenues in coming years. In trying to minimize opposition from one industry group, the legislature invoked fierce new opposition from another.

The tenuous support big business had offered in support of a health care reform initiative evaporated when the policy evolved to include hospital financing elements that,
from the perspective of business, would elude the objective of containing health insurance
costs (Bailey 1987, October 2). In the words of one reporter,

business was on board but took back support when the legislators made
changes that ‘blew off the caps’ on hospital cost containment...from the
point of view of major business, extending health insurance to all workers
in the Commonwealth would not necessarily be that expensive if soaring
hospital costs could be contained and if the burden of picking up the tab
for those currently uninsured is spread around a bit. Virtually all major
businesses already offer medical insurance to employees and, presently, end
up paying extra for businesses that don’t insure because of mandatory
contributions to the hospital’s bad debt pool – the uninsured pool….Big
business then stood to pay no more overall, and perhaps to pick up some
savings if the Dukakis guaranteed health plan did not get too generous with
mandatory benefits and if it curbed hospital costs. (Butterfield 1987,
October 4)

Just as economic interest had prompted business to the table to support health care
reform, as the details of a policy evolved, economic interest prompted business to decry
the prospect of this reform initiative. As one representative from a business industry
organization was quoted, “…always, big business had a bottom line. Last week, the line
was crossed” (Butterfield 1987, October 4). Goldberger (1990) highlighted in her article
chronicling the passage of the Health Security Act that the universal health care law
evolved from legislation focused solely on increasing access to health insurance to become
a vehicle by which hospitals and business hoped to accomplish their respective financing
and cost objectives. The difficulty in reconciling these contrasting objectives nearly
undermined the reform initiative entirely.

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8 New provisions in the universal health care bill were amended to allow hospital costs to increase with
inflation plus three percent; previously the legislation capped these increases at inflation plus one percent.
Dividing responsibility: the relative role of the state vs. the market

In addition to the arguments above launched by business and the hospitals, a fundamental controversy inherent in the policy reform discussion regarded who – the public sector or the private sector - should be responsible for managing and resolving the problem of the uninsured and how – through regulations and mandates or market incentives – it might best be accomplished. This tension also pervaded the rhetoric following the introduction of the McGovern and Dukakis reform proposals. For example, some perceived the Massachusetts Health Partnership, the agency proposed in the original Dukakis health care bill, as a potentially unwieldy government bureaucracy that would have too much power. One hospital director decried, “if this [the Dukakis health care reform proposal] passes, we might as well turn over our keys to the state” (Knox 1987, September 20).

Interestingly, while hospitals were opposed to the development of such a large state agency because of concerns it might adversely impact their ability to negotiate rates, some private health insurers wanted to ensure expansive powers of the agency to inspect individuals’ bank and insurance records in order to guarantee that those purchasing through the Partnership were not individuals who could afford to purchase health insurance through the private market. Other insurance representatives expressed qualms about the vagueness in the language establishing the Partnership, and the possibility that such a large organization could ultimately be a large competitor for smaller health insurance organizations. Despite reassurances from state administrators regarding the

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9 In the initial draft of the Governor’s proposal, the Authority would set hospital charges and also serve as the largest purchaser of health insurance in the state (see for example, Knox (1987, September 20)).
Round 2: The resurrection of reform

On October 1, 1987 in the midst of the commotion surrounding the universal health care reform, the existing legislation (chapter 574) guiding the transfer of funds to hospitals for the provision of free care expired. This event heightened the stakes and urgency of reform for the hospital industry and provided policymakers with some new negotiating power. The legislature did plan to file an extension to the existing financing law, which eventually had political relevance for the outcome of a universal health care bill. If the legislature extended the existing hospital financing law for a long period of time, the hospital industry might be more willing to negotiate on a universal health care bill that also allowed an increase in hospital revenues (Knox 1987, October 14). As one article in the Boston Globe explained, “the length of an extension is considered crucial by both [state and hospital] sides, since a longer-term extension puts greater financial pressure on hospitals to compromise. Thus, if hospitals succeed in shortening the extension, their position in
further negotiations over cost control and *other* [emphasis added] issues would be strengthened” (Knox 1987, October 14). Moreover, without some legal action relative to the existing hospital financing system, the expiration of the law meant that although revenue for hospitals was still being collected via the surcharge on hospital bills, there was no longer any legal regulations dictating the distribution of those revenues to hospitals that had provided free care (Knox 1987, October 15). In the end, despite opposition from Representative Forman who pressed for extending the existing hospital financing legislation for 60 days, the House of Representatives passed and sent H. 6096 to the state Senate in mid-October. This legislation authorized an extension of the existing hospital financing arrangement for six months (Office of the House Minority Leader 1988, February).

When it arrived at the Senate, this legislation was solely dedicated to hospital financing. However, having been unsuccessful at building consensus for a universal health care bill, both Patricia McGovern and Michael Dukakis promptly recognized the political opportunity presented by the concurrence of discussions regarding the need for hospital financing and health reform. This circumstance was one that could be utilized to resurrect the prospects for a universal health care bill; given the perceived urgency of the hospital financing situation, this piece of legislation might also be a viable vehicle for revival of universal health insurance legislation.

*Political leadership*

Given their investment in health care reform, neither Senator Patricia McGovern nor Governor Michael Dukakis were willing to let the possibility of health care reform slip
away easily. Despite the dramatic change in attitudes toward health care reform among vested interests, and the growing rift between those involved in the health care reform debate, these political leaders were determined to reignite interest in, and build consensus for, a health reform package. To rekindle this focus on health care reform, Senator Patricia McGovern announced a Senate Ways and Means Committee hearing to address this topic. By making this announcement and scheduling this hearing, Senator McGovern re-centered the debate on health care reform, not simply hospital financing, and prompted advocates and other supporters to refuel their lobbying efforts in support of health care reform.

On October 27, 1987, the Senate Ways and Means Committee held a day long hearing on health care reform. Not surprisingly, given both the Governor’s and the Senator’s dedication to health care reform, both leaders testified at this well attended event. Addressing the crowd of approximately 1,000 to 2,000 people, Governor Dukakis tried to prompt policymakers to action declaring that, “The eyes of the nation are on Massachusetts. We fired the shot once that was heard around the world, and I suggest to you today that we have an opportunity to fire another shot that will be heard in Washington and in state capitals all across this country” (Sleeper & Knox 1987, October 28). Chairwoman McGovern also galvanized support by arguing that “vested institutional interests” should not be able to keep Massachusetts from passing much needed health care reform. Her remarks initiated a call to action. “I say we can beat them [vested institutional interests], and I think we should beat them” she affirmed (Sleeper & Knox 1987, October 28). This hearing marked a turning point in the debate on health care reform; just as it seemed the drive for universal access was about to die, this event reestablished the importance of this issue and redefined health care reform as a legislative priority. The
general public, advocates, opponents, policymakers, and the powerful vested interests who had been involved in smothering the previous reform bills recognized these political leaders were not willing to let the opportunity to address this issue expire without legislative action.

Senator McGovern’s dedication to devising a reform package that met her objective of increasing access to health insurance for the uninsured and also appeasing the concerns of vested interests was especially noted by the media. Over the next few months, she worked tirelessly to listen to the concerns of hospitals, consumer groups, insurers, and business – all parties interested in health care reform and concerned as to how it might impact them. Her objective was to formulate a reform proposal that would be mindful of these concerns, yet still include some mechanism to provide universal health insurance.

Numerous groups and individuals who were involved in the policy process at this time also noted the importance of Senator McGovern’s dedication to building consensus among different stakeholders in order to devise a consensus reform package. Health Care for All, one advocacy organization that was just becoming the prominent player it has since become, has chronicled the passage of Chapter 58. In their chronology, they identified Senator McGovern as the individual who “engaged in intensive negotiations to re-establish a consensus for health care reform that included universal access” (Health Care for All 1988, May). According to the written chronology of a Republican legislator at the time, in November of 1987, Senator McGovern held a series of closed door negotiations with the

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10 See for example, Knox (1987, October 20); “Countdown on health care” (1987, November 9); Knox (1987, November 22); Mansfield (1987, November 29); Knox (1987, December 10); and Knox (1987, December 18).
diverse constituencies that might be affected by a universal health care law (Office of the House Minority Leader 1988, February).

These meetings with key stakeholders enabled Senator Patricia McGovern to gain a better appreciation of concerns associated with the reform, but also forced involved stakeholders to recognize the anxieties of other key players. Perhaps most importantly, holding these meetings with key players to discuss and negotiate aspects of health care reform gradually allowed players to respect and trust one another. One policymaker intimately involved in these meetings described them as follows,

…we used to meet a couple times a week. We finally started meeting Saturday mornings …we had breakfast. And people could wear jeans or dress down and people who didn’t like each other got to start asking each other about kids, there were other kids that you know….’I got to go to a soccer game; I have to leave today at 12.’ And somebody else would say ‘Oh, your kids play soccer? Well, my kid does too. And you’d start relationship building and people realized that the people in the room were good hearted, meant well, each had a job to do and….built consensus by keeping people in the room, bringing them together and by such techniques as, you know it sounds funny in retrospect, but providing coffee and muffins and donuts and bagels and they’d come in a little early, have a little breakfast, and we’d start the discussion. (Interview 35)

As a result of these meetings and the information she learned from them, Senator McGovern began re-crafting a health insurance reform plan that still aimed at universal access, but included some different mechanisms to placate the concerns of these stakeholders. This new plan included an allowance of about 4.6% increase in hospital rates due to inflation plus two percent in FY 1988 and an allowance of inflation plus one percent in FY 1989, as well as the following elements to be phased in over time: a requirement that all Massachusetts businesses provide either $1,680 in health insurance benefits for employees who are heads of household, and work at least 30 hours per week, or a
contribution of that amount toward a state fund which would provide basic coverage for these employees; a temporary tax credit available to businesses not currently providing insurance to encourage them to offer health insurance available through a newly created state Department of Health Security; the availability of state assistance to businesses whose health care costs consume more than five percent of gross revenues; the imposition of a small surcharge on the unemployment insurance premiums business must pay to fund insurance coverage for workers actively seeking work; and a program to provide coverage to the disabled who wish to work and for students through colleges and universities (Wong & Knox 1987, December 21; Knox 1987, December 22). These elements were to be phased in over time and the surcharge on employers who did not provide their employees’ health insurance (often referred to as the “pay or play” provision of the law) would not be instated until January of 1992. Recognizing the political opportunity before her, Chairwoman McGovern and her committee voted to attach this universal health care plan as an amendment to the hospital financing bill, H. 6096, which had arrived at the Senate from the House. The Senate promptly approved the bill with this amendment on December 21, 1987 and sent it back to the House for its consideration and approval.

Governor Dukakis, recognizing how close the state was to passing a universal health care law, canceled a scheduled Presidential campaign trip to Iowa in order to be present at the State House and encourage the House to pass the health reform bill. The hopes of Dukakis and McGovern were quickly dashed, however, as House Speaker George Keverian did not put the bill on the legislative docket of the House. While the Speaker argued this decision was a practical one, arguing there was insufficient time left in the legislative session (ending January 5th, 1988) to address such a complex bill, many
questioned whether this decision was instead a political one designed to remind the executive branch and the Senate that the House was an equally powerful political player that would not simply sign off on the work of the other branches. The House did not pass the comprehensive universal health care and hospital financing bill that was sent over by the Senate, but both houses of the legislature did manage to pass and send to the Governor a hospital financing bill that would immediately provide funds to community hospitals before the end of the legislative session.

Governor Dukakis began the start of the 1988 legislative session by drafting a memo to both houses of the legislature restating his commitment to health care reform and his desire for Massachusetts to become the first state to make this historic achievement. Shortly thereafter, he re-filed the outline of a bill quite similar to that previously passed by the Senate. During this time, he mulled the possibility of pocket vetoing the hospital financing legislation designed to bring aid to community hospitals presented to him at the close of last session; without his signature, the bill would die. The Governor recognized the possibility that by signing this legislation without the universal health care portion attached, the opportunity to pass comprehensive legislation might be lost. These defiant actions – Speaker Keverian’s dismissal of the health care reform bill and the Governor’s resistance to sign hospital financing legislation - inaugurated a political power struggle between the House and the executive branch. By dismissing the financing legislation, the Governor enraged many of the legislators in whose districts these hospitals were located, and consequently they were increasingly unwilling to support the Governor’s universal health care bill. In addition, because of his refusal to sign the hospital financing legislation,
many of the hospitals rescinded the support they had previously indicated for the universal health care bill that had been so carefully devised. The result was gridlock.\textsuperscript{11}

Ultimately, in an effort to break this gridlock and re-establish an environment conducive to negotiating health care reform, Governor Dukakis agreed to a temporary aid package that would be granted to those hospitals most adversely impacted by the expiration of the hospital financing legislation. However, the Governor was sure to emphasize that his agreement to the legislation that would provide this aid was based on it providing a \textit{temporary} fix (that would allow hospitals to postpone layoffs and cutbacks that they argued were imminent) until a grander resolution could be reached (Mohl 1988, January 15).

\textit{Shepherding the bill through the final stages}

Having appeased many of the original political foes, Governor Dukakis once again committed himself to endorsing universal health care reform; this time, he actively lobbied and met with members of the House who had been previously opposed and tried to work closely with the members of the legislature to acquire their support for a universal health care bill (Knox 1988, February 25). In mid February, the House finally began to coalesce around a health care reform bill that did not look dramatically different from the one sent over from the Senate at the conclusion of the 1987 legislative session. The main differences included: last minute amendments to the House bill that would dramatically increase state aid given to hospitals (estimates indicated this would cost the state between $30-$50 million dollars over each of the subsequent four years); a provision that exempted

\textsuperscript{11} See for example, Office of the House Minority Leader (1988, February); and Wells (1988, January 15).
businesses of 6 or fewer employees from the mandate (vs. no business exemptions regardless of size in the Senate bill); the requirement that businesses cover employees who work 27 hours per week or more (vs. 30 hours per week in the Senate bill) and employees who work 20 hours or more per week after six months of employment; and a revised deadline of October 1, 1989 by which date colleges and universities would be required to provide health insurance to all students (vs. July 1, 1988 in the Senate bill) (Wells 1988, March 1; Knox 1988, March 10). For about a month, representatives wrestled with each other over plan details behind closed doors as the House sought to finalize the reform plan. Finally, the House passed this new version of a universal health care bill and sent it to the Massachusetts Senate.

Given its similarity to the previous legislation passed by the Senate, the Senate Committee on Ways and Means was able to promptly pass the legislation onto the Senate floor after stripping some of the additional hospital aid amendments and exemptions for small business from the bill received from the House (Fehrnstrom 1988, March 14). On the Senate floor there was heavy opposition from the Republican minority, who ineffectually sought to remove all aspects of the legislation dealing with anything other than its original intent to address hospital finance. Lacking success there, the Republicans tried to remove the mandate requiring business to provide health insurance by 1992. Attempts to impede passage of the bill were futile; on March 15, 1988, the Senate passed a universal health care bill (Knox 1988, March 16).

The next step for the universal health care legislation was a conference committee of representatives from both the House and the Senate. For about three weeks this committee negotiated in order to develop a compromise bill based on the bills that passed
each of their respective chambers. The product of the compromise committee was then sent to each chamber of the Massachusetts General Court (Knox 1988, April 12; Fehrnstrom 1988, April 12). Some of the key elements of the final conference committee report included:12

- By July 1, 1988 - the development of a new state agency called the Division of Medical Security which will offer low-cost insurance to workers in small companies, the disabled, and the unemployed.

- By July 1, 1989 – the introduction of tax credits and incentives to encourage businesses to provide health insurance to their employees; one new incentive for smaller business is the creation of a hardship pool for small businesses to purchase insurance at group rates.

- By September 1, 1989 – the requirement that colleges and universities provide health insurance to all students who are attending college at least three quarters of the year.

- By April 1, 1990 – the availability of state insurance coverage to laid off workers who are collecting unemployment.

- By January 1, 1992 - the requirement that all businesses of six or more employees provide health insurance to their employees or pay an annual surcharge of up to a maximum of $1,680 on payroll taxes (a .12% surcharge on the first $14,000 of each salary) for any employee who has worked 20 hours a week or more for at least six months. The surcharges would be funneled to a state fund that will then provide insurance coverage for the uninsured.

- A cap on private sector responsibility for the uncompensated care pool of $325 million in FY 1988, and decreasing to $311.5 million in FY 1989. The state agreed to pay for bad debt and free care above the cap up to 115% of the cap, and for 50% of care above 115% of the cap.

- An allowance for hospitals to increase their rates to the national health care cost inflation rate plus two percent (analysts at the time suggested this would allow for as much as $1 billion in additional hospital revenue over the next four years), as well as an additional $50 million in state assistance to hospitals to offset Medicare cutbacks between the current year and FY 1991.

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12 See for example, SHNS (1988, April); Fehrnstrom (1988, April 12); Knox (1988, April 14); Office of the House Minority Leader (1988, February); and Kronick (1990).
Illustrative of the gridlock surrounding this legislation during its many months of debate, the final Conference Committee report narrowly passed in both chambers of the Massachusetts General Court with votes of 81-72 in the House and 19-15 in the Senate (SHNS 1988, April). Nonetheless, after nearly nine months of wrangling over health care reform, it appeared as though Massachusetts would become the first state in the country to guarantee health insurance to all its citizens.

V. Policy Punctuation

Though by a tight margin, the universal health care law did pass the General Court and was signed into law by Governor Michael Dukakis on April 21, 1988. Given the highly contentious debate and lobbying that characterized the evolution of this bill, it is remarkable that such dramatic policy change was able to occur. However, as Kingdon (2003) theorized, in this episode, the problem, the politics, and the available policies converged, and there were active policy entrepreneurs who recognized this window of opportunity to make change. Moreover, Baumgartner and Jones (1993) describe the political system as one that is generally stable or at equilibrium, but that can become “punctuated” or interrupted with periods of dramatic change as new issues are raised or existing issues are redefined. This final section will illustrate how that theory is helpful in explaining what occurred in 1988. In doing so, this section will consider key political and economic circumstances and variables, as well as describe how the critical debate regarding the division of responsibility between the public and the private sectors was resolved in order to explicate how and why this “policy punctuation” occurred.
A. Politics: The Moral Imperative

Numerous characteristics of the political arena during 1987-1988 provided a ripe atmosphere for policy change. Politically, the attitude that there was a moral imperative to guarantee all citizens health insurance helped promote this policy. As was illustrated in a previous section, highly emotional stories in the media captured the attention of legislators and the public and made them empathetic toward the plight of the uninsured. Witnessing these struggles, the public and policymakers felt compelled that passing this legislation was “the right thing to do” and used this rationale to convince others to be supportive of this legislation. One editorial published early on in the health reform debate argued, “But most of all, it [Governor Dukakis’s health care reform proposal] marks the beginning of the end of the historically unjust condition that leaves hundreds of thousands of Bay Staters with little or no health coverage” (“A visionary health bill,” Sept. 12). In a Democratic caucus prior to the House session in which the health care bill was to be debated, House Speaker Keverian argued to his Democratic colleagues, that though there may be some who cite cost as a reason the state should not adopt this legislation, “I would argue that we can’t afford not to do it. If an issue is important enough, we will find a way to do it.” He also suggested that his colleagues think about hidden benefits of the bill, such as “human dignity” (SHNS 1988, February). Later, during the full House session, in his testimony in support of the bill Speaker Keverian argued,

I don’t know an issue that has had more input [than universal health care]. I have been reading in the newspaper that the fragile coalition is about to be destroyed. I have always been one to try and deal with consensus politics, but in the final analysis, all these groups are special interest and that doesn’t mean a bad thing. But there is only one group that represents all
the citizens and all the groups, and that is the 160 members of this House and the 40 members of the Senate and the governor. I believe that the time has come in this Commonwealth for this idea. I think we should have universal health insurance. I would say that the concerns about cost are legitimate. In the end, because it is the right thing to do [emphasis added], we will find a way to do it. This issue is important. It has to be done and it will be done. (SHNS 1988, February).

One advocate who has been involved in health reform initiatives in Massachusetts for the past twenty years argued that in order for health reforms dedicated to access to prevail, there has to be some “moral buy in.” She explained, “Even in ’88 there was a shift from individual financial interest to movement on access and then Dukakis touted it that way” (Interview 5). The notion that morally the state was obligated to address this issue certainly assisted in influencing perceptions as to the validity and righteousness of this legislation. Moreover, this attitude reinforced the notion that the issue of un-insurance, which may have previously been conceived of as a private problem, was one deserving of public intervention. Now, there was a ethical obligation to address this issue.

The influence of a governor vying for the presidency

Interviewees, floor debates, and news archives all suggested that the importance of a governor vying for presidential candidacy cannot be understated in describing the political climate that enabled universal health care legislation to pass. Baumgartner and Jones (1993) argue, “no single actor can focus attention as clearly, or change the motivations of such a great number of other actors, as the president” (p. 241). Though not yet president, this assertion appeared to extend to a presidential candidate in this episode.
One interviewee went so far as to state, “I would argue that it wouldn’t have passed if he [Michael Dukakis] wasn’t running for president and he wasn’t behind this” (Interview 13).

When asked what factors enabled the reform to occur, many interviewees cited the importance of Governor Dukakis’s bid for the presidency. One interviewee who was a legislator in 1988 argued,

The biggest was the presidential campaign. And that was significant at two periods. One was getting the governor’s support for the bill. If you read the timeline and some of the history on it, it was really Pat McGovern who kind of launched this idea. And at the time, Dukakis and Phil Johnston were opposed to it saying it goes too far, too big. As we started getting into the issue and then healthcare started to be identified as a major concern, I suspect that the governors’ advisors found that health insurance might be a wedge issue or a latent issue that candidates weren’t really focusing on and would be an important tool for him going into the presidential race. So it was important for him. Mike Dukakis controlled the state in the late eighties. He controlled bureaucracy with just incredible discipline and skill. He controlled the party and for practical purposes was the party. He had tremendous sway over the media coverage and the framing of political issues so if you did not have his support for an initiative as aggressive or bold as this, it probably would have been stillborn. And I think the presidential race got him interested in it. As it started to develop and was running into a lot of opposition, again it was the presidential race, having come out of the convention and the primaries, where legislative leaders forced this through because he was now wedded to this and there was a perception that his presidential campaign might be wedded to it. That’s why they pushed it through with an effective date [the employer mandate] that was well passed not only his presidential election; the effective date was after his term in office. So, the presidential race was the biggest force that was moving this forward from Dukakis’s first endorsement to the passage. (Interview 2)

Reinforcing this same idea, another interviewee explained, “And so anyway, the way it passed was for two reasons. First, because Michael was running for the presidency and so the leadership was told, you know, basically Keverian who was the Speaker and Bulger who was the Senate President were told, ‘look, this is going to be a center piece for the Dukakis presidential campaign so this is important to the governor presidentially’” (Interview 25).
Another interviewee involved in health care reform advocacy in Massachusetts for nearly twenty-five years stated, “You had a governor running for president. It provided the political imperatives for both the legislature and governor; the governor first and then the legislature to do something on reform. He was running for president. The uninsured was an issue, the democratic legislature certainly wanted to see a Democratic president. If the reform had failed, it wouldn’t have been helpful [to his candidacy]” (Interview 14).

Collectively, conversations with major players during the 1988 reform reinforced the notion that the presidential campaign had a major influence on the outcome of this legislation. Not only did it expand the media attention to the issue, but it enhanced the political stakes attached to it. The prevailing attitude at the time seemed to be that passage of this legislation was critical to Dukakis’s campaign since health reform had become a primary focus of his platform. If Massachusetts could pass universal health insurance legislation, Michael Dukakis might have a better shot at winning the presidency. That alone motivated many to support this piece of legislation. One interview went so far as to suggest that policymakers were willing to support this legislation for Dukakis with the hopes that should he win the presidency, their support would be rewarded with federal positions (Interview 2).

Excerpts from session debates on this legislation revealed a similar attitude among some policymakers, although the governor’s presidential campaign could be a lightning rod for opposition as well as support. Representative Poirier stated in the debate on February 29th,

…Republicans are concerned. We’re concerned about what is being shoved down your throats today. We are very concerned about this [the universal health care] bill….This weekend I was down South, I had the
television on and all of a sudden a commercial came on. It was a very familiar person, who doesn’t spend much of his time in the Commonwealth. It was a commercial for president of the United States. Talk about priorities. We are dealing with a bill we are trying to get through for the man on the commercial. What I am saying is don’t be duped. (SHNS, February 29)

In the Senate, Senator Locke argued, “this [the universal health care bill] has got to be the most blatant attempt to arm the governor with more campaign tools…The legislature has become a plaything for the governor. It is almost a toy for him to use, and I might say abuse. …..the only effect this will have is so the governor can traipse across the landscape proclaiming Massachusetts as the first state to adopt universal health care” (SHNS 1988, March 14). Evidently, some policymakers felt the governor’s presidential ambitions had a profound effect on the motivations and actions of some state policymakers.

Early on in the debate, news articles highlighted the influence of the presidential race on this health care reform initiative. One article rhetorically asked, “How did Massachusetts get to such an extraordinary pass?” and then responded “The answer has much to do with presidential politics, specifically: the effect that running for president of the United States has on a candidate and the political risks he is willing to take” (Knox 1987, September 27). The same article argued that Dukakis succeeded in creating a “climate for action” on this issue, and quoted Senator Patricia McGovern as stating, “If we don’t do it [pass universal health insurance] now, we may lose the golden opportunity.” After the bill had passed, McGovern was quoted in the Boston Globe as stating, “His [Dukakis’s] involvement in the national campaign made everybody focus on it. It might never have happened if he didn’t agree” (Loth, 1988, April 22).
Collectively, these sources suggest that the politics associated with a governor running for president helped open the window of opportunity for health care reform. Consideration of additional political and economic variables provides greater insight into how this opportunity was capitalized on to produce a successful policy change.

Policy entrepreneurs: Political leadership and persistence

Kingdon (2003) defines policy entrepreneurs as “advocates who are willing to invest their resources – time, energy, reputation, money – to promote a position in return for anticipated future gain in the form of material, purposive, or solidarity benefits” (p. 179). According to this definition, both Senator Patricia McGovern and Governor Michael Dukakis might be considered policy entrepreneurs. As was detailed in the previous section on the resurrection of reform, both Senator McGovern and Governor Dukakis were vested enough in this issue to dedicate considerable time to constructing and drafting bills addressing universal health insurance. In addition, when time came for legislative consideration of their bills, both were actively involved in lobbying for their proposals. Though there was some debate as to the anticipated gains each hoped to earn, in interviews with both each indicated a purposive commitment to ensuring a right to health insurance and health care access for all citizens in the Commonwealth.

At the Senate Ways and Means Committee hearing held after the House sent the hospital financing legislation over to the Senate, both Governor Dukakis and Senator McGovern took the time and energy to testify at the hearing. In addition, various sources suggested Dukakis invested much time at this point in the policy process in lobbying various legislators and meeting with legislative leaders to convince them of the importance
of supporting universal health care legislation.\textsuperscript{13} As was cited previously, Governor Dukakis was credited with creating the right atmosphere for change. When asked who some of the key players were in the 1988 reform, one stakeholder explained, “I’m not remembering who might have been the two or three political leaders. Clearly the governor wanted something. I don’t want to diminish his role one bit. He created the atmosphere to try and change. And it was partly political I’m sure because of the campaign, but he believed in it” (Interview 3). In addition, Governor Dukakis’s decision to cancel a campaign trip to Iowa in December in order to stay and lobby for the health care bill also illustrated the investment of time and energy into this policy issue. Despite the importance of this campaign trip, Dukakis opted instead to remain in Massachusetts and dedicate his time to supporting the health insurance bill. The explanation as to why Dukakis was committed to ensuring universal health insurance was hotly contested by many. Some believed, and a personal interview with Governor Dukakis iterated, that Dukakis’s dedication to this issue stemmed from a social welfare ideology that all individuals should have health insurance, what Kingdon (2003) categorizes as a “purposive” incentive (p. 123). Alternatively, others suspected this was a policy issue he promoted because a direct, personal gain was at stake (i.e. political gains in his presidential campaign), what Kingdon classifies as a “material” incentive (p. 123). Regardless of what incentives motivated him, his role and influence as a policy entrepreneur cannot be denied.

Senator Patricia McGovern was referred to as “the mother of chapter 23” by one interviewee (Interview 2). Countless other news sources and interviews, as well as legislative session references, pointed to her as the primary mover and shepherd of the

\textsuperscript{13} See for example, Woodlief (1987, October 28); and Sleeper & Knox (1987, October 28).
universal health insurance legislation. In describing McGovern’s role in the policy process one reporter said, “For the Senate Ways and Means Committee Chairman, Patricia McGovern, universal health care has been a magnificent obsession. From the moment McGovern first detailed a plan for guaranteed health insurance in a policy report, 14 months ago, she has dogged the issue with the persistence of a bull terrier and with twice the teeth” (Loth 1988, April 22). In the same article, Senate President William Bulger said of McGovern, “[she] has been the inspiration and soul of this whole undertaking….very few people would have had that tenacity and commitment, and the honest belief in what she’s doing.” Throughout the entire process McGovern was credited with working to build consensus among key stakeholders in order to construct a piece of legislation that all were willing to support. In December of 1987 releases from the State House News Service (SHNS) explained McGovern “has been working feverishly to bring together the many special interests involved in the health care delivery system” (SHNS 1987, December) and then again in February remarked on McGovern’s persistence in negotiating with special interests in order to craft a piece of legislation on universal health insurance (SHNS 1988, February).

One interviewee who worked for the administration as a state bureaucrat during the late 1980s was asked what factors enabled chapter 23 to pass. She too cited Pat McGovern’s critical role as a negotiator. In her words,

…I think the other reason it passed was because of Pat McGovern’s leadership. She basically brought everybody into a room and made them all sit there and confronted people with that what they needed to trade-off. Many of us often remarked over the months leading up to chapter 58 [in 2006] that we didn’t have a Pat McGovern, at the points where we were feeling low, where things might fall apart. She really did…there was a great phrase about her that was in the Globe at the time….it was something about
she dogged the issue with the tenacity of a bulldog, which she really did. (Interview 9)

As has been highlighted here, and in more detail above, Governor Dukakis and Senator McGovern invested much time and energy in promoting and working to gain support for a universal health insurance bill. Regardless of their end goals, the actions and characteristics of both clearly illustrate their role as policy entrepreneurs. Both entrepreneurs clearly linked the problem of un-insurance to a policy of universal health insurance, and perhaps more importantly, both recognized and sought to take advantage of the opening of a window of opportunity. Their persistent advocacy and commitment to this issue was clearly a factor in enabling reform to occur.

B. Economics: Assuaging Dominant Structural Interests

In the end, what enabled the business and hospital stakeholders to support, or, at the very least - not outwardly oppose – passage of the universal health insurance law? Given the tumultuous attitude of businesses and hospitals toward health care reform, and the continued importance of these industry stakeholders in health reform, it is enlightening to consider what enabled them to not impede the reform effort.

Business as usual: Protecting the bottom line

When the issue of health care reform initially surfaced in the spring of 1987, business was supportive because of their concerns associated with the rising costs of health insurance imposed on them due to their liability in financing the free care pool. In the end, assuaging this cost concern was one of the ways in which business was brought back on
board and their opposition was diffused. The deal that was ultimately struck between
business and policymakers ensured there would be a cap on business’s responsibility for
funding of the free care pool. Accordingly, business would still end up financing free care
through surcharges for up to $325 million, but beyond that, the state would assume
responsibility. In addition, the legislation included stipulations to further appease business,
bringing down this cap arrangement over time. By inserting provisions that were
responsive to the economic concerns of business, policymakers were at least able to silence
business lobbying in opposition to the bill. In describing this decision, McGovern
explained, “The free care/bad debt pool is the nexus of this legislation, the part that has to
deal with both hospital financing and health care access. If one is going to move toward a
new system, you have to get out of the old system without saying to business, you’re going
to have to pay for both at the same time” (Wong & Knox 1987, December 21).

In addition to this protection of the business bottom line, the voice of the business
community was also quieted by phasing in some of the most controversial pieces of this
legislation. The delayed imposition of the employer mandate to 1992 provided business
with short-term assurance that their existing arrangements of providing (or not providing)
health insurance would not be disrupted; businesses would either have time to develop a
mechanism to provide insurance or lobby more intensely for repeal of this piece of the
legislation.14 Jointly, these aspects of the legislation spoke to the economic concerns of
business and quieted their outspoken opposition to a universal health insurance reform
(Knox 1987, December 19).

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14 See for example, Knox (1987, December 17); HCFA (1988); and SHNS (1988, February 28).
There is certainly some irony surrounding the position of the hospitals and their role in influencing the evolution and passage of the universal health insurance law. Some have argued that the hospitals’ need for financing legislation was manipulated and taken advantage of in order to meet the political goals of the governor. However, interestingly, in the end, the hospitals also played upon the importance of this legislation to the governor and capitalized on the stakes attached to this bill in order to manipulate the legislation to satisfy their own economic self interest.

Numerous sources argued that the governor used the underfunded hospital bill (that he opted to pocket veto) and the expired hospital financing law as bargaining tools to get his universal health care bill passed.\(^\text{15}\) As Ascuaga (1992) argued, McGovern and Dukakis married universal health insurance and hospital financing in order to increase the likelihood of passing universal health insurance. After this decision was made and members had the opportunity to debate the bill, many explicitly expressed their frustration with this political ploy. In the House, Representative McKenna argued, “the governor, in his quest for the presidential bid, is holding these hospitals literally as hostage” (SHNS 1988, January). In later debate, Representative Poirier argued,

Back when this bill was initially addressed, the issue was strictly universal health care. And I noticed we have a number of people with us today who are with the hospital industry. I commend them, but that was a deceptive move that got the hospitals involved. That was a deceptive move by the

\(^{15}\) See for example, Office of the House Minority Leader (1988, February); SHNS (1988); and Knox (1988, January 6). In a personal interview with Governor Dukakis, he indicated the expiration of the hospital financing law was important, but could not recall other specific strategies used by the Administration to force action on the universal health care bill.
Duke of Deceit. He couldn’t get his bill through, so what did he do? He held another bill hostage. It was not fair and it was not fair to our hospitals. (SHNS 1988, March 1)

In the Senate, Senator Celluci offered a concurring argument that,

the hospitals are putting tremendous pressure on the members, but why is that? The governor promised eight weeks ago that the hospitals would be given relief and he hasn’t. He is holding the hospitals and the people they serve hostage and I am shocked that the Senate wants to take part in this political extortion. (SHNS 1988, March 14)

In the end, the political tactics of the Governor were equally matched by those of the hospitals.

Frustrated by the unwillingness of the legislature or the governor to pass a hospital financing piece, the demands of the hospital industry intensified over time. Though it was Dukakis and McGovern who initially made the decision to link hospital financing legislation with reforms addressing access, the hospitals now used the dedication of the governor and Senator McGovern to universal health insurance to manipulate the hospital financing elements of the legislation. The struggle now became one of balancing the political goal of universal health insurance held by the governor and the chairwoman of Ways and Means with the economic demands of the hospital industry.

Though Senator McGovern had worked arduously to get all stakeholders on board, the hospitals now recognized how desperately Senator McGovern and Governor Dukakis wanted to pass this legislation because of the universal access amendment. They also recognized that their support was critical to passage of the bill. Given the intense power of their broad lobbying tactics (for example, the rally they sponsored in front of the State House) as well as their direct lobby of legislators with hospitals in their district, the support of the hospital industry and their willingness to sign off on the health care legislation was
critical to its passage. Some argued that the governor had held the hospitals hostage, now it appeared the hospitals were holding him hostage as they refused to support the bill unless their financial demands were met. After so much time and energy invested in this bill and such high political stakes attached to it, due to the governor’s national campaign, neither McGovern nor Dukakis was willing to let this bill die.

Some have argued that, consequently, the dominant economic interests “won out” in this game. One interviewee who was a prominent state bureaucrat at the time of the reform stated broadly, “I think the hospitals are always powerful. There is always a buy-in cost in every health reform and it’s usually more money for the hospitals. It’s always been more money for the hospitals. So in ’88, that was a huge piece of it” (Interview 9). One high-level policymaker at the time explained this situation with a bit more information,

The Congress, I guess, made some relatively modest cuts in Medicare reimbursement which were going to cost the hospitals 50 million bucks as I recall…I mean I’m pulling these numbers out of my head, right? At a time when the hospitals are spending 4 billion a year and they come to us and say, ‘if you don’t give us the 50 million, we’re going to oppose you.’ This was threatening our very existence. Well at the time it was serious. I mean, I didn’t want to lose this thing; we worked like dogs on it. But when you think of it, $50 million on a base of about $4 billion; who’s kidding whom, you know? It’s ridiculous! So, we sit there getting played with, then they start revving up their employees, then we start having demonstrations in front of the State House, then you know, we got another $50 million. Finally, Pat McGovern said we have to do it so she kind of negotiated on this $50 million ….and we had almost lost the vote over this thing. (Interview 27)

Another high level politician reiterated these same details. In his interview, when asked about the factors that enabled the universal health insurance bill to pass in 1988 he explained,

it wouldn’t have passed had not, had Pat McGovern who was Chairman of Ways and Means, not bought off the hospitals for 50 million dollars. And
that’s basically how it got through, was that she put 50 million dollars on the table for the hospitals and it was essentially a bribe to the hospitals…The hospitals said we’re not going to do this unless we get something. And this is what happens in health reform always. Everybody wants their piece of the pie and it’s all about money…She basically at a crucial moment she brought the hospitals into her office and she said, ‘the train’s leaving the station. Either you’re on board.’ And she said, ‘I’ll give the hospitals $50 million if you support it and the way the legislature works is you know, every legislator has a hospital. And if the hospitals were against it, they would go out and lobby legislators against it and they would have a lot of influence. If they were for it, they would lobby the legislators for it and they have a lot of influence. So they said alright, you give us the $50 million and we’ll lobby for it and so they did and that’s how the bill got through. (Interview 25)

In addition to the numerous political factors that created the right atmosphere for policy change, then, being responsive to the economic interests of dominant structural players was also critical in enabling this reform to pass. Only in this way could legislation be crafted that all parties were willing to sign off on. The power of dominant players in the political system to shape policy outcomes is a common enough pattern in public policymaking and one that was to be repeated in later episodes of health care reform in the Commonwealth.

C. Sharing Responsibility: Resolving the Roles of the Public and Private Sectors

In time, it appeared as though there was agreement that the problem of the uninsured was certainly a growing private problem that now required a public response. However, a struggle arose over the normative roles of the state and the private sector in resolving this problem. As Berghold (1990) suggests, it was only when the private sector and the state were able to reach agreement on their responsibilities that policy punctuation occurred.
One of the most preliminary versions of the universal health insurance bills filed by Governor Dukakis included the development of a very large state agency that would be created as part of the law to implement certain aspects of it. As was described in a previous section, this was immediately perceived as an example of the government attempting to exert too much control by creating a huge government bureaucracy. In the end, the state and the private sector interests compromised. A new state agency, the Division of Medical Security, was established to provide insurance to workers in small companies, the disabled, and the unemployed. However, the scale and responsibilities of this agency were stripped down considerably from those of the Massachusetts Health Partnership initially proposed by Governor Dukakis. This was one way in which the role of the state was restricted in an effort to appeal to the concerns of the private sector; although the agency would be responsible for the provision of health insurance to some, it no longer was intended to have a regulatory role.

Another critical aspect of the universal health insurance legislation was the decision as to who should be responsible for financing of the free care pool. Reaching agreement on this was crucial to enabling this reform to pass. Again, business was clearly resistant to continuing to have an unlimited role in financing free care; however, the state was reluctant to assume this financial responsibility in its entirety. Though the process of reaching an agreement was highly contentious, in the end business and the state were able to reach the agreement that business would be responsible for financing this care up to a certain amount (their responsibility for financing this care would be capped), and the state would be responsible for free care costs in excess of this cap (SHNS 1988, February).
Perhaps one of the most controversial decisions regarding the onus of responsibility concerned whether businesses should be responsible for the provision of health insurance to their employees. In the end, the legislation did impose this responsibility on business, but included numerous other provisions designed to alleviate some of the economic pressure of this requirement and provide alternative options. For example, the state would initiate new tax incentives to businesses that newly offered health insurance, and, in addition, the state would expand its responsibility by providing coverage for the disabled, unemployed, and the workers of small employers. Moreover, if businesses of six or more employees opted not to provide health insurance, they would instead pay an annual surcharge of up to a maximum of $1,680 on payroll taxes. Each of these features, along with the decision to delay the imposition of the mandate until 1992, enabled the state and businesses to feel comfortable with their responsibilities delineated in this legislation with the aim of reaching universal health insurance. Just as Goldberger (1990) argued, to secure business support for the insurance plan, the state was willing to cap its contribution to the free care pool and delay for four years the payroll tax on employers not providing coverage. It was only after the state and the private sector players were comfortable with their respective roles and responsibilities that this new legislation could pass.

The effort to assuage dominant structural interests during the policymaking process resulted in a “Christmas tree” affect on this legislation. Distributive politics satisfied the various interests lobbying in response to this bill; as the bill was made its way through the legislature, the legislation was adorned with elements (e.g. additional hospital funding, delayed implementation of the mandate, a cap on business responsibility for the uncompensated care pool) designed to meet the interests of different policymakers and
stakeholders. Consequently, the Health Security Act though not the most efficient legislation, became a politically feasible piece of legislation.

VI. Conclusion

As a close look at this reform episode has highlighted, a political economy perspective offers much insight in explaining how this policy punctuation, passage of chapter 23 of the acts of 1988, occurred. The perhaps auspicious, perhaps manipulated, alignment of certain political and economic variables allowed a dramatic change in health policy to occur in the state of Massachusetts.

Interestingly, the problem of the uninsured was demonstrated in a very public way through the extensive personalized press coverage of this issue. Newspaper articles profiling working families who lack insurance and struggle with medical needs sharpened attention to this issue and elicited public sympathy and support for health reform. The efforts to develop a solution to this problem, however, did not occur in the public arena. Rather, elite interests hammered out the details and a solution to this problem with prominent legislators, who framed this as a moral issue, arguing it would be unjust to allow the problem of the uninsured to persist.

However, as the title of this chapter suggests, Governor Dukakis’s and Senator McGovern’s victory on the universal health insurance front was only temporary; over time, different elements of this legislation were repealed. Ultimately, the employer mandate, which was the pivotal piece guaranteeing universal health insurance, was also repealed. Again, the political economy perspective helps elucidate how the change in political and economic circumstances shortly after the passage of this bill explain the temporary nature...
of this legislation as well as the origins of the second health care reform episode considered in this study. This unraveling of chapter 23, and how it fostered the development of a new health care reform initiative, will be the focus of chapter three.
On July 24, 1996, the Massachusetts General Court overrode Governor Weld’s veto to enact chapter 203 of the acts of 1996, An Act to Improve Access to Care. The health care reform plan included in this legislation was markedly different from the universal health care bill passed in 1988 under the Dukakis administration. This chapter will illustrate how changes in political and economic circumstances impacted both the process and the content of health care reform policy.

From a political standpoint, proponents of the 1996 reform were skillful in their use of rhetoric. The discourse on McDonough’s reform plan focused on the impact this plan would have on access to care for children and the elderly, two populations viewed positively by the public. Subsequently, the emphasis on these populations assisted reform proponents in building a strong coalition of supporters. Groups that were invested in the welfare of children and the elderly, but had not previously been involved in the health care reform debate, were quick to join the side of advocates. Proponents also utilized the employer mandate as a bargaining tool to bring others to their side of the debate. From an economic perspective, the circumstances in Massachusetts had declined since 1988. However, receipt of the section 1115 waiver provided a strong economic impetus for reform. Then, proponents garnered public support for additional funding through a new tobacco tax; children and the elderly were depicted as “good” populations that would benefit from a tax on an “evil” industry. The waiver and revenue from the cigarette tax would allow the state to make expansive changes with minimal adverse economic
repercussions on the majority of people. As a result of these circumstances, the health care
reform effort in 1996 was successful.

I. Transitions in Massachusetts’ Political Economy: The Impact on Health Care Reform

In *Rethinking Health Care Policy*, Hackey (1998) analyzed the policies adopted by four
Northeastern states in the 1980s and 1990s to address hospital costs. He utilized a policy
regime framework to explain the differences in policy choices adopted by these states.

According to his framework,

> Interactions between public officials and health care providers reflect the
> larger relationship between state government and the private sector, for the
devolution and implementation of the health care regulatory policies
> occur in the context of a state’s prevailing culture and institutions. The
design of political institutions, the policy preference and economic interests
> of public and private decision-makers, and the resources available to public
> officials all influence the nature, timing, and effectiveness of state regulatory
efforts. Since both political culture and the autonomy and capacity of
> political institutions vary from state to state, different policy environments
> will produce different approaches to cost containment and different policy
> outcomes. (Hackey 1998, p. 2)

In a related fashion, this study on the health care reform experience in Massachusetts
illustrates that *changes* in political institutions, the policy preferences and economic interests
of public and private decision-makers, and the resources available to public officials *within
one state* all influence the nature, timing, and effectiveness of state reform efforts.

Therefore, since political culture and the autonomy and capacity of political institutions can
change over time *within* one state, *different policy environments will produce different policy outcomes
within the same state at different points in time*. In order to explain why Massachusetts
ultimately repealed the universal health care law and passed a health care law that expanded
health care access via a very different mechanism, it is necessary to appreciate the
numerous political and economic transitions that occurred in Massachusetts between 1988 and 1996 to alter the policy environment in the state.

A. Political Upheaval

The political situation in Massachusetts changed markedly following the state election in 1990. In this election, the Republican candidate for Governor, William Weld, narrowly defeated his Democratic opponent, John Silber. This change in leadership had a profound impact on the future of the universal health care bill. While Governor Dukakis was characterized as a “policy entrepreneur” vested in adoption of his universal health care bill, William Weld was adamantly opposed to the employer mandate and was anxious to repeal this fundamental piece of the 1988 law as soon as possible (Kingdon 2003; McDonough 2000). According to one New York Times article, in his request to the state legislature to repeal the mandate, Governor Weld argued the mandate was “an obstacle rather than a vehicle for improved health benefits for all” (Eckholm 1991, April 11). In addition to Weld, the appointed members of his Administration were deeply opposed to the employer mandate and as committed to its repeal as Dukakis was to its enactment. Charles Baker, Weld’s Secretary of Health and Human Services, was outspoken in his disdain for the employer mandate; he “publicly talked of how much he ‘hated’ the mandate and said he would resign his job rather than implement the requirement” (McDonough 2000, p. 248).

The partisan composition of the Massachusetts General Court also changed in 1991 as a result of the 1990 election. Of forty members in the State Senate, the number of Republicans doubled from eight to sixteen (“State Senate Political Complexion” 1867 to
Date). Although not as pronounced, Republican representation in the House also increased over the same time period. Of one hundred forty members, the number of Republican representatives increased from thirty-two to thirty-eight (“State House of Representatives Political Complexion” 1867 to Date). Collectively, these changes represented a dramatic change in the political culture and composition of state government. As evident by passage of the universal health care bill in 1988, policymakers in the 1980s supported regulation and the involvement of government in responding to public issues. However, this new group of public officials was fiscally conservative and preferred strategies of deregulation and competition, encouraging reliance on market mechanisms to address public policy issues.

B. Economic Downturn

Economic circumstances in Massachusetts also changed after passage of the universal health care law in 1988. The economy in Massachusetts, referred to as the “Massachusetts Miracle” in the 1980s, plummeted into deep recession in the 1990s (Blendon et. al. 1992, p. 1117). The unemployment rate, one proxy indicator of economic vitality, was nine percent in Massachusetts, considerably higher than the national average of 6.9% (Ascuaga 1992).

Looking back, one interviewee who was a prominent public official in the 1980s contrasted how different the economy was in the 1980s in comparison to the 1990s. He explained,

[Massachusetts was in] good shape financially [in the 1980s]. [There was] a real sense in this state that boy there wasn’t anything we couldn’t do! This Massachusetts Miracle thing wasn’t just a joke. It was beyond just the 2.5%
unemployment, it was just this sense that man we were doing it!...The lowest unemployment rate of any industrial state in the country year after year after year. I mean, a labor market which was unbelievable; I mean really labor shortages – anybody who wanted to work can get a job. So here was this contrast [in comparing the economic situation in the 1980s to the 1990s]. (Interview 27)

Another policymaker actively involved in negotiating passage of the universal health care law also highlighted how drastically the economy changed in Massachusetts subsequently:

...We were doing fine and then all of a sudden the economy, having nothing to do with this bill of course, in the whole northeastern part of the country was just awful. And I remember going to the Federal Reserve Bank of Boston....and I remember one of their researchers....said it is the worst recession in this area since the Great Depression....They started looking at all these economic indicators and then of course we had the housing market collapse, we had jobs being lost, it was just awful. (Interview 35)

Finally, one interviewee who was working as a staff member for the House Committee on Ways and Means corroborated how both the political and economic climate changed, following enactment of the universal health care law. In his words,

the economy was in the throes of a recession. The unemployment rate was between nine and ten percent, so kind of unheard of, very, very high. Governor Weld had won. He was opposed to the mandate ever taking effect...So Bill Weld wins for Governor and says we’re not going to implement it; it’s bad for Massachusetts business. The economy was awful. (Interview 13)

In *Experiencing Politics: A Legislator’s Stories of Government and Health Care*, McDonough (2000), who served as a state representative from 1985-1997, details the impact of political and economic changes following passage of chapter 23 in 1988. He corroborates that the state recession in 1989-1990 resulted in state budget crises, unemployment, and business failures, and raised concerns among policymakers that implementation of the employer mandate would exacerbate already dire economic
circumstances. McDonough (2000) also underscores that during this same time period, health care inflation surged nationally. Aggravating this trend, policymakers in Massachusetts had just allowed hospital rate increases as part of their negotiations which enabled passage of the Health Security Act. These circumstances meant businesses, already strapped by the recession, were unable to keep up with rising health care costs. Despite passage of health reform in 1988, workers lost health insurance coverage and state health care program costs soared, while state revenues declined. The health care system did not appear to be working as was intended.

In a relatively short period of time then, the political and economic climate in Massachusetts changed considerably and these changes had a profound impact on the policy environment. The result was a gradual erosion of support for the employer mandate, a fundamental piece of the universal health care law. Though the law had passed amongst great fanfare in 1988, only a few years later the public and state policymakers were skeptical as to its viability. A new plan that could fix existing problems and win majority support had not yet been developed (McDonough 2000).

C. Different Political Economy, Different Policy Preferences

The changing political landscape and economy in Massachusetts had clear ramifications for the prospects of implementing the employer mandate scheduled to become effective January 1992. Many policymakers who had been proponents of the law in 1988 saw its popular and political support dwindle. Even during Governor Dukakis’s tenure as Governor, Republicans in the House filed legislation designed to repeal the employer mandate (Knox 1990, May 19). However, at that time even if legislation to
repeal the employer mandate had passed, it would most certainly have been vetoed by Dukakis. Nonetheless, the universal health care bill had passed the Massachusetts General Court by a narrow margin and with new leadership and new membership following the election, the balance of power changed (Loth 1989, July 18). Governor Dukakis, one of the primary entrepreneurs of this legislation, was no longer in office. The other champion of the universal health care law, Senator Patricia McGovern, no longer had the political backing necessary to support the bill as a result of the increased Republican representation in the Senate.

Economic changes in the state also affected the state resources available and influenced the interests of key stakeholders. Two key aspects of the 1988 law that enabled hospitals and business to support the legislation were the agreement that the hospital community’s economic viability would not be adversely impacted by a revenue cap or funding shortfalls for providing free care, and the agreement that business costs associated with the uncompensated care pool would be capped. Numerous sources suggested that with the state experiencing severe budgetary shortfalls, it would be difficult or impossible for the state to follow through with these plans (Stein 1988, August 31; Knox 1988, October 4; Turner 1990, March 4).

Consequently, state policymakers faced the difficult decision of either leaving the hospitals in what the hospitals argued was a dire economic situation, or asking business to assist in paying this debt through an increase in insurance premium costs (Stein 1991). Both options would negate the compromises that policymakers and industry stakeholders had reached in order to pass universal health insurance just a few years prior. When asked
what led to the gradual unraveling of the universal health care law, one advocate for health care reform surmised,

…I mean, there is a number of dynamics. I think the hospitals got a lot of money in the deal and that sort of made it harder for business to support because their premiums were going to increase. I mean, the overall political situation changed dramatically with Dukakis losing and with the economy in the deepest recession since ’45 or whatever it was; it was an incredibly deep recession. This was going to be, as Susan Goldberger says, ‘a gyro-gear loose contraption’ held together by state money. To some extent, the business community and the hospitals got bought off. When the state money went away, then you couldn’t afford to buy them off anymore, so there was that. (Interview 8)

The prospect of no longer having a guaranteed cap on their responsibility for uncompensated care costs aggravated the fears business already had regarding the impact the mandate would have on a slow economy. The Pioneer Institute for Public Policy issued an analysis arguing that the universal health care law was an inefficient and inequitable way of meeting the goal of providing universal health insurance. Moreover, its analysis argued that the mandate, requiring firms with six or more workers to provide health insurance to their employees, would cost the state 9,000 new jobs. Perhaps what resonated most with business was the projection that the law would cost Massachusetts businesses $642 million in 1992, roughly $215 per full time worker, for an increase of 1.1% of private sector payrolls (Knox 1988, October 5).

Small business opponents of the pay or play tax also argued that it would force some of them to go out of business and/or reduce the number of workers they employed. As Kronick (1990) stated, these concerns resonated more strongly when unemployment was over six percent in comparison to when unemployment was at three percent. The National Federation of Independent Businesses (NFIB), a small employer trade
association, sought to influence policymakers to be mindful of the economic interests of small business. Carolyn Boviard, a leader of this organization, explained, “we’ve been doing a lot of educating, trying to let a lot of people know that it’s not wise to issue a mandate at a time of economic downturn” (Knox, 1990, May 19). Gradually the tenuous support of the business community for the universal health insurance law, particularly the employer mandate piece, eroded. Small business organizations denounced support, and even the Associated Industries of Massachusetts (AIM) and the Massachusetts Business Roundtable who had been on board in 1988, were no longer willing to support an employer mandate (McDonough 2000).

In light of this pressure from stakeholders and a more powerful contingent of Republican legislators, policymakers began to grapple with the difficult question of repealing the employer mandate piece of the universal health care law (Phillips 1990, May 18). This possibility would have dire impacts on the objective of universal health insurance coverage, since the mandate was the primary tool to insure the working uninsured. In the words of Hal Beladoff, the Deputy Commissioner of Medical Security, “repeal of the mandate removes the guts of the bill” (Knox 1988, October 4). The political and economic circumstances in Massachusetts changed considerably from the 1980s to the 1990s. This change in political economy impacted the policy preferences of both public and private interests, spurring a new debate on health care reform. Consistent with Hackey’s (1998) assertions, these changes would ultimately result in a policy outcome very different than what had prevailed less than a decade before.
II. Salvaging Reform

A. Political Strategies and Circumstances

As one legislator’s research director described, the health care reform legislation passed in 1996 was “Chapter 23 [the universal health care law passed in 1988 during the Dukakis administration] with a hole in the middle for the employer mandate” (McDonough 2000, p. 283). Though this is an oversimplification, a description of the process leading up to the health care reform passed in 1996 reveals how critical repeal of the employer mandate was to enabling the 1996 health care reform.

Realizing that support for the employer mandate was waning, state policymakers who remained committed to universal health insurance devised a postponement strategy to avoid outright repeal of the mandate (McDonough 2000). Cobb & Ross (1997) explain how issue opponents can use strategies of postponement to make action on an issue impossible at a given time. Interestingly, in this instance, issue proponents relied on a legislative postponement strategy to prevent their issue from agenda consideration. Health care reform proponents Carmen Buell, Chair of the Health Care Committee, and Representative John McDonough sought to keep the possibility of universal health care alive by delaying the scheduled implementation date of the employer mandate. According to their strategy, even if the employer mandate itself could not be retained as the policy tool for providing universal health insurance, the postponed implementation ensured the mandate was impending without further action, thereby guaranteeing that the state legislature would be forced to revisit the issue of health care reform. Indicative of the effectiveness of their strategy in forcing continued attention to health care reform, a high level state bureaucrat at the time explained that the continual postponement of the
employer mandate “kept being held out as if you don’t do other things, we’re going to put this in place” (Interview 9).

Many Republican members of the State Senate and Governor Weld desired all-out repeal of the mandate, but both recognized that the House would not pass such legislation (McDonough 2000). As a temporary compromise, Weld signed legislation delaying implementation of the employer mandate from January 1992, as originally stipulated in 1988, to January 1995. This date was politically acceptable for both the legislative and executive branches of government. Since it was beyond Weld’s current term it allowed him to keep his campaign promise that the mandate would not become effective under his leadership, it allowed the House to keep alive the possibility that a new governor might take a different stance on the employer mandate than Governor Weld, and it allowed state senators under pressure from the business industry to temporarily assuage fears of the dire impact of the mandate (McDonough 2000).

Though take-up was initially slower than anticipated, many of the programs and expansions established in the 1988 universal health care law were ultimately very successful in increasing access to health insurance. The CommonHealth program, the Healthy Start program, expansions in eligibility for Medicaid coverage, and the requirement that colleges and universities provide and require students to have evidence of health insurance coverage, all enabled previously uninsured individuals to obtain health insurance coverage (Sacchetti 1990, June 28; Knox 1990, December 11). As of December 1990, estimates indicated 76,000 Massachusetts residents had acquired health insurance coverage through one of these programs following the inception of the 1988 universal health care law (Knox 1990, December 11). These successes, coupled with state public opinion data revealing
that 64% of Massachusetts residents “strongly agree that ‘everyone in America should have health care, regardless of their ability to pay for it’” encouraged Governor Weld, and his chief spokesperson on health care reform issues, Lieutenant Governor Paul Celluci, to maintain a focus on health care reform (Loth 1990, April 3). Consistent with Arnold’s (1992) theory explaining the policy preferences and political actions of elected officials, re-election ambitions encouraged Weld to illustrate his responsiveness to the interests of his constituents. Weld was also beginning to ruminate on the possibility of running for national office in the future, if he should win a second term as governor of Massachusetts. In light of these circumstances, Weld was anxious to illustrate his dedication to and skill in devising a plan to address health care access, an issue that was receiving much attention not only in Massachusetts, but also in the national political scene given President Clinton’s health care reform plans (McDonough 2000).

B. Economic Pitfalls and Opportunities

In the spring of 1994, with the assistance of Charles Baker, now the Secretary of Administration and Finance, and Bruce Bullen, the Commissioner of Medical Insurance, Weld requested a Section 1115 waiver from the federal government. The purpose of acquiring this waiver was to allow the state to re-design its Medicaid program. The federal government shares in the funding of state Medicaid programs and has a number of regulations regarding the structure of the program that a state must comply with in order to receive the federal contribution. However, the federal government does authorize experimental or demonstration projects that allow a state the right to deviate from these guidelines in order to evaluate an approach that has not yet been pursued under the
Medicaid statute. If a state wishes to alter its program and still use federal subsidies to fund the Medicaid program, permission is required to allow federal financial participation under the new arrangement (Centers for Medicare and Medicaid Services 2007).

The Weld Administration thought Massachusetts could revise the structure of its Medicaid programs in ways that would allow the state to increase access to health insurance while maintaining federal budget neutrality (Greenberg & Zuckerman 1997). The administration had developed a plan that consisted of six different provisions, two of which required federal approval because they would require changes in the ways federal funds were allocated. These two provisions included: first, that the state would expand eligibility guidelines for Medicaid to allow enrollment for families with incomes up to 133% of the Federal Poverty Level (FPL); and second, that the state would develop a new program called the Insurance Reimbursement Program (IRP). Through the IRP, tax credits would be provided to employers and subsidies to employees with family income below 200% FPL when the employer was offering health insurance coverage and agreeing to finance 50% of the cost.

The plan developed by the Weld Administration also included the following elements: to assist in funding the IRP by diverting money from the uncompensated care pool (UCP); to develop reforms for the non-group insurance market that would allow many who do not obtain insurance through an employer to be able to purchase affordable health insurance through the open market; to create a state tax break for medical savings accounts, thereby allowing individuals to set aside funds that would be tax-free to use for certain health care costs; and finally, to repeal the 1988 employer mandate (Committee on Health Care, Massachusetts General Court 1995). Eventually, the Weld Administration
plan would have to be approved by a vote of the state legislature, but Weld opted to first seek federal approval for the waiver, necessary to implement the first two elements of this plan. Until the Administration received word regarding the status of its 1115 waiver request, it would not formally present the plan in its entirety to the legislature for a vote.

In the fall of 1994, Governor Weld was re-elected to a second term. With Weld’s re-election, Chairwoman Buell and Representative McDonough recognized that their hope of sustaining the employer mandate was improbable. However, they again sought to delay implementation to January 1996. Included in the legislation authorizing the postponement of the mandate was the establishment of a Commission that would study the health care reform plan developed by the Weld Administration and report to the legislature on its recommendations for implementation. Postponement was a tactic to ensure that even if the employer mandate was not implemented, health care reform would be a pending issue on the legislative agenda, forcing at the least a discussion on health care reform. Delay also provided state policymakers determined to use this opportunity for health care reform additional time to develop a politically viable plan. This political strategy kept the issue alive, and the 1115 waiver became the vehicle that, if approved, might provide the economic opportunity to enable health care reform.

On December 24, 1994, Christmas Eve, still awaiting word from the federal government on the status of the waiver request, Governor Weld initiated a freeze in enrollment in the state’s Children Medical Security Plan (CMSP). Designed to provide basic routine and preventive health care services to uninsured children, enrollment in this program had grown over time, and state budgetary constraints prompted Weld to halt the allowance of any additional enrollments. As will be discussed later, this event would have
profound implications on the forthcoming health care debate (Interview 5, Interview 8, Interview 10, McDonough 2000).

Finally, in the spring of 1995, the Weld Administration request for an 1115 waiver was granted by the Health Care Financing Administration. However, in order for a governor to implement a Medicaid waiver, both federal approval and approval from the state legislature are necessary. Weld had opted to submit his waiver request directly to the Health Care Financing Administration, prior to obtaining approval from the state legislature. With federal approval in hand, it was time for the Administration and legislature to agree upon a reform and implementation plan.

III. Stalemate: The Inability to Agree on a Policy Plan

Pursuant to chapter 274 of the acts of 1994, Governor Weld was now responsible for selecting the members that would chair the Special Commission Established for the Purpose of Making an Investigation and Study of Methods for Achieving Universal Health Coverage for Residents of the Commonwealth (“the Commission”). The Commission was to be composed as follows: three Senators and four Representatives including one Republican from each branch; the Secretary of Health and Human Services; the Commissioner of Insurance; and six members appointed by the Governor – two consumers representing diverse cultural backgrounds and geographic regions, three members of the business community representing different size employers, and one member nominated by the Massachusetts AFL-CIO (McDonough 2000). The objective of the Commission was to study the 1115 waiver and the original reform plan devised by the Weld Administration. Then, the Commission was to make recommendations as to the
health care reform plan that should be implemented (Committee on Health Care, Massachusetts General Court 1995).

In May of 1995, Governor Weld made his appointments to the Commission. Though the intent of the guidelines defining who should be appointed to the Commission was to ensure cultural, geographical and industry diversity, some felt Weld’s appointments did not align with these legislative intentions. Nonetheless, Weld’s appointments were not contested because the Commission was already short on time given the report deadline of September 30th. Soon after the Commission’s initial meeting, Democratic policymakers on the Commission recognized that the governor was not expecting to receive a health care reform plan brought about by compromise through the work of the Commission. Rather, his appointments had been made to intentionally stack the Commission with members supportive of his original plan. While Democratic policymakers questioned various elements of the plan and sought to negotiate a new reform plan, Weld’s appointees staunchly supported his plan and resisted any changes. Representative McDonough repeatedly questioned some of the Administration’s projections regarding increased insurance coverage through the Insurance Reimbursement Program (IRP). His primary concern, in light of the experience of other states, was that the provision of tax credits would be welcomed by employers currently offering health insurance, but would not be

16 State legislators on the Commission included: Senator March Pacheco (co-Chair), Representative John McDonough (co-chair), Representative Carmen Buell (who resigned in July 1995), Senator Mark Montigny, Representative Byron Rushing, Senator Robert Hedlund, Representative John Stefanini, and Representative Valerie Barson. In addition, the following individuals were also on the Commission: Gerald Whitburn, Secretary, Executive Office of Health and Human Services; Linda Ruthardt, Commissioner of Insurance; Shannon Linde, Vice President, Massachusetts Business Association; Rich Marlin, Legislative Director, Massachusetts AFL-CIO; Missy Grealy, Director of Government Relations, The Stop & Shop Companies, Inc.; Carolyn Boviard, State Director, National Federation of Independent Businesses; Werner Schuele, Senior Vice President, Texas Instruments, Inc.; and Benjamin Holmes, Retired Vice President, Hewlett-Packard Company.
sufficient incentive for employers not already providing this benefit to begin to do so (McDonough 2000; Knox 1996, January 11). Recognizing that the Commission was stacked against them, and that the Commission was not the place where a compromise reform bill would be developed, Democratic policymakers allowed one of Weld’s representatives to write the report on behalf of the Commission, so long as dissenting views were documented in appropriate sections.

Not surprisingly, the Commission’s report revealed that emphasis was placed on the Governor’s reform bill, H.4928, and that members were able to concur on some of the reform elements that he proposed. The Commission agreed on the recommendation to expand Medicaid eligibility to include families with incomes up to 133% FPL, and also agreed on the need to support measures targeted at providing health access to children, given the freeze in enrollment in the CMSP. In addition, all Commission members concurred on the need for non-group insurance market reforms that would limit waiting periods and pre-existing condition clauses that were allowable in the existing non-group market. Like the Special Commission devised in 1987, “having reviewed recent changes in the Massachusetts health care system, and the data on the number of uninsured residents, the Commission is [was] unanimous in its belief that a unique opportunity now exists to expand access to health insurance coverage” (Committee on Health Care, Massachusetts General Court 1995, p. 1). However, also like the 1987 Commission, the members of the Commission were unable to reach a consensus on a comprehensive reform plan. Consequently, the Commission disbanded in September of 1995. Lacking agreement on Governor Weld’s reform plan and without an alternative plan for action from the Commission, the issue of health care reform could easily become displaced on the agenda.
IV. Last Chance Legislation

As the report stated, Commission members agreed on the need for health care reform that would increase access to health care, but could not agree on the mechanisms to reach that end. Still committed to this charge, Senator Mark Pacheco and Representative John McDonough, co-chairs of the Health Care Committee, sought for the final time to delay the employer mandate to August 1996. Again, the rationale to persuade their colleagues to pass this postponement was that they would use this time to develop and build consensus for a health care plan, but they promised to sponsor a repeal of the employer mandate if they were not able to develop a plan by the new deadline of August 1996 (McDonough 2000).

Passionate about health care access, and feeling the pressure of a proximate deadline, Representative McDonough became engrossed in the development of a health care reform plan that would address the issue of access and have both political and economic viability. While sitting in a House session among colleagues debating an increase in the state’s minimum wage, the details of a new legislative proposal began to materialize in McDonough’s mind (McDonough 2000).

In October 1995, McDonough introduced what he called the health care “Minimum Wage” bill. Unlike the employer mandate which required employers to offer health insurance or pay a fee of $1,680 to the state, McDonough’s plan sought to establish a health care “minimum” by requiring employers to offer health insurance, and pay at least 50% of it. At the time, these guidelines might have enabled employers to pay considerably less than the $1,680 under the Dukakis plan and therefore this represented the “minimum”
health care contribution McDonough hoped employers might be willing to make toward
their employees health insurance coverage.

To assist low wage employers in meeting these minimum requirements,
McDonough’s plan also included the Insurance Reimbursement Program (IRP) introduced
by the Governor in his original health care reform plan. Coupled with the “health care
minimum wage,” this design was intended to prompt employers not currently offering
insurance to do so and ensure employers paid at least 50% of health insurance premium
costs. With funding from the UCP, tax credits to employers and subsidies to employees
would make this a more appealing, more affordable, proposal. McDonough also included
the Medicaid eligibility expansions included in the Governor’s original health care reform
proposal. This would allow Medicaid coverage for all families with incomes below 133%
FPL.

The fourth feature of McDonough’s reform proposal - to decrease the recently
passed increase in minimum wage from $5.15 to $5.05 - was designed to ameliorate
anticipated objections from employers regarding too many concurring increases in labor
costs. In light of Weld’s closure of the CMSP, and agreement from the Commission on
the need to insure children, McDonough inserted a provision endorsing major expansions
in the CMSP and allocating $70 million to fund this program. The Senior Pharmacy
program was another element of this plan. This piece emerged as a result of the advocacy
and lobbying activities of the Massachusetts Senior Action Council and was designed to
assist low income seniors with the purchase of prescription drugs. Funding for this
program was set at $30 million. To assist in financing these expansions, McDonough
inserted a $.25 cigarette tax increase in his plan. Again, this legislation also called for the
creation of a commission to study ways of restructuring the hospital UCP system, a persistent challenge and controversial financing issue. Finally, the last feature of this proposal called for repeal of the 1988 employer mandate. With a new plan finally devised, Representative McDonough and other health care reform advocates now had to keep health care reform on the state agenda and reignite a sense of urgency on this issue.

A. Political Strategies: Numbers Tell a Story

Stone (2002) asserts “numbers make normative leaps. Measures imply a need for action, because we do not measure things except when we want to change them” (p. 167). Reflective of this supposition, the first summary statement in written testimony provided to the Massachusetts state Health Care Committee by Alan Sager and Deborah Socolar (1995) was “the number of people without health insurance in Massachusetts rose by 335,000 from 1987 to 1993, a jump of 91% (p. 1).

Representative McDonough and his staff also intentionally sought to use numbers illustrative of the growing number of uninsured individuals in Massachusetts to refocus public attention on this issue (McDonough 2000). Press coverage once again began focusing heavily on the issue of the growing number of the uninsured; news stories seemed to echo some of the same sentiments of just a few years prior. “Since 1989, the number of Massachusetts residents without health insurance coverage has risen by 50 percent, from 455,000 to about 700,000” began an article submitted to the Boston Globe by McDonough (McDonough 1996, January 16). Similarly, a letter to the Boston Herald from Representative McDonough and Senator Montigny, now co-chairs of the Health Care Committee, began “Massachusetts has witnessed a dramatic increase in the number of residents without
health insurance, from about 455,000 to about 700,000 in 1995” (McDonough & Montigny 1996, May 20). Finally, the author of one editorial insinuated the growing severity of this issue by explaining, “the ranks of the uninsured have nearly doubled since the days when Michael Dukakis launched a presidential bid on the promise of universal health coverage. It was a crisis then. Today, half a million adults in the state, most of them working, have no health insurance (“Rep. McDonough’s sound health plan,” 1996, January 12). This emphasis on numbers was just one part of a larger strategy that allowed issue advocates to facilitate the placement of health care reform on the state political agenda.

B. Political Power: Expanding the Number of Advocates for Reform

Schattschneider (1975) argued that the outcome of any political conflict is determined by the number of people who become involved in it. Moreover, the dynamics guiding whether and how a conflict is expanded include the competitiveness of those “losing” the conflict, the visibility of the conflict, and the effectiveness of government in responding to the conflict (Schattschneider 1975, p. 16). In this instance, the application of Schattschneider’s theory is helpful in gaining some insight into how the political conflict surrounding health care reform was ultimately decided.

As aforementioned, on Christmas Eve 1994 Governor William Weld initiated an enrollment freeze in the state’s CMSP. The CMSP originated in 1991 and was initially called the Healthy Kids program. Carmen Buell, Chairwoman of the Health Care Committee at the time, had been the primary advocate of this program. It was designed to provide basic primary and preventive health care services to children under the age of six who were ineligible for Medicaid and lacked health insurance. This program later
expanded eligibility requirements to include children up to age twelve. One of the major benefits of the Healthy Kids program was that all uninsured children, regardless of income, were eligible. However, funding limitations for the program had historically limited its effectiveness in enrolling all of the state’s uninsured children (Greenberg & Zuckerman 1997). In 1994, advocates invested in considerable outreach to inform eligible individuals of the program, but funding limitations caused the state to limit enrollment in the CMSP (McDonough 2000; Interview 8).

Though it seemed a dire situation at the time, Weld’s closure of the CMSP was in some ways serendipitous for issue advocates. Health care reform advocates skillfully used this situation to increase visibility of the need to expand health care access. In addition, the “losers” at this time, advocates of the state funded insurance program, and those who would have been eligible for CMSP but were unable to enroll, used this event to build their coalition and increase the number of people involved in this conflict.

An interviewee who was working at Health Care for All (HCFA) during the 1990s explained the process leading up to closure of the CMSP and the origins of the coalition advocating for health care reform. In his words,

So this [the original establishment of the CMSP] was a huge victory for Health Care for All and we said, ‘OK, let’s move on the kids piece. Let’s really move on a program to provide universal coverage for kids.’ And so what we did was we started really promoting this program [CMSP] and it went from I think 6,000 kids to 24,000 kids in the first year, and we were all over the place. And so the day before Christmas, 1994, Governor Weld did me the biggest favor I have ever had and he closed the program for new enrollment…So suddenly we said, ‘we could really do this.’ The head of the Massachusetts Teachers Association called me up and said ‘we want to have universal [health insurance] for kids.’ So suddenly I am having conversations with the most powerful union in Massachusetts ready to put resources behind us. (Interview 8)
Another health care advocate validated that there was an explicit strategy on behalf of HCFA focused on universal coverage for children. This interviewee also suggested Weld’s closure of CMSP played a critical role in prompting the development of a reform coalition. He explained,

…Then there was this children’s program [CMSP] and we [HCFA] actually got some money to do outreach and we started signing everyone up for the program, and that was just the beginning of the children’s campaign. That was part of our strategy – let’s just start signing everybody up and break the bank. Let’s demonstrate that this program needs to be bigger, and then Weld shut it off on Christmas Eve…I helped organize the first conference of all the children’s advocates to address what was happening with the Children’s program. We started explicitly reaching out to children’s advocates in the community – the pediatricians; that was the start of the children’s coalition. (Interview 5)

Another very experienced political leader in Massachusetts explained in an interview, “if you’re going to get anything done in the public sector, it’s all about building coalitions and bringing people to the table” (Interview 27). Closure of the CMSP not only heightened the visibility of inadequate health insurance coverage, but also mobilized advocates to work together in order to reach shared goals for health insurance coverage. Ultimately, the increased pressure from a growing coalition of reform advocates hastened a government response to this issue.

Though the issue was initially “owned” by HCFA and focused on children’s access to health insurance, the coalition membership and the scope of the issue expanded swiftly (Rochefort & Cobb 1994, p. 14). As is mentioned above, following closure of the CMSP, there were a number of groups that promptly joined the children’s access coalition initiated by HCFA. These included: the Massachusetts Teachers Association (MTA), the Massachusetts Medical Society (MMS), and the Massachusetts Academy of Pediatrics.
Each of these industry groups had a clear stake in promoting access to care for children. Shortly thereafter, the Success by Six Coalition also joined the group of advocates for children’s health care reform. This group was composed of selected business and civic leaders in Massachusetts with the objective of promoting public policy change for children up to age six (Knox 1996, April 30). Issue areas of interest to this group were education and health care. The American Cancer Society (ACS) also joined the coalition supporting McDonough’s reform plan. The motivation for joining the advocacy coalition for this group was the prospect of decreasing smoking rates as a result of the imposition of a tobacco tax. When the many different elements included in Representative McDonough’s reform plan began to emerge months later, the number of participants involved in the debate surrounding health care reform grew once again.

Many of the players emerging to assume large roles in the health reform debate in the 1990s, including HCFA, the MMS, and the ACS, were not major actors in the political fray surrounding the 1988 health care reform. While the health reform debate in 1988 was characterized by negotiations among policymakers and dominant interests, the debate in the 1990s was a very public debate shaped by the grassroots efforts of these organizations. McDonough worked closely with these advocates as they sought to build coalition membership and sell this plan to the public (McDonough 2000). Over time, the coalition was aided by the political and economic support of other provider and insurance organizations in Massachusetts (e.g., Children’s Hospital, Harvard Pilgrim Health Care, and Blue Cross).

Shortly after McDonough introduced his plan, many of the stakeholder groups that might be impacted should it pass began to voice their reaction to his proposal. One of the
most politically powerful groups opposed to his plan was labor. McDonough had included a decrease in the state’s minimum wage (which the legislature had just voted to increase) in an effort to allay employer arguments regarding too many concurring cost increases. Though labor union representatives were supportive of the health care minimum wage requirement, they were unwilling to forego the minimum wage increases they had recently won. Not wanting to add unions to the team of opposition, McDonough “threw in the towel on that [the decrease in the state minimum wage] element of the plan” (McDonough 2000, p. 267).

In addition to labor unions, smokers, seniors, hospitals, and children, among others, might all be impacted if this reform passed. As a result, additional stakeholders entered the debate to voice their stance on this reform proposal. When asked to identify groups and/or individuals that played a fundamental role in enabling the 1996 health care reform, one interview participant who was a state policymaker at the time quickly responded,

Well, Health Care for All was key, and the children’s health access coalition they started. At that point in time, the Mass Teachers Association was critically involved. The Mass Medical Society was a key participant. American Cancer Society got in once we linked it [the legislation addressing health care reform] to tobacco. Blue Cross and Partners became involved as a secret financier. Partners actually paid the money for Health Care for All and hired Judy Meredith as their lobbyist and never made that publicly known. It was a secret because back then Health Care for All……was kind of the barbarians at the gates, the black throwers, the brick tossers, the grenade launchers, and had an antagonistic stance with large parts of the health care community. And, something clicked in the mid ‘90s where Rob Restuccia [at Health Care for All] and the folks he had on staff started to realize there’s a lot of people out there who share our [Health Care for All’s] goals….we might actually be able to collaborate with these people and get a lot done. And it just ended up working spectacularly well and really created a mind shift in Health Care for All away from confrontation and toward collaboration. (Interview 10)
As this commentary reveals, coalition members were now brought together not because of a fundamental agreement on children’s health insurance, but because their respective causes had been linked in McDonough’s reform plan. Recognizing a shared interest in the outcome of this legislation, these different organizations established a coalition to advocate for this plan and increase the number of participants on their “side” of this debate. One advocate who was very involved in the coalition explained the political implications of this situation as follows,

In 1996, the state was used to hearing from Health Care for All about health care reform, but then legislators began hearing from the Cancer Society, Mass Teachers Association, and seniors. Health Care for All had built a more credible grassroots organization – HCFA, Massachusetts Senior Action, Cancer Society – these are unusual allies and are many voices that the legislators are forced to listen…The MTA wanted to play a role in a community issue so the Health Care Committee took this on. Additionally, Health Care for All built a relationship with the Cancer Society because of the tobacco tax. Pediatricians also got on board and contacted their legislators. This was one of the first time legislators were hearing from these groups. (Interview 5)

The existing academic literature on the health care reform of 1996 cites the importance of coalition building in enabling the reform to pass (see for example McDonough, Hager & Rosman 1997; Greenberg & Zuckerman 1997; McDonough 2000). Clearly, the sentiments of these interviewees involved in the reform substantiate these findings. As additional players became involved in the debate, the legislature felt increasingly compelled to respond to this issue. Though initially “losers” (in that the CMSP was closed for additional enrollments in 1994), the children’s health insurance advocates broadened their team and in doing so increased the likelihood of a political outcome more in line with their goals.
C. Issue Framing

As the number of players and interest groups involved in this conflict increased, so did the intensity of the debate. Many of the features included in McDonough’s plan were analogous to those initially proposed by Weld. However, Weld ardently opposed the imposition of governmental mandates on business, and refused to support any increases in taxes; prior to his tenure as governor his campaign pledge included a promise to repeal the employer mandate passed during the Dukakis administration and to oppose any new taxes. Though McDonough’s plan included repeal of the 1988 employer mandate, Weld viewed the health care minimum wage requirement as akin to an employer mandate and the cigarette tax as a violation of his campaign pledge for no new taxes. Therefore, these two critical features made it impossible for Weld to support McDonough’s health care reform legislation, though many of the other pieces of the reform were part of the initial plan his Administration had developed (Knox 1996, January 11).

Armed with many of the same arguments as in the late 1980s and early 1990s, business also opposed McDonough’s reform plan. They were pleased to see repeal of the 1988 mandate, but the inclusion of the “health care minimum wage” piece provoked the same complaints of adverse economic implications for business that the employer mandate had initiated in the 1980s (Knox, 1996, January 17; Lasalandra & Hayward 1996, January 11; and Kowalczyk 1996, January 20). Industry stakeholders again argued, “the requirement would be devastating to the state’s economy…Jobs will be put at risk and businesses will choose to locate elsewhere. So, the good news is that employees would get health insurance, but the bad news is they won’t have jobs” (Pham 1996, January 12). Further echoing the arguments in 1988, business also warned that implementing a state
level mandate would encourage businesses to relocate from or fail to open in Massachusetts. After much deliberation with business leaders over ways in which the health care minimum wage provision might be revised to win their support, Representative McDonough heeded advice from Rob Restuccia, the Executive Director of HCFA at this time, and opted in March of 1996 to drop the health care minimum wage element from his reform plan (McDonough 2000). This decision was prompted by what these two leaders described as “political pragmatism”; it appeared politically impossible to pass the health care minimum wage bill as it was currently structured, but by dropping the minimum wage piece, it might be possible to still pass a reform that would result in great improvements in health care access (McDonough 2000).

This policy change profoundly impacted the direction of the conflict over health care reform. Health care reform advocates had successfully eliminated opposition from unions and now business. However, the debate on health care reform was not yet concluded. Governor Weld was still opposed to the reform plan because of the imposition of new taxes, and the tobacco industry also emerged as a well funded political force staunchly opposed to increases in the cigarette tax. Many small business owners located near state borders also voiced concerns of lost tobacco sales, arguing consumers would opt to make their purchases in nearby states with lower tobacco taxes. As the players involved in this conflict expanded, the reform coalition worked to frame this issue in a way that would maximize support from the “audience,” who as Schattschneider (1975) explained, ultimately determines the outcome of the fight (p. 2).
Good versus evil: Health insurance for children and the elderly vs. tobacco

Rochefort and Cobb (1994) argue “not only are problems given descriptive definition, so too are the afflicted groups and individuals” (p. 22). Schneider and Ingram (1993) specify four types of socially constructed target populations. According to their categorizations, the elderly and dependents (such as children) are generally considered positively constructed populations (Rochefort & Cobb 1994, p. 23). This is important since public perception of afflicted populations is crucial in influencing which side of the debate the audience will join in a political debate.

A sampling of the press coverage on the health care reform debate at this time illustrates the positive construction of both children and the elderly. For example, former Governor Dukakis is quoted in one article stating, “clearly, a more incremental approach [in comparison to his plan in 1988] is the one that’s needed. The McDonough bill is a first-rate piece of work. If we have to approach health care one chunk at a time, let’s start with the kids” (McNamara 1996, June 8). Another editorial addressing the McDonough health care bill stated, “the bill…would expand Medicaid to include tens of thousands of children and set up a program to help needy elderly buy medicine. The bill would not solve the problem of the uninsured overall, but would provide help to two groups [children and the elderly] especially deserving of support” (“Two worthy bills” 1996, June 16).

Conversations with key participants in the 1996 reform confirmed the important influence these images of children and elders had in shaping the reform debate. For example, one interviewee closely involved in the development of the reform bill highlighted the incongruity between the public portrayal of this bill in comparison to its actual details. In his words,
What’s really interesting is that the public’s focus of the cigarette tax was for kid’s health. The bill [McDonough’s health care bill] had a lot more to do with adults’ health than kids’ [health]. The kids stuff was really the public’s image of this bill; it was ‘the bill to improve kids’ health’. The real bill was the MassHealth Basic program, the Insurance Partnership, the Insurance Reversal program, simplification of MassHealth. The kids stuff was really the public drive for kids and seniors, whereas the meat and substance [of the bill] was not kids. And we [those involved in drafting the legislation and advocating for its passage] knew that and didn’t say a word. (Interview 7)

Another advocate for the 1996 reform reinforced the importance of linking the bill to a worthy population and also suggested the importance of introducing a moral element to this debate. According to this interviewee, “in 1996, the focus was on kids and seniors which was important in terms of the ‘mission’ perceived by the press and legislators. For example, I remember using the ideas of, ‘well, how many kids are uninsured? What does that say about us as a state?’” (Interview 5). And finally, to explain what enabled this reform to pass an interviewee who was working as a state bureaucrat in 1996 stated, “I think also there was this realization that kids were sympathetic. There was a pretty broad based alliance to increase the tobacco taxes…since it was the only way to fund that [children’s health insurance]” (Interview 9). As these examples illustrate, this positive construction of children and the elderly as populations deserving of the assistance this legislation would provide was used skillfully by reform advocates to recruit new participants to their side of this debate.

Morone (2003) argues that morality plays a critical role in determining the outcome of political decisions in the United States. He states, “the focus on sinners…powerfully tilts the political debate.” In this instance, the conflict was quickly depicted as good versus evil; since children and the elderly were perceived as “worthy” populations deserving the
benefits of this reform, their supporters were “good”. Conversely, tobacco companies and tobacco users were considered “sinners” and therefore those opposed to the reform were considered “evil.”

Perhaps one of the most blatant examples of this depiction of good versus evil is illustrated in the following excerpt from an editorial in the *Boston Globe*.

On the one hand we have needy children – sweet, innocent, little children, children without health insurance. On the other hand we have the tobacco lobby – evil defenders of that nasty, dirty habit, smoking. Good cause vs. bad cause. Good guys, bad guys. This is easy, right? Well, this is still Massachusetts, remember, and it's an election year, and Bill Weld for all his alleged political savvy keeps getting boxed in by far savvier Democrats dedicated to making life miserable for the Big Redhead. So why should we be surprised when at the end of last week Sen. John Kerry calls a news conference to denounce his Republican Senate rival for refusing to sign on to an increase in the cigarette tax to pay for state subsidized insurance for uninsured children?... ‘You can side with the tobacco companies on this one or you can side with the kids’ he [John Kerry] said. ‘I’m with the kids’ he added. (Cohen 1996, June 26)

In describing the political turmoil surrounding this legislation, another news article explained,

For Weld, the issue [signing McDonough’s health care bill] poses a ticklish political problem. Pledged to uphold a promise never to raise taxes, the Governor is trying to sidestep accusations that he has sided with the tobacco industry to block legislation that would provide health coverage to 125,000 uninsured children and provide help in paying for prescription drugs for an estimated 65,000 low-income elderly and disabled citizens. (Knox & Phillips 1996, June 25)

Finally, one cartoon (see below) parodied William Weld’s opposition to funding health insurance for children (“Quotes of Note” 1996, June 22). The comic suggested Governor Weld had greater concern for his political reputation than for children, the population “deserving” of the assistance this legislation would provide. Implied is that by siding with the tobacco industry, he has joined the “evil” side of this debate.
Although the public focus on this legislation centered on its provision of insurance to children and prescription assistance to the elderly, the McDonough plan contained numerous elements beyond these. Interestingly, interviewees intimately involved in the policymaking process acknowledged an intentional decision to allow this distortion to perpetuate because of the favorable public sentiment it generated. As one policymaker involved in drafting this legislation explained,

This was a huge, large bill and the way we advertised it was we are raising cigarette taxes twenty-five cents to provide health insurance to uninsured kids and prescription drugs to needy seniors, and that’s it. An in fact, those pieces were maybe 20-25% of what we did, we never talked about all this other stuff at all...If you ask me in ’95-’96 I would have said the kids and seniors was about 30 to 50% of it. Now I would say that those pieces were like 10 to 15% of the whole thing. But I don’t think any of us appreciated how big this MassHealth thing was going to grow with the help of the
federal waiver. But the public, if you were to ask them would have said the kids, seniors, and tobacco tax was 100% because that is all we talked about. That was deliberate, strategic portrayal on our part. (Interview 10)

Later in the interview, when asked if there were any slogans or messages that stood out as important during this time, the interview participant responded, “in 1996, we had a very simple message: we are raising tobacco tax to cover uninsured kids and provide prescription drugs to needy seniors, how’s that? And basically people looked and said, ‘wow, yea, absolutely, easy, no-brainer, great’” (Interview 10). The comments of another interview participant involved in the development of this reform proposal reiterated the importance of this message. This interview participant began by referencing the cartoon depicted above, and described this as “the image of Weld sticking up for the cigarette companies versus kids; that was the framing we tried to do. The issue was kids versus tobacco” (Interview 7). By carefully framing this issue, proponents of health care reform sought to persuade the audience into joining their side, the “good” side of this political conflict.

D. Bargaining with Business

Representative John McDonough and other health care reform advocates had intentionally sponsored delays of the employer mandate passed in 1988. Initially their plan had been to keep the law on the books with hopes of a Democratic administration that would facilitate its implementation. However, changing political and economic circumstances prompted a reconsideration of this strategy. Ultimately, policymakers recognized that the employer mandate could be used as a critical political bargaining tool to garner support for the health care reform plan in 1996.
Advocates for reform recognized that business is a very powerful stakeholder in the political arena. Health care reform proponents had successfully diminished business opposition to McDonough’s health care plan in 1996 by dropping the “health care minimum wage” element. However, instead of solely placating business and allowing them to passively watch the reform debate, reform proponents sought to actively engage the support of business in 1996. Business aversion to implementation of the employer mandate – which was now scheduled for implementation in August 1996 - provided the perfect bargaining tool to elicit this support. If proponents could shape the reform in such a way as to add business to the team of supporters, their political power would be dramatically strengthened. Moreover, since Weld had traditionally been an ally of the business community, the alignment of the business community with reform proponents would heighten the political pressure on Weld to support the reform.

McDonough’s (2000) account of the process leading to passage of chapter 203 details the strategy for building support for reform among business groups. As mentioned above, Success by Six was the first of the business organizations to join the coalition supporting McDonough’s health reform proposal. Relying on allies in this group to provide a sense of business reaction to his plan, McDonough and other coalition members began actively outreaching to business organizations who might be persuaded to support the reform. Because of the inclusion of the cigarette tax, the business association representing businesses on the New Hampshire border refused to support McDonough’s plan, but AIM, the Massachusetts Business Roundtable, and the Greater Boston Chamber of Commerce all officially pledged their support of the new policy. Though the business community was generally opposed to any new mandates or new taxes, the reform coalition
persuaded most members of the business community to accept a tax on cigarettes in exchange for repeal of the health insurance mandate.

Press coverage and discussions with key players involved in this debate highlight how reform proponents strategically used the impending implementation of the employer mandate as a bargaining tool to elicit support for McDonough’s health care reform plan in 1996. One executive level political official explained,

they [the advocates for health care reform] wanted to get everybody into this, they finally went to the employer community and said, ‘look, will you support this in exchange for our repealing the employer mandate?’ And I remember talking to John [McDonough, sponsor of the bill] and protesting and he said, ‘look, this is a practical matter. We’re never getting an employer mandate unless we get a Democratic governor. You know that and I know that so we’re not giving up on this, it’s just that is we’re going to get the children’s piece we’ve got to kind of isolate Weld. (Interview 27)

Without legislation to change it, the employer mandate would be implemented August 1, 1996. From a business perspective, time and options to prevent the mandate were limited. In light of these circumstances, Carolyn Boviard, representing the National Federation of Independent Businesses (NFIB), explained to a *Boston Globe* reporter, “we’re intrigued by the proposal [McDonough’s health care reform plan], especially since it would repeal the employer mandate” (Knox 1996, April 30). Looking back, an interviewee who had been one of the key advocates of the 1996 reform expressed similar sentiments. He recalled, “part of the reason that ’96 worked so well is that people had to take, somewhat seriously, that the employer mandate would be implemented” (Interview 8). Later in the interview he expounded on this idea stating, “I think it [trying to engage the support of the business community] was a brilliant idea. The idea of implementing the employer mandate, they [business] had to do something. The business community had to support an
alternative…it was a brilliant strategic move” (Interview 8). Likewise, when asked to reflect on what factors enabled the 1996 reform, a state policymaker who had been deeply involved in promoting passage of this proposal commented,

that [repeal of the 1988 employer mandate] was a critical piece that we deliberately put in there [the legislation] and structured in a way so we got the business community in a check mate move where they either kill the whole bill and thus trigger implementation of the mandate or they agree to the tobacco tax to get rid of the mandate. So, when we presented it that way and they had no other choice, they said ‘we’ll take the tobacco tax.’ Ok, all right, rock’n roll. So then we split the business community away from Bill Weld. (Interview 10)

Pressure from business to pass this reform proposal heightened over time as the prospect of implementing the 1988 employer mandate became imminent (Vaillancourt 1996, July 10). In the beginning of July 2006, the House and Senate passed McDonough’s reform plan. Now, it was up to Governor Weld to act on this legislation. Weld contemplated using delay tactics to prevent the bill from becoming law (Battenfeld 1996, July 9). By law, the governor is granted ten days to veto the bill or send it back with proposed changes. If the legislature opts to reject the proposed changes, the governor is then granted an additional ten days to veto the legislation again. In order for the legislation to become law, the legislature must then override the governor’s veto. Though the state legislature had passed the bill by wide margins sufficient to override a gubernatorial veto, formal legislative session would end on July 31. Any delay tactics used by Weld could prevent the legislature from voting on the bill prior to the conclusion of formal business (SHNS 1996, July 15). Without a final vote, the bill would die at the conclusion of the legislative session.
Governor Weld was faced with a very difficult political dilemma. If he supported the legislation, he would violate his campaign promise to not increase taxes. However, by blocking the legislation, he would infuriate the business community by triggering implementation of the 1988 employer mandate. Moreover, he had also promised repeal of the employer mandate during his original gubernatorial campaign. As one *Boston Globe* article explained,

the strategy [to stall to death the McDonough health care bill] is fraught with danger for Weld, because the bill he opposes contains a provision that would delay a new annual business tax of $1,600 per worker for companies that do not provide health insurance. The Dukakis health tax is now slated to take effect Aug. 1 unless Weld signs the bill raising cigarette taxes – or finds some way to get legislators to back down. (Villaincourt & Sue Wong 1996, July 9)

According to at least one interviewee and numerous news articles, the business community recognized this conundrum for Weld, and actively lobbied him to act in accordance with its interests (Interview 7).

Ultimately, as a result of political concern that delay tactics could foster residual opposition to Weld in his coming campaign for U.S. Senator, the governor did not follow through with the delay tactics he had threatened (Battenfeld 1996, July 10). Though Weld did symbolically veto the legislation, he did so without extensive delay and his veto was overridden by both houses of the state legislature on July 24, 1996.

**E. Economic Enablers: 1115 Waiver, the Tobacco Tax and Budget Neutrality**

The political strategies used by reform advocates were essential to passage of the reform, but there were also economic factors that were crucial in making this reform possible at this time. In tracing the legislation back to its origins, it is apparent that the
Weld Administration’s filing for the 1115 waiver was a fundamental factor in prompting and enabling this reform. Approval of this request not only maintained the issue of health care reform on the political agenda, but it also provided the economic opportunity for the state to contemplate reform, since it ensured the provision of federal funds for the redesign of the state Medicaid program. Though the reform had many different pieces, these expansions were the primary features that initiated the debate on health care reform and ultimately enabled dramatic increases in access to health insurance.

One high level state administrator argued subsequently that filing for the 1115 waiver was prompted by an economic interest in using state funds most efficiently. Then, acquiring the 1115 waiver provided the impetus for reform. He explained,

we [the state of Massachusetts] had so much state money already in the budget appropriated for healthcare purposes that we felt that by using it more wisely and taking advantage of the federal reimbursement that could come with the Medicaid expansion, we could in fact insure a lot more people than were currently insured. And we had an uncompensated care pool that was running at state expense, trying to insure people who had a lot of, what we thought were duplicative programs, that weren’t leveraging federal money and the combination of existing funds and new funds would give us the basis for a comprehensive insurance system. (Interview 15)

Another interviewee that participated in this study who was working in the state legislature at the time of the reform suggested that acquiring the 1115 waiver enabled the reform to occur. He argued,

it [the 1115 waiver] was crucial because we wouldn’t have done it [passed a reform expanding the state Medicaid programs] if we didn’t know the federal government would support us and we would get the federal matching funds. You know, I mean that’s how all these Medicaid expansions are pretty much contingent upon the federal government granting us these waivers otherwise the whole burden falls on the state and no state wants to start taking this on by itself. (Interview 13)
In addition to the singular importance of federal funds, the inclusion of the tobacco tax resulted in a reform proposal that was projected to be budget neutral for the state. Despite how contentious the imposition of a cigarette tax was, in the end the ability to propose a plan that would be funded through a new revenue stream was a primary factor facilitating passage of this legislation. According to estimates, the $.25 per pack increase on cigarettes and the 15 percent tax on cigars would raise approximately $100 million in revenue for the state to use to administer the insurance programs proposed in McDonough’s bill (Sue Wong 1996, July 23).

In Senate debate on the plan, Senator Montigny illustrated the importance of this funding arrangement arguing, “if you want to implement these things, you must have a dedicated revenue stream. We’ll have $100 million in revenues through this [the cigarette tax]” (SHNS 1996, July 24). In the House, Representative Flaherty also supported the use and viability of the cigarette tax to fund the health care reform. During house debate on this bill he stated, “the biggest concern my colleagues have is that the higher cigarette tax will discourage more people from smoking and reduce revenues. We have short term memories. We are going to be swimming in revenues over the next five or ten years because of the wise tax policies we have voted” (SHNS 1996, July 24). Senate President Thomas Birmingham, a frequent smoker, also rationalized the utility of the cigarette tax stating, “I think this is the only politically viable tax increase that we could put on the table and it’s addressing a pressing social need” (Murphy 1996, June 11).

Finally, one advocate during this reform episode reinforced the importance of these combined economic factors – the federal funding and the revenue generated from the cigarette tax – on passage of the 1996 health care reform. In her eyes, this plan provided
macro level economic benefits that went beyond consideration of the state budget. This interviewee explained,

for the Children’s bill in 1996 [the McDonough reform plan], we got federal funding through the Medicaid expansion and also used the tobacco tax. So, this was nearly budget neutral and employer budget neutral. Medicaid is a smart way to expand because you bring in federal money. And, bringing in federal money for health care is important because it means more jobs and that builds a strong alliance between advocates and providers. (Interview 5)

Collectively, the political and economic factors addressed here help explain the passage of McDonough’s reform plan, chapter 203 of the acts of 1996. Politically, health care reform proponents constructed a positive policy image of their plan and the populations it would impact, and successfully used the employer mandate as a bargaining tool; these efforts swayed the “audience” to their side of the debate. Economically the circumstances in 1996 were quite different from those of 1988. The section 1115 waiver and eventually the new cigarette tax garnered public support because they allowed the state to make expansive changes with minimal adverse economic repercussions on the majority of people. As a result of these circumstances, the health care reform effort in 1996 was successful, and many of the features of this reform currently remain in effect in Massachusetts.

V. Conclusion: The New Health Care Reform Plan

Before concluding this chapter, there are a few interesting aspects of this health care reform episode that are worthy of discussion. To begin, chapter 203 of the acts of 1996, formerly titled An Act Providing for Improved Access to Health Care, was colloquially known as “McDonough’s health care bill”. However, the evolution of this bill
reveals some political irony behind this colloquial reference. Many of the elements that were passed as part of “McDonough’s reform plan” were in actuality first introduced by Governor Weld. One Democratic policymaker at this time chided,

The irony of the whole thing is that...probably 80% of that law was the intellectual property of the Weld administration through Charlie Bake and Bruce Bullen. That was the core. That was what was truly important about it and the irony that it ended up being a situation where Bill Weld had to veto his own intellectual property. (Interview 10)

Individuals working for the administration during the reform’s passage offered a similar perspective on this situation. One high level administrator griped,

Well, people forget the bill was filed by Governor Weld, even though he later vetoed the bill because it was returned to him with a tax included that he did not like. The bill he filed did not include any taxes and it was a proposal to reallocate existing funds to support the federal waiver that the Administration had been successful in negotiating with the Clinton Administration. So that bill, which reflected the terms of a Medicaid waiver that was negotiated, was really the impetus for health reform. It [the addition of a cigarette tax in the bill the legislature ultimately passed and presented to Weld] was a political ploy from my point of view. It was designed to insure that Governor Weld vetoed the bill because he was running in a Senate race against Kerry. (Interview 15)

Finally, another bureaucrat working for the Weld Administration explained,

Politically, the Weld Administration could not have put forth the cigarette tax. And, the cigarette tax McDonough brought through was the thing that brought it all together. And so in some ways, there was a little bit of jealousy, frustration, just a little bit around the fact that he really, McDonough was able to put in the last piece of the puzzle to make it work because Weld had taken the no new taxes pledge he just couldn’t. (Interview 11)

These comments illustrate one of the first ironies of this reform episode. Though Weld may have been one of the primary architects of many of the features in this health care reform episode, in the end, political circumstances forced him to issue a veto.
Another irony associated with this reform episode is that to facilitate its passage, reform proponents were forced to nullify the 1988 employer mandate. This had been a fundamental provision of the 1988 universal health care law. However, to acquire the political support necessary to pass a health care reform in 1996, advocates felt compelled to concede this element to the business community. One interviewee even suggested that leveraging the employer mandate was the critical factor that enabled health care reform to pass in 1996. She argued, “so that was put off [the employer mandate] and I say it was a major victory to keep it on the books for the next few years. We had to fight about it for every year. It was repealed; it was the deal, the ‘chit’ for the children’s [health care reform in 1996]” (Interview 5). Regardless of whether repeal of the 1988 employer mandate served as the primary, or one of many influential factors that enabled the 1996 reform, it is certainly ironic that in order to enable one health care reform, it was necessary to nullify a major piece of the health care reform plan passed just years before.

Finally, at the outset of this chapter, I argue that this study on the health care reform experience in Massachusetts illustrates that changes in political institutions, the policy preferences and economic interests of public and private decision-makers, and the resources available to public officials within a state all influence the nature, timing, and effectiveness of state reform efforts. Since political culture and the autonomy and capacity of political institutions can change over time within one state, different policy environments will produce different policy outcomes within the same state at different points in time. In explicating the political and economic changes that occurred from 1988 to 1996, and describing the very different health policy plan that resulted in 1996 (in
comparison to 1988), this chapter has shown how this argument applies to the case of Massachusetts.

Some of the individuals interviewed for this project also offered interesting commentary on the way in which changes in political or economic circumstances can affect policy outcomes. For example, when asked what factors caused the unraveling of the 1988 reform, one interviewee who had been a prominent supporter of the 1988 universal health care law asserted, “Weld. Weld. Charlie Baker. Weld didn’t care about anything, but it was Charlie Baker. I hold him personally responsible [for repeal of the 1988 employer mandate]” (Interview 25). In the eyes of this interviewee, a changed administration with new political views forced the demise of the 1988 universal health care law. Offering a different perspective, another policymaker suggested that passage of the 1988 universal health care law was actually passed solely for political reasons, without any intention to actually implement it. In his words, “this kind of stuff was designed to ‘I’m going to do for the country what I’ve done for Massachusetts’ type of thing. But as soon as he was out of that [the Presidential race], they voted to delay the implementation of the mandate and they delayed that for two or three more sessions or whatever and they just killed it, flat out” (Interview 6). From this perspective, the failure to implement the 1988 employer mandate was intentional from the beginning and not the result of an administration opposed to it. Nonetheless, both arguments highlight the importance of changing political circumstances – a change in administration and a lost presidential bid, respectively – on policy outcomes.

Though the employer mandate was repealed, chapter 203 of the acts of 1996 established a new reform plan that would increase access to health insurance for thousands of individuals and provide seniors with much needed pharmacy assistance. Though some
may have initially considered this a Pyrrhic victory, the expansions established through this legislation are still in place in Massachusetts over ten years later. Despite the success of this health care reform episode, however, subsequent chapters will illustrate that the issue of the uninsured would persist in Massachusetts as both a political dilemma and policy problem.
CHAPTER FOUR
GIVING THE PUBLIC ITS SAY: THE 2000 BALLOT INITIATIVE

Despite passage and implementation of chapter 203 of the acts of 1996, concerns associated with the health care system in Massachusetts persisted. In the late 1990s, consumers and providers became increasingly dissatisfied with the role of managed care organizations (MCOs) in the health care system. Illustrative of public frustration with the growth of managed care, in September 1998, public opinion polling in Massachusetts revealed 70% of voters favored the right to sue MCOs (Pham, 1998, September 18). Though this system for monitoring or regulating access to care was devised as a mechanism to control rising health care costs, doctors argued managed care practices were dramatically weakening their decision making autonomy and posing a threat to patient safety (Pham 1998, March 6).

Financial woes were also a root cause of dissatisfaction with MCOs for providers. In the quest to compete for members, MCOs charged artificially low premium rates. This did aid in slowing the rise of premium costs in the mid to late 1990s, but the result of this strategy had unintended consequences that adversely impacted providers in the state. Insurers were struggling to adequately reimburse providers for patient services. Perhaps the most infamous example of this situation is the financial collapse of Harvard Pilgrim Health Care in 1999. This insurer was put into receivership by the state, after being unable to provide hundreds of thousands of dollars due to hospitals and providers for care provided to its members (Convey & Heldt Powell 2000, January 25).

Dissatisfaction with the managed care system provided the impetus for calls to reform the health insurance system. However, advocates for reform did not limit their
solutions solely to targeting the practice of managed care. The debate expanded to include calls for reform of the system in its entirety and the provision of universal health insurance. For example, in April 1999 one group known as Mass-Care staged a rally at the State House to focus attention on health reform and try to mobilize support for a single payer universal health care system that would include the 700,000 residents still lacking insurance (Kong 1999, April 26).

This chapter will begin with an account of the climate in which initiative petition 99-4, An Act to Protect the Rights of Patients and to Promote Access to Quality Health Care for All Residents of the Commonwealth, materialized. This reform initiative may have been prompted by backlash to the managed care industry, but its supporters also sought to expand access to health insurance. A detailed description of the way in which this reform developed and was subsequently marketed to the public will elucidate the factors that contributed to the demise of the initiative, despite the initial popular support that earned it a spot on the ballot.

Chronicling the debate over this initiative illustrates Schattschneider’s (1975) theory of the contagiousness of conflict and the importance of issue definition, as explained by Rochefort and Cobb (1994), in enabling one side to gain advantage in a political debate. Examination of this struggle also reveals the way in which opponents adopted conflict containment strategies in an effort to prevent deliberation on this initiative. Consideration of other key factors, such as the use of numbers and symbols in the rhetorical debate, and the role of focusing events and the media is critical to explaining the outcome of this political battle.
I. The Dynamics of Conflict Expansion

In explaining the nature of political conflict, Schattschneider (1975) emphasized the “contagiousness of conflict” and argued that “the outcome of all conflict is determined by the scope of its contagion” (p. 2). According to Schattschneider’s model, it is in the interest of the weaker side to expand or socialize the conflict so as to bring in new participants. As new participants enter the fray, the balance of power between sides is likely to change. However, though the number of participants that become involved in a problem affects the results, critically important is the way in which those that do become involved divide into groups or factions (Schattschneider 1975). In political struggles, the primary objective of the antagonists is to define the problem or issues in such a way as to mobilize participants to their side of the debate, while also “exploit[ing] the cracks in the opposition” (Schattschneider 1975, p. 67).

A. The Role of Problem Definition in Conflict Expansion

Rochefort & Cobb (1994) illustrate how the dynamics of problem definition, or the way in which issues in the political arena are characterized, impact the policy process and policy outcomes. In the context of conflict expansion, problem definition is an important strategic tool that can be used by opposing sides in a conflict to sway the audience to their side of the debate. Analysis of the rhetorical tactics and strategies used in a political contest provides insight into how a debate unfolded and resulted in a given outcome.

In reviewing the way in which different groups categorize an issue, Rochefort & Cobb (1994) highlight several recurrent types of problem definition claims. For example, to gain the attention of the general public and public officials issue advocates often
concentrate on the severity of an issue. In this case, proponents seek to demonstrate that a
given issue or problem has reached a threshold that now requires immediate attention. In
addition to the severity claim, proponents of a given issue may define a problem in terms
of its growing incidence. By defining a problem as one that is rapidly increasing and that
threatens to continue to do so without intervention, proponents hope to pressure the
public into immediate action. Defining a problem as a crisis is another problem definition
claim used by issue proponents to persuade the audience that action is overdue and of
absolute necessity.

In addition to the use of the aforementioned problem definition claims in political
arguments, Rochefort & Cobb (1994) also describe how the “instrumental versus
expressive” conflict can provoke interesting debates (p. 24). In this circumstance, the
opposing sides in a political conflict differ in the way they focus on the policy issue under
consideration. For those focusing on the instrumental orientation, the focus in defining
this issue is the end goal or practical result of the proposed policy. Conversely, for the side
focusing on the expressive orientation, the focus is not on the end result of policy action,
but on the policy recommended for reaching that end; an expressive approach considers
how the policy aligns or deviates from established cultural or political values. This
contrasting focus on the same policy proposal can result in an intense battle between
opposing sides as they struggle to convey their perspective to the public.

B. Conflict Containment

Though both sides in a political conflict can use problem definition to mobilize
support for their side, the political system favors the status quo over change. In The
Rhetoric of Reaction Hirschman (1991) highlights three common themes that have been employed to block progressive policy proposals since the French Revolution. Themes of perversity, jeopardy, and futility are three common rhetorical themes employed by “conservatives” or “reactionaries” to discount policy proposals (p. 7). The perversity argument is used by opponents to suggest that a proposed action or policy solution will only exacerbate the problem it is intended to address. The second argument is that of futility, or the notion that the proposal will be ineffective in resolving the problem proponents have identified. Finally, reactionaries may use jeopardy arguments to suggest that a new policy will undermine a previous reform or policy accomplishment.

Cobb & Ross (1997) also provide insight into the tactics and strategies used by those opposed to a new policy proposal. Though agenda denial is sometimes the first course of action for issue opponents, when it becomes apparent that an issue will make the public agenda, opponents will often rely on issue containment strategies to diminish the likelihood of policy passage. Cobb & Ross (1997) identify four strategies, deemed low cost, medium cost attack, medium cost symbolic placation, and high cost, used by opponents to defeat new policy initiatives. Low cost strategies involve minimal people and consume minimal time and are often the strategies first considered by issue opponents in an effort to prevent an issue from even being considered. Using low cost strategies, opponents try to defeat a policy initiative at the outset by either denying a problem exists, or by undermining the legitimacy of issue advocates.

Cobb & Ross (1997) distinguish between two types of medium cost strategies. Opponents may try and attack the perspective proponents are offering on a given problem, or, they may attack the group itself. Most frequently, the basic premise of the sponsoring
group’s argument is challenged in an effort to discredit the issue or the policy proposal. In doing so, opponents create uncertainties for the public as to the actual scope of the problem or the ability of the proposed policy to address it. Often, the impact of the opponents’ attack is to heighten the fear of the general public. The second type of medium cost strategy is labeled symbolic placation. Opponents using this type of strategy may acknowledge that a problem exists, but question its urgency and the proposed method of resolving it. Therefore, those against the proposal might offer alternative recommendations to address the grievances raised by policy initiators in an effort to acquire control of an issue, but their solutions would actually be of minimal immediate impact. Finally, high cost strategies are the last resort of opposition groups. These strategies include electoral, economic, legal, or physical threats by opponents.

C. Key Factors in the Conflict Expansion Process

As detailed above, there are a variety of tactics that opposing sides in a political conflict might adopt in an effort to prevent a proposed policy from agenda consideration or to sway outside participants to their perspective. In addition to the importance of these strategies in influencing the outcome of the debate, there are several other factors that may affect the conflict expansion process and ultimately the way in which an issue or policy is decided. In Policy Paradox: the Art of Political Decisionmaking, Stone (2002) illustrates the ways in which two opposing sides can offer equally plausible though very different perspectives on a given policy. The discourse used by either side to describe a problem or policy impacts the construction of the issue in the political community.
For example, Stone (2002) illustrates the importance of numbers in defining a policy problem. It is not numbers alone, but rather the way in which they are strategically presented, with evaluative or normative discourse to reinforce a specific perspective on a problem or policy that makes them a strong political tool. The discourse of rights is another problem definition strategy often used by advocates. Arguments based on the concept of rights pervade American political culture (e.g., the “right” to life, the “right” to equal education), and are used to suggest the existence of a collective problem requiring a collective solution. Finally, symbolic representation is another discursive tool Stone (2002) identifies as used in policy debates to persuade or emotionally compel individuals to a certain side in a policy dispute. Symbols are often used to depict a larger issue or idea, and one’s subjective reaction to a symbol often influences how they view the larger issue or problem that symbol connotes.

Like Stone (2002), Cobb & Elder (1983) identify the importance of symbols in political conflicts. They suggest that symbols with historical precedence or which imply action or urgency are likely to generate additional political support for a group. In addition, they suggest that the importance of a symbol may be enhanced when it is used by a person the public recognizes. However, Cobb & Elder (1983) caution that while symbols can be helpful, overuse or incorrect use of symbols may have negative impacts.

Part of what impacts the level of exposure symbols acquire is media coverage of issues. Cobb & Ross (1997) suggest that media coverage, including the press and television, often has a direct impact on the result of political conflicts. Both sides of a policy debate seek to sway media coverage of an issue to favorably represent their perspective. For policy proponents, it is essential to maintain media coverage and a sense
of urgency on this issue. The use of powerful symbols or tactics, organizing public
demonstrations, and/or using celebrity advocates to appeal to the public are strategies
often used to maintain media attention to an issue. In addition, money also enables a
group to ensure media coverage of an issue since it allows direct purchasing of media space
or time.

A triggering or focusing event can enhance public attention on a given issue.
Birkland (1997) defines a focusing event as a sudden, relatively rare, reasonably harmful
event or an event suggesting the possibility of future harms that can illuminate a problem
and impact group mobilization. According to Kingdon (2003), a focusing event may be a
crisis or disaster that calls attention to a problem, but a powerful symbol that catches on or
a new emphasis on a personal experience of a policymaker may also serve as a focusing
event. The occurrence of these external variables may greatly impact the conflict
expansion process, as the public becomes engaged in an issue or conflict by an
unanticipated event, powerful symbol, or new emphasis on a personal experience.

II. A Call to Action: The Origins of the 2000 Campaign

In 1997, in response to his frustration with the “commodification of health care,”
Dr. Bernard Lown founded the Ad Hoc Committee to Defend Health Care in
Massachusetts (hereafter “the Ad Hoc Committee”).17 Shortly after its founding, the Ad
Hoc Committee began working on a public campaign to raise awareness of their concerns
with the health care system. In December of 1997, the Journal of the American Medical

17 The Ad Hoc Committee to Defend Health Care is now known as the Alliance to Defend Health Care. For
more information on their origins and current composition and principles, visit
Association (JAMA) published the Ad Hoc Committee’s “Call to Action”. In this article, the authors, a group of Massachusetts physicians and nurses, criticized “market medicine” and the impact of profit driven incentives on the health care system (“For our patients, not for profits: a call to action” 1997). The call acknowledged differing perspectives among its authors on health care reform approaches, but indicated agreement on five principles. These principles included: that health care clinicians must be able to focus on their primary tasks identified as the relief of suffering, the prevention and treatment of illness, and the promotion of health; that corporate profit and personal fortune have no place in caregiving; that financial incentives that may adversely impact the standard of care or type of services provided to a patient should be prohibited; that patients should have a right to a see the health care professional of their choice; and finally, that access to health care should be a universal right for all citizens.

The authors argued that only through “public outcry” would it be possible to “reclaim medicine” (“For our patients, not for profits: a call to action” 1997). About a year after publication of the Call to Action, the Ad Hoc Committee acted upon their words. Their “public outcry” was a re-creation of the Boston Tea Party. This public illustration of their frustration with the impact of for-profit health care managers and organizations on health care was representative of with what Cobb & Elder (1983) categorize as historical symbolism. Just as Americans threw tea into Boston Harbor to rebel against Great Britain in the 1700s, so too did the Ad Hoc Committee members throw annual reports of for-profit health care corporations into Boston Harbor to rebel against the managed care industry (Barg 1998; Interview 33; Interview 36). This action served as a triggering or focusing event, used intentionally by the Ad Hoc Committee in their efforts to draw
attention to this issue and prompt a revolt against a market driven health care system, not only in Massachusetts but also nationally (Interview 36).

Following this event, members of the Ad Hoc Committee drafted and subsequently collected signatures for an initiative that would become Ballot Question 5 in November of 2000. The process to establish an initiative petition for a law in Massachusetts is lengthy. The first step to place a petition before the General Court requires that initiative sponsors collect a minimum number of residents’ signatures. The number of signatures must be at least equal to three percent of the total vote cast for all candidates for governor at the last state election. In 2000, this meant petition sponsors needed to collect at least 57,100 signatures. The Ad Hoc Committee easily collected the requisite signatures necessary to present this petition to the General Court by January of 2000. In fact, estimates suggested that over 70,000 Massachusetts voters signed the petition in the fall of 1999 (Knox 2000, April 7). The Massachusetts General Court then has until the first Wednesday in May to act upon petitions submitted to them in January. If both Houses have not acted on the petition by this deadline, its sponsors may move the initiative petition process forward and put it on the ballot by collecting a new set of residents’ signatures equal in number to at least one half of one percent of the vote cast for governor at the last state election. In this instance, following inaction of the General Court on the petition as of May 3rd, 2000, the Ad Hoc Committee promptly gathered the additional signatures required, at least 9,517, to assure placement of this item on the November 2000 ballot (Altman et. al. 2000).

The petition, An Act to Protect the Rights of Patients and to Promote Access to Quality Health Care for All Residents of the Commonwealth, addressed universal health insurance coverage, a bill of rights for managed care patients, and conversion of hospitals
and health plans from non-profit to for-profit status. As the voter brochure summary stated, “A YES vote [on Question 5] would require health insurance carriers to guarantee certain rights to their patients and providers, and it would prohibit the conversion of non-profit hospitals, HMOs, and health insurers into for profit entities until a system is created to provide comprehensive health care coverage for all Massachusetts residents” (Galvin 2000). News that this question would appear on the November 2000 ballot unleashed an intense battle between its sponsors and those opposed to the initiative. Both sides employed numerous strategies in the ensuing debate in trying to persuade participants to join their respective teams.

III. Policy Opponents Push Back

The Ad Hoc Committee’s ability to swiftly collect sufficient signatures to put this initiative on the ballot illustrated its initial popular support. However, stakeholders vested in preserving the status quo, especially the business community and health insurance industry, were not willing to let an outcome unfold complacently. Concerned about the implications that passage of Question 5 might have on their economic interests, these stakeholders used multiple political avenues in their effort to contain this issue and prevent a yes vote on the referendum in November.

First, when the General Court failed to act on this petition by the May deadline, Health Maintenance Organizations (HMOs) reached out to members of the advocacy community in an effort to negotiate an alternative reform plan. In the spring of 2000, some members of the group supporting Question 5, consisting of doctors, nurses, academics, unions, and health care advocacy organizations, along with representatives from
HMOs, worked with state policymakers to devise a legislative proposal that would appeal to each of these stakeholders. Ultimately, they created a bill slightly different from the ballot initiative, but with similar objectives. This action represented the first of opponents’ issue containment efforts. The requisite signatures to put this question on the ballot served as evidence that the public considered this a legitimate issue and concern. Therefore, issue opponents could not rely on the low cost strategy of refusing to admit that a problem exists; instead, they resorted to trying to control the actions used to address it (Cobb & Elder 1997).

While the ballot initiative required that all Massachusetts residents have a right to health care coverage (without outlining the system to reach this end), the bill would create a universal health care advisory committee that would develop a plan for bringing affordable care to all Massachusetts residents. This, the creation of a committee to study a problem, is one of the most common symbolic placation strategies according to Cobb & Elder (1997). Based on their theory, this medium attack strategy serves as a symbolic action that helps defuse a conflict by mollifying public concern that this issue is not being addressed. This tactic is effective for opponents because by the time the work of the committee is concluded, the public is likely to have moved on to a new issue. Other features of the negotiated bill included: a provision that would allow the Attorney General to regulate the conversion of non-profit to for-profit entities (in contrast to the petition, which would prevent these transitions entirely) and a “Patients’ Bill of Rights” (Washington 2000, July, 10). The Patients’ Bill of Rights was designed to provide doctors in HMOs more latitude in making treatment decisions and patients certain rights regarding access to care within an HMO (Mishra 2000, July 14; Heldt Powell 2000, July 22).
State policymakers and health plan representatives promised to support and shepherd this legislation through the policy process in exchange for advocates’ withdrawal of their initiative petition. However, the sponsors of the petition had already submitted the number of signatures necessary to put this question on the November ballot. Legally, the residents who had signed the ballot had the right to have a public vote on this question; it could not be rescinded (Mishra 2000, July 7). Nonetheless, this negotiated legislation, chapter 141, passed at the end of July and became known as the Patients’ Bill of Rights. The historically symbolic “Bill of Rights” terminology used to describe this legislation illustrates the conscience strategy to counter the Ad Hoc Committee and the supporters of Ballot Question 5 who launched this issue into the public eye with their own historically symbolic recreation of the Boston Tea Party.

Although opponents’ efforts came too late in preventing the petition from reaching the ballot, the political negotiation and deal-making that led to passage of the Patients’ Bill of Rights presented a major political setback for the reform coalition. Many of those who had supported the referendum question opted to cease campaigning for Question 5, arguing that passage of the Patients’ Bill of Rights made the referendum unnecessary (Mishra 2000, September 17). Most notably Health Care for All (HCFA), one of the most influential health care advocacy organizations in Massachusetts, pursued this course. This is illustrative of what Cobb & Elder (1997) categorize as the co-opting of prominent people from the initiating group, used by policy opponents to weaken the stance of the group that prompted attention to this problem.

In describing the “co-opting” of HCFA by the opposition, one doctor who remained committed to the referendum explained, “they [HCFA] initially said they were
going to support it [the ballot initiative] but then they cut a deal…Basically, Health Care for All said if you [the state legislature] pass this [chapter 141] we'll oppose the ballot initiative. And they did” (Interview 30). In explaining their position at this time, a representative from HCFA explained,

there was an enormous internal issue here about what our position should be and what was the right thing to do. And, it split that coalition apart…My understanding…was there was an agreement where if the majority said to drop they would drop it [the campaign for the initiative petition]. And, the majority did want to drop, but the minority kept going anyway. It was a conscious strategy in 2000...to do a ballot initiative that forced the legislature to act. If we get a bill, we'll drop the ballot. And that was the deal in 2000. It got screwed up by the groups that wanted to keep going. (Interview 7)

Regardless of the actual political agreement at the time, the result of HCFA’s departure from the coalition was a dramatic decline in the size of the group dedicated to passage of the referendum.

One of the original members of the Ad Hoc Committee who stayed on to campaign for Ballot Question 5 spoke metaphorically about the petition as “an orphan without parents” after the Patients’ Bill of Rights passed (Interview 33). He further explained that “the coalition that had been backing this thing [the initiative petition] just vanished. [It] just vanished and it was the end of July 2000 and there was no more coalition” (Interview 33). An article in the Boston Globe also emphasized the dramatic decline in the size of Question 5 supporters. According to the article,

most of the advocacy groups that once supported Question 5 have bowed out, saying that a Patients’ Bill of Rights passed by state lawmakers in August is enough reform. The remaining Question 5 supporters, a passionate but small band of doctors and nurses, have $4,433 in their coffers. (Mishra 2000, September 17)
Those who remained committed to the campaign felt the Patients’ Bill of Rights did not sufficiently address the issue of universal health care access. Therefore they persisted in their quest to pass comprehensive health care reform guaranteeing all residents health coverage. In the words of one of the doctors who remained part of the campaign, suddenly you had this new piece of legislation [chapter 141]…There were some interesting and good things in there but there was nothing in there that would have moved us conclusively toward universal healthcare. The only thing in there [chapter 141] in that direction was to setup this Commission… (Interview 33)

The only recourse for Question 5 supporters was to recoup their loss in membership by engaging new members of the public to their side prior to the November vote. Unlike the reform coalitions in 1996, however, the advocates for this reform initiative were unable to garner a diverse coalition of supporters. The group did not include some of the major political players who advocated for reform in 1996, business and insurers for example, but consisted primarily of physicians and other health care providers. Nonetheless, proponents hoped that by emphasizing the importance of universal health insurance and presenting this as a straightforward, simple “rights” issue, it would bring new players to their side of the debate. However, HMOs voiced their intent to spend millions, if necessary, to defeat their efforts (Mishra 2000, July 14).

IV. Contentious Conflict

Consistent with Schattschneider’s (1975) theory, chronicling the rhetorical debate on Question 5 illustrates the ways in which both sides used the tactics and strategies described above to attract participants to their side of the debate. Moreover, close review
of the political struggle preceding the vote on Question 5 also highlights the role of numbers, symbols, and focusing events in shaping the outcome of this contest.

A. Question 5 Proponents: Prompting Public Interest in the Problems of the Health Care System

To provoke the public’s interest in the initiative, advocates of Question 5 relied upon problem definition strategies that described the growing incidence and increasing severity of problems associated with the Massachusetts health care system. Proponents of the ballot initiative even went so far as to characterize the health care system as in a state of crisis. Question 5 supporters hoped that by exposing this perspective, the public might be convinced of the need to consider this a social problem in need of prompt resolution.

Interestingly, in the midst of the ballot initiative campaign, the results of both a state survey and a federal survey designed to assess the number of uninsured were released. The state survey sponsored by the Division of Health Care Finance and Policy (DHCFP) and the federal survey sponsored by the U.S. Census Bureau suggested widely different estimates of the uninsured in Massachusetts. Even more surprising, however, was that the surveys revealed contradictory trends; the state survey suggested a decline in the number of uninsured, while the national survey suggested an increase. This discrepancy highlights what Stone (2002) identifies as the fundamental issue of any policy conflict – how to count or measure a problem. In developing survey methods for measuring the uninsured, the two studies used different approaches; the decisions regarding how to categorize or count items (or individuals in this case) impact the final count. Therefore, the process of reaching a number is, in itself, political.
Nonetheless, illustrative of the importance of numbers in framing an issue, the opposing sides of this issue quickly latched on to the statistic that best supported their political position. For example, a *Boston Globe* article highlighted that while Governor Celluci, who was opposed to Question 5, announced that the state’s uninsured rate had dropped by over one third from the prior year, advocates emphasized the federal numbers indicating over 600,000 people in Massachusetts still lacked health insurance. According to the advocates, these numbers indicated that the problem of the uninsured had not improved (Mishra 2000, October 9).

Another article written by two doctors supporting Question 5 sought to convince the public of the dire need to address the health care situation in Massachusetts. In their words,

> Unfortunately, while the Legislature has been fiddling, Massachusetts health care is aflame. This summer HMOs announced plans to drop thousands of seniors and demand double digit premium increases from their remaining customers. Recently, federal statisticians delivered two more pieces of bad news. First, our state has the highest health care costs in the world, 30 percent above the national average, despite having the nation’s highest HMO enrollment. Second, the number of uninsured is actually rising in the Commonwealth, while the national numbers are inching down – 636,000 residents of Massachusetts, 10.5% of the population, have no health coverage according to the Census Bureau. Twelve years ago only 368,000 were uninsured. Our health care system is failing…Question 5 rejects this status quo and mandates salutary reform (Woolhandler, & Himmelstein 2000, October 19).

The discourse used in this article indicating the health care system was “aflame”, that “thousands of seniors” were losing health insurance, and that customers should expect “double digit” premium increases was used to incite public participation in this debate. In addition, the emphasis on the increase in the number of uninsured over the past decade suggested this was a problem that would continue to grow without intervention.
Subsequent articles in the *Boston Globe* quoted advocates stating these circumstances indicate “a crisis in the state” (Lasalandra 2000, October 30). Question 5 advocates hoped that these problem definition claims would awaken public concern and encourage people to side with reformers.

B. Emphasizing the End Goal: The Instrumental Focus of Proponents

An interview participant who was the leader of a large health care professional organization and one of the original ten signers of the initiative petition explained,

> Question 5 grew out of this system is broke, it’s not working, there needs to be comprehensive reform. There needs to be comprehensive access for care. There needs to be restrictions on managed care and what happens, and patients’ rights in the managed care environment, and there needs to be a commitment to a safer care for all patients and some oversights. So that was the impetus. We realized the value of having a ballot initiative to deal and draw and focus the issue and force that [comprehensive reform].

(Interview 36)

This commentary reveals the instrumental focus of policy initiators. For proponents, though the petition was tri-faceted, the focus throughout the ensuing debate on health care reform centered on the end goal of guaranteeing health insurance coverage for all Massachusetts residents. An interviewee who was closely involved in organizing and designing the campaign for the Yes on 5 contingent explained, “the tag line was affordable healthcare for all or affordable healthcare for everyone and that just really summed it up. The meat and potatoes was the universal coverage part of it so the rest just kind of….other things that could happen would be positives” (Interview 17).

In their effort to convince the public of the importance and legitimacy of this objective, the sponsors of Question 5 sought to simplify this issue to one of basic social
rights. As Stone (2002) asserts, political demands are often framed in terms of rights and the concept of rights is one that has historically been successful in mobilizing action. A sample of newspaper articles published during this time illustrates the rhetoric proponents utilized in following this strategy. For example, an article in the *New York Times* on state health care referendums quoted John Kenneth Galbraith, a well known economist, as stating that he “joined the Yes on 5 campaign with all sensible people in not wanting to see anyone die because they can’t afford the requisite medical treatment” (Goldberg 2000, June 11). This same article stated that the Yes on 5 campaign in Massachusetts viewed universal health care as the “morally correct path” (Goldberg 2000, June 11). In addition to John Kenneth Galbraith, Question 5 also acquired the political support of another prominent and influential public opinion leader, Senator Edward Kennedy. In responding to a reporter’s question as to his stance on Question 5, Senator Kennedy focused on the theme of “universal health care” as the end goal of this initiative, stating he “intended to vote for it” since “the overall objective is compelling” (Mishra 2000, November 1).

Editorials endorsing Question 5 also skillfully used rhetoric that appealed to the public’s conscience. One editorial submitted to the *Patriot Ledger* stated,

> while other nations, more civilized than ours, have made health care a nationally funded humanitarian right, we consign millions to no care, poor care, or hospital emergency room triage…We are in this crisis because a powerful minority of political conservatives and profit-driven health/drug industrialists believe there is no better way to make money than through the ill health of men, women and children…Massachusetts voters should keep in mind that they will have a chance to be heard on the issue of an all-embracing health care system when they go to the polls in November. (Menzies 2000, August 2)

Another editorial in the *Boston Globe* depicted Question 5 as a referendum question that, “speaks of ‘rights’ and ‘coverage for all’ “ (Mishra 2000, October 29). Though the elements
of the petition may have been complex, proponents of Question 5 focused on the objective of this initiative, rather than the course required to reach it, in their effort to garner the support of the public.

C. Highlighting Question 5’s Harmful Implications: The Expressive Focus of Opponents

Recognizing the political appeal of these arguments, the opposition did not refute the policy objectives endorsed by advocates, but rather the proposed method (or lack thereof) for achieving these goals. The issue proponents intentionally used broad language in drafting Question 5. Rather than outlining the details of a plan for comprehensive access to health care, the sponsors of this question instead opted to establish some broad and basic principles. Once these principles were adopted by state residents, the sponsors thought it would then be possible to discern the reforms necessary to ensure adherence to them (Interview 33). Ironically however, the decision to use general language backfired as opponents of Question 5 exploited the vagueness of the question, and the lack of a policy plan to discredit it and manipulate its possible consequences.

In one Boston Globe article, a spokesperson for the No on 5 coalition stated, “one of the fundamental problems of the ballot question is that it’s badly written” (Heldt Powell 2000, October 24). An interviewee who served as the President of an Association of Massachusetts employers opposed to the initiative explained,

the question was totally open ended and it directed the legislature to figure out how to provide access. We just don’t support putting these vaguely worded initiatives on the ballot and therefore tying the hands of the legislature. You know – you have to figure this out. So we said for lots of reasons, this is not a good idea and should not be approved. (Interview 13)
Many legislators also expressed concern with the vague language of the ballot initiative. For example, during a public hearing on the proposed ballot initiative in April, Representative Harriette Chandler, co-chair of the Healthcare Committee, explained,

> What they’ve [sponsors of the petition] left us with is a petition that is all things to all people. Everyone can agree to the abstract concept of this, but we have to come up with a specific plan. It is so broad, there’s no way to determine what people really want. The devil is in the details here and these details are not going to be easy to work out. (Heldt Powell 2000, April 19)

Similarly, Senator Richard Moore, the other co-Chairman of the Healthcare Committee, voiced concerns that the ballot measure “offers no details on how to provide health care coverage for all Bay State residents or how to pay for it” (Heldt Powell 2000, April 19).

Because of the lack of a clear policy directive, opponents of Question 5 were able to manipulate the debate to a discussion of the potential or hypothetical impact of this referendum. Much of the rhetoric employed by Question 5 opponents was designed to convince the public that this initiative could harm more than help the Massachusetts health care system. Consistent with Hirschman’s framework (1991), the opposition relied on themes of futility, perversity, and jeopardy to launch an attack strategy that created uncertainty and fear amongst the public.

Cognizant of typical American skepticism with government intervention, adversaries of Question 5 elevated concerns as to the potential expansion of government bureaucracy and wasteful spending if this initiative passed. Insinuating the futility of this reform proposal, those opposed to Question 5 sponsored advertisements stating, Question 5 “hands bureaucrats a blank check” and “Question 5 would create two new government bureaucracies with broad authority over the development of a health care entitlement.
system. There is no limit on how much tax money these new bureaucracies could spend, no limit on what the entitlement system would cost, and no requirement for voter approval” (Rochefort 2002). Alongside this rhetoric was the following powerful symbol (Figure 2).

![Figure 2: Symbolic images](image)

Without using words, this picture suggested the public would be “throwing money out the window,” if Question 5 passed.

Interestingly, when asked about businesses opposition to Question 5, an interview participant who worked as the director of a small business association in 2000 explained, what we were afraid of in 2000 was comprehensive plans that would become too expensive for small businesses and that would be paid through, you know, through our big government bureaucracy and here we go. There was no fundamental change I guess in the um....that was going to impact
cost. They [sponsors of Question 5] were just going to shift it all over to government and we couldn't see that as getting us anywhere. (Interview 31)

However, Question 5 did not specify the respective roles of the state or the market in administering or financing this reform. Nonetheless, as is evident in this quotation and the above advertisements and symbols, the potential implications of Question 5 were easily manipulated by its opponents to arouse public concern regarding growing government bureaucracy and spending.

Looking back on this reform episode, one of the first sponsors of the petition admitted,

> When you look back at things hindsight is 20/20. We knew it [that the petition was vaguely worded] when we did it; our organization knew it when the question was written. The problem for us was the confusion in messaging. Meshing those two concepts [access and managed care] together was a problem…It was a very confusing and convoluted question to begin with. That was a mistake. (Interview 36)

And in fact, opponents of Question 5 capitalized on this “mistake” to persuade members of the public to join their side of the debate.

In addition to the strategies designed to convince the public of the futility of this reform, those opposed to Question 5 also relied on perversity claims, suggesting passage of Question 5 would only exacerbate health care problems. A sample of newspaper articles illustrates the rhetoric used by issue opponents to convince the public of the dangers associated with a yes vote on this ballot question. In one *Boston Globe* article, Dr. Harris Berman, Chief Executive of Tufts Health Plan during this time, contended, “this [Ballot Question 5] could absolutely destroy the health care coverage of most people in this state” (Knox 2000, April 7). The quote itself is powerful, but coming from an individual
identified as a doctor in a high level position within the health care system enhances its ability to influence public opinion. Another article explained, “opponents of Question 5 argued that it would so disrupt the system that HMOs would face financial crisis, the state government would be hit with huge health bills, premiums would skyrocket, and more people than ever would ultimately be without insurance” (Mishra 2000, November 8). Drawing attention to economic implications, one editorial argued, “the doctors’ plan [Ballot Question 5] would only make matters worse, sending the state’s economy into a competitive tailspin of soaring insurance premiums” (Warsh 2000, January 8).

Citing “soaring insurance premiums” was not the only discourse designed to raise cost concerns. The opposition also relied on numbers generated from a Massachusetts Taxpayers Foundation study indicating this reform would “increase health insurance rates – up to 40%” and “cost taxpayers $1.8 billion more per year” to incite fear as to the large financial impact the public would feel as a result of this reform (Schubarth 2000, October 30; Battenfeld 2000, October 31). Using inflammatory language, other articles published at this time argued passage of Question 5 would result in “holy hell” and “chaos” in the Massachusetts health care system (Knox 2000, April 7; Mishra 2000, September 17).

In making their appeal to the public, opponents also relied on direct attack strategies to raise fears regarding the impact these changes would have on access to and consumer experience with the health care system. For example, one tactic utilized by opponents was to distribute a brochure directly to the public stating that Question 5 would lead to “substantial chaos…higher prices, and reduced choices for consumers” (Battenfeld 2000, November 3). An interview participant who was the leader of a large health care professional organization supporting Question 5 in 2000 also explained that he received a
The personal letter from Blue Cross Blue Shield, his insurance company during this debate. The letter indicated that he should “vote no on Question 5 [because] it’s going to drive your premiums through the roof” (Interview 36). Using this as an example, he suggested the opposition sought to directly “reach out to people…..and scare them” regarding the implications of voting Yes on 5 (Interview 36). A doctor who supported Question 5 concurred; according to his memory, “what they [the opponents of Question 5] were telling people was this is going to threaten your care” (Interview 30). Finally, in describing the overall strategy of the opposition, one of the directors of the Yes on 5 campaign explained, “it was really a fear campaign…saying this was going to cause a collapse in the healthcare system, it was going to devastate and destroy the health care system” (Interview 17).

Finally, the opposition to Question 5 also argued that passage of this initiative would jeopardize the Patients’ Bill of Rights. One strategically written editorial argued,

> Although a vote for ‘universal health care’ sounds like a winner, it is vital that voters reject this convoluted, counterproductive measure that tellingly, now is opposed by most of the groups that originally supported it. If approved, it would undo the health care legislation – including a strong Patients’ Bill of Rights – enacted in July after years of collaborative effort by lawmakers, employers, insurers, and consumer advocacy groups (“Ballot roulette; beware simplistic solutions to complex problems” 2000, November 9).

The rhetoric employed in this editorial mocked the problem definition strategy of Question 5 supporters, used the co-opting of Health Care for All by the opposition to suggest a decline in support base for Question 5, and sought to convince the public that passage of Question 5 would undermine the Patients’ Bill of Rights and the work of a diverse group of stakeholders. Similarly, another member of the No on 5 coalition stated for a news
reporter that the Patients’ Bill of Rights had passed, “as a result of a three year collaboration among doctors, nurses, patients’ rights advocates, hospitals, insurers and employers. Question 5 would undo this important new law before it even has a chance to work” (Mishra 2000, September 17). The No on 5 coalition also created an advertisement with a picture of a doctor identified as Dr. Mitchell Rabkin alongside his commentary that “Question 5 would undo our new Patients’ Bill of Rights.” In sponsoring this advertisement, those opposed to Question 5 not only reinforced their “jeopardy” arguments, but also relied on the image of a doctor, a symbol of both clout and medical expertise, to influence the public’s stance on this issue.

D. Question 5 Opponents: Avoiding Triggering Events and Monopolizing the Media

In the weeks just prior to the November election, the media uncovered two issues that might have become triggering events, hurting the cause of the group opposed to Question 5. First, in late November, five of the state’s health insurance carriers sought extensions from the state Attorney General’s office for filing their annual financial disclosure reports. These reports include detailed information pertaining to the carriers’ compensation packages for top officials, as well as assets, revenues, contracts, and other administrative expenses. The Yes on 5 coalition argued that the HMOs sought to avoid financial scrutiny during the intense debate over Question 5 and that the public should be disturbed that salary and other administrative spending information was being withheld from them. Some questioned whether release of this information might have prompted a backlash against the carriers. Nonetheless, the Attorney General’s office granted carriers
the extension they requested; reports were required to be filed on November 15th, a week after the vote on Question 5 (Phillips 2000, October 26). Those opposed to Question 5 circumvented what might have been a dramatic focusing event that may have greatly impacted this debate's outcome.

In addition to avoiding this situation, the No on 5 coalition was able to skillfully avoid another potential focusing event that might have adversely impacted their support base. About a week prior to the vote on Question 5, the media picked up on the inability of Tufts Health Plan and Partners Health Care to settle contract negotiations allowing Tufts’ members to continue to use the Partners’ Health Care system of doctors and facilities. According to newspaper reports at this time, Partners claimed its hospitals and physicians lost forty-two million dollars in treating Tufts Health plan members in the preceding year. As a result, Partners requested a nearly thirty percent reimbursement increase from Tufts Health Plan for treating its members, and indicated it would refuse seeing Tufts’ members if the deal could not be brokered (McNamara 2000, November 1).

In the end, an agreement was arranged between Partners and Tufts, though the details were not released to the public. Still, resolving this issue prior to the election assuaged public concerns (and potential public protest) that their coverage options would be adversely impacted by financial negotiations between insurers and providers (Heldt Powell 2000, November 2). Yet again, the No on 5 members diverted what might have been a focusing event that negatively impacted their standing with the public.

Throughout this conflict, the opposition used television commercials, the radio, and other media advertisements in an effort to reach the Massachusetts public. When it first became apparent that this initiative might reach the ballot, the President of the
Associated Industries of Massachusetts, the largest business association in Massachusetts that was part of the opposition to Question 5, explained “we’re just getting into campaign readiness…it’s probably going to take millions of dollars, because if you want to get your message out to voters, you need to advertise, and that is very expensive” (Goldberg 2000, June 11). Conversely, advocates for Question 5 had limited financial resources and therefore relied primarily on more traditional grassroots campaigning.

As the conflict surrounding Question 5 intensified, news articles emphasized the unbalanced economic positions of the two teams in this debate. One article comparing the money spent on the campaigns for all the questions on the November ballot identified Question 5 as “the most lopsided mismatch” (Mooney 2000, October 18). Illustrative of this inequity, in September, an article in the *Boston Globe* suggested that opponents to Question 5 were outspending supporters by a ratio of one hundred to one (Mishra 2000, September 17). One month later another *Boston Globe* article suggested that if trends continued, this disparity could increase to nearly one thousand to one by the election date (Mishra 2000, October 16). In October, estimates suggested the opposition was spending nearly one million dollars each week to defeat Question 5 (Woolhandler & Himmelstein 2000, October 19)! With more money at their disposal, those opposing Question 5 were able to rely on television, radio, and mail to broadcast their perspective on this question; the opposition monopolized media coverage of this issue. Foreshadowing the outcome of this contest, one of the leaders of the campaign supporting Question 5 lamented, “in ballot questions, there’s a correlation between money spent and which side wins” (Mishra 2000, September 17). The veracity of this statement would soon be proven.
E. Decision Day: November 7, 2000

Early public opinion polls suggested that nearly three quarters of Massachusetts residents supported Question 5 (Kowalczyk & Mishra 2000, October 7). However, as opponents waged the public campaign described above to expand the audience and persuade the public to their side, polls reflected a gradual but steady decline in the margin of support for Question 5. Polls taken during the week prior to the vote indicated proponents were leading by approximately 20% (Sullivan 2000, November 7). Polls taken just days before the vote suggested even greater erosion of public support for Question 5; one poll found that only 50% of voters now supported Question 5, with 25% opposed to the initiative, and 25% still undecided (Mishra 2000, November 8). Ultimately, despite initially high popular support, Ballot Question 5 was narrowly defeated by a vote of 48% in favor versus 52% opposed (Heldt Powell 2000, November 8) (see Table 1 below). This illustrates a recurring pattern in health care reform episodes of broad based popular support, ultimately followed by the demise of the reform initiative.

<table>
<thead>
<tr>
<th>Poll Timeframe</th>
<th>Yes on Question 5</th>
<th>No on Question 5</th>
<th>Undecided</th>
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</thead>
<tbody>
<tr>
<td>Late September…</td>
<td>72%</td>
<td>16%</td>
<td>12%</td>
</tr>
<tr>
<td>Days before vote…</td>
<td>50%</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>November 7, 2000</td>
<td>48%</td>
<td>52%</td>
<td></td>
</tr>
</tbody>
</table>

To describe the overall public reaction to the Ballot Question 5 campaign, one interview participant representing a small business association explained, “the uninformed and uneducated voter knew that something was awry with health insurance and they wanted to see some sort of change, but as they learned more and more, they didn’t think this was the solution” (Interview 21). By broadcasting messages suggesting potential
increases in costs and threats to patient care, Question 5 opponents monopolized the information presented to the electorate on this ballot initiative. Ultimately, persuaded by the information before them, many members of the audience joined the side of Question 5 opponents (Rochefort & Pezza 1991). As the coordinator of a national organization advocating for universal coverage explained in 2000, “one of the difficulties with something like a health care issue is that health care is so complex that people are scared and they’re willing to say ‘don’t do anything’ as opposed to ‘change it for the better’ because they’re afraid it won’t be for the better” (Goldberg 2000, June 11). Even though the notion that all residents should have the right to health insurance coverage may have appealed to residents initially, in the end, the fears opponents raised regarding the potential impact of this reform were more persuasive for voters.

V. A Political Economy Perspective on the Public’s Decision in November 2000

In addition to the importance of the political tactics and strategies described above, economic factors also had a profound influence on this contest’s outcome. In addition, this episode also highlighted the power of economic elites in protecting the status quo and controlling the direction of a reform initiative.

A. The Impact of Money on the Outcome

As most scholars investigating the relationship between campaign spending and ballot measure outcomes have concluded, campaign spending is effective in beating ballot initiatives, though it cannot guarantee their success (Hadwiger 1992). That is, while proponents of initiatives are not necessarily able to ensure passage of their initiative by
outspending the opposition, groups opposing initiatives can almost guarantee defeat of the initiative if they significantly outspend its sponsors. The results in this case are consistent with these findings.

Numerous interview participants and newspaper articles pinpointed economic resources as a primary factor contributing to the defeat of Ballot Question 5. The availability of economic resources enabled political activists opposed to this initiative to monopolize coverage of this issue through marketing and advertising efforts, thereby disseminating their message and framing of this issue. When asked to explain the erosion of support for Ballot Question 5, numerous interview participants cited the differing fiscal circumstances of the two sides of this debate and the impact this had on the messages the public received. One of the original petition sponsors who also served as the leader of a large health care professional association explained,

Even up to the last month it was 70-30. Well what happened was, how it unraveled, is that the insurance industry invested a ton of money in killing it. At that time we didn’t have a lot of money. We were running a campaign on the ballot initiative, on free media on publicity, and on word of mouth and our organizational, our combined organizational action to communicate with our constituencies but there was no big advertising budget; there was none. (Interview 36)

Corroborating this account, one of the directors of the Yes on 5 campaign posited,

You know, I think it just stacked up to money. We ran a $100,000 campaign and the opposition poured over five million into it. Right there, we didn’t have television ads, we didn’t have direct consumer literature going out to millions of households. That was really the tipping point. (Interview 17)

Another interview participant who was a doctor and one of the authors of the initiative petition revealed lingering frustrations with the way economic resources were used to
influence the outcome of this ballot initiative. Again, when asked what explained the change in popular support for the ballot initiative, this interview participant retorted,

> If you spend six million dollars lying about it [the impact of the reform], you can defeat it...there’s no question that it failed because there was a massive campaign well-financed by my insurance premiums, against it and including substantial lies. I mean, there was a mail drop that arrived shortly before Election Day that included condemnation of it by the Deans of all the medical schools in the state. When we went to some of those Deans, they said ‘actually, my views were taken out of context’...So, there was a massive propaganda campaign that we had no way of countering. (Interview 30)

As newspaper excerpts and commentary from those who participated in this battle reveal, disparate economic resources impacted the ballot outcome. Opponents of Question 5 were able to use expensive modes of communication to quickly reach a broad sector of the public and convince them of the adverse impact and “dangers” Question 5 would have on the health care system. Conversely, lacking the financial backing the No on 5 campaign had, advocates struggled to convey their definition of this issue - as one of basic social rights - to the public.

B. The Power of Elites in Controlling the Debate

One of the persistent themes in the political economy literature is the ability of “dominant structural interests” to control the direction of reform initiatives in a market economy (Alford 1975, p. 14). Expanding on this, Gordon (2003) argued that the political status of these dominant economic interests has enabled them to acquire cultural clout. He concluded that “all of this has had a direct political effect: powerful economic interests throttle popular reform efforts that might otherwise threaten them” (Gordon 2003, p. 210). Indeed, this episode provides a valid illustration of this assertion.
Though public opinion polls initially indicated widespread support for Question 5, when dominant economic interests such as the business community and health insurance industry entered the debate, the attitude toward this reform gradually, but dramatically, changed. One interviewee who represented the small business community described the membership and attitude of the group opposed to Question 5 as follows:

First of all you have the health plans; the Harvard, Tufts, and you have their association and the head of that. Ok, then you have, you had the Business Roundtable, Mass Taxpayers Foundation, and those groups. Then you have in addition you have Blue Cross and Blue Shields, Associated Industries of Massachusetts, and then there’s a whole business group that met on a regular basis. I would say the health plans and the health insurers led us in that group [the coalition opposed to Question 5]. And then, the business community like I said, was very much united in our concerns about where this question would take us….in terms of what healthcare would look like. (Interview 31)

This commentary reveals the stakeholders that comprised the opposition, but is vague in identifying the specific concerns of this group with respect to the reform’s impact on the healthcare system. In contrast, another interviewee who was Director of the Massachusetts Nurses Association at this time and supportive of Question 5 candidly suggested, “well, for the insurance industry, the critical thing is that it [this reform, Question 5] puts them out of business, potentially” when asked for reasons why other stakeholders opposed the initiative (Interview 30). Similarly, when asked to explain the sources of opposition to this reform episode a doctor who became an active participant in the Yes on 5 campaign responded,

You know the people who are a problem are the people that are the leaders of the big players because they don’t want to change…The inertia is huge. And you know the problem is that it’s that very inertia that keeps us from doing the right thing…We can’t figure out a way around this. And, it may be un-doable. It may be that we’re so infatuated with figuring out how to make the bottom line work that…when they [insurers, business] start to
feel threatened that their economics are threatened, that they might be economically disadvantaged by this…that became too scary [for the public]. (Interview 33)

As the words of these interview participants indicate, structural elites entered this debate due to concerns associated with the economic impact of this reform. Moreover, the latter quote illustrates the cultural clout these elites had garnered. Prompted by concerns regarding the possible impact of this reform on their livelihood, the opposition began to define this issue in ways that would persuade the public to their side. Instead of being mobilized by a call to provide all residents with a basic, fundamental right to insurance, the public sided with the opposition.

The expansive messaging and public denunciation of this reform initiative by dominant structural interests was decisive. While many members of the group supporting Question 5 were politically unknown, the political clout of insurers, the business community, and the other groups comprising the opposition to the initiative powerfully influenced the electorate. In summarizing what occurred in this reform episode, and explaining the challenge of health reform broadly, one interviewee supportive of Question 5 succinctly stated “the parties that be wanted to protect the current system and that current system isn’t working in our view. So how do we get that to change?” (Interview 36).

Also indicative of the power and cultural clout of dominant structural interests was the ability of insurance carriers to control the direction of this conflict by avoiding two potential triggering events. First, as described in the previous section, Partners Health Care announced they would no longer provide services to Tufts Health Plan members if Tufts did not increase their reimbursement rates. Fortunately, Tufts was able to negotiate an
agreement with Partners Health Care system just prior to the election date. If they had not and members had been denied services from doctors or facilities affiliated with Partners Health Care, public outrage with the health insurance system and these dominant interests might have surged. Also representative of the power and clout of dominant structural interests was their ability to negotiate an extension for the filing of financial information. If these reports detailing the administrative expenses and salaries of health care executives been released just prior to the November 7th vote, supporters of Question 5 would certainly have used them to demonstrate the adverse impact of for profit medicine on the health care system and bolster support for reform. Because of the clout and power of insurers, they were able to negotiate an extension, skillfully avoiding what might have been a politically disastrous event. If either of these events had unraveled differently, it might have changed the result of this initiative.

VI. Conclusion

On November 7, 2000, Ballot Question 5 was defeated. Of those voters who responded to Question 5, 48% voted yes, while 52% voted no. Despite initial public support for this reform, opponents vested in maintenance of the status quo successfully utilized political tactics and strategies as well as economic resources to expand the audience for this debate and persuade the majority of voters to their side. Indicative of the power of dominant structural elites, the existing health care system in Massachusetts would be maintained. However, health care reform would not be off the political agenda for long. As the next chapter will describe, the Massachusetts General Court would soon revisit
health care reform, ultimately passing landmark universal coverage legislation in April of 2006.
CHAPTER FIVE
MASSACHUSETTS LANDMARK LEGISLATION:
CHAPTER 58 OF THE ACTS OF 2006

In *Agendas, Alternatives and Public Policies*, Kingdon (2003) identifies two types of agendas. The first, the governmental agenda, includes those subjects and topics that people both inside and outside of government are paying attention to at any point in time. Within the governmental agenda, is a smaller set of issues that are actively being debated or decided upon; this more focused agenda is referred to as the decision agenda. Kingdon (2003) developed a model to describe the circumstances or factors that enable an issue to transition from the governmental agenda to the decision agenda. To describe those instances where this move has occurred and resulted in policy change, Kingdon (2003) argues,

> instead of incremental agenda change, a subject rather suddenly ‘hits,’ ‘catches on,’ or ‘takes off.’ After decades of thinking about the problem, a sudden flurry of interest…produces a program within two years. (p. 80)

Application of Kingdon’s (2003) model for agenda and policy change provides insight into the circumstances that enabled passage of comprehensive health care reform in Massachusetts in 2006. As the previous chapters of this study have illustrated, the problem of the uninsured persisted on the Massachusetts governmental agenda since at least the 1980s. Though vestiges of the 1988 reform and major portions of the 1996 reform have remained in place, the state has grappled with this issue for decades. However, in November 2004, attention to the issue of the uninsured heightened and just two years later in April 2006 Massachusetts became the first state in the nation to pass legislation requiring most residents to have health insurance coverage.
I. Policymaking and the Kingdon Model

Kingdon’s (2003) model of agenda setting and policy change hinges on the alignment of three “streams”: the problem stream, the policy stream, and the politics stream. These three streams generally develop independently of one another and influence what issues are on the broader governmental agenda. If they converge a unique opportunity called a “policy window” opens, prompting a new proposal to be elevated to the decision agenda and potentially enabling policy change. Kingdon (2003) emphasizes that policy windows do not open frequently and that policy change does not occur automatically. Rather, there are specific circumstances and certain players acting both inside and outside of government that enhance the likelihood of intersection of these streams and a policy window’s opening.

A. Problem Stream

Clearly, government is unable to address all issues or potential problems. Consequently, several political scientists have studied the factors that influence governmental attention to an issue. A few common themes emanate from these analyses.

First, Cobb & Elder (1983), Kingdon (2003), and Birkland (1997) all identify the importance of a “triggering” or “focusing” event as an important element in the agenda setting process. According to these scholars, such an incident or event attracts the attention of the public and people in government and highlights a problem. Cobb & Elder (1983) argue that following a triggering event, initiators then launch a broader campaign for governmental attention to an issue, suggesting this incident illustrates the results of
ignoring the problem they want addressed. As a result of this new or unexpected attention on an issue, these types of events “cause issues to shoot high onto the agenda in a short period” (Baumgartner & Jones 1993, p. 10).

Another key theme in the literature on agenda setting is the importance of problem definition, or how a given social problem is described, in determining public and government consideration of an issue. As Rochefort & Cobb (1994) and Kingdon (2003) argue, conditions can be interpreted in many different ways. The interpretation that is disseminated to the public impacts the perception as to whether this problem merits government intervention.

Stone (2002) and Kingdon (2003) both emphasize the importance of survey results or other indicators that allow quantification of a problem in sharpening attention to an issue. However, equally important to the use of numbers to describe a problem is the rhetoric used to present these numbers (Stone 2002; Rochefort & Cobb 1994). Frequently, in policy debates numbers are relied upon to conjure concerns that a problem is worsening over time. Since numbers can be manipulated, they can easily be used to paint a picture of a problem or to support specific claims.

In order for any policy proposal to arrive on the decision agenda, government must first be convinced that there is a legitimate problem that needs to be fixed. Therefore, as Kingdon (2003) highlights, the problem stream is one of the critical elements in determining the decision agenda.
B. Politics Stream

Political circumstances and variables also impact which items receive agenda consideration. According to Kingdon (2003), governmental participants’ sense of the public mood or public climate serves to elevate some items on the agenda and demote others. Government officials detect which issues are of most interest and concern to the public by considering the issues constituents have contacted policymakers about, assessing public opinion poll results, and determining the existence and nature of social movements. As Arnold (1992) argues, policymakers are prompted to act based on constituents’ preferences because they wish to avoid adverse electoral consequences. A shift in the public climate or mood may therefore make some policies or issues rise in agenda status as legislators react to the interests of their constituents.

In addition to the ability of the political context outside government to influence the agenda setting process, political events within government also have a profound impact on the agenda. For example, incumbents may be prompted to shift their policy priorities as a result of an upcoming election, feedback from their constituents, or to accomplish a particular policy objective prior to the conclusion of their tenure. Similarly, newly elected officials may seek to raise the agenda status of an item in an effort to fulfill a campaign promise. Kingdon (2003) also highlights the importance of jurisdictional “turf” in setting the agenda; people within government may compete with each other in an effort to take credit for an initiative that they expect will become popular with the public.

Baumgartner & Jones (1993) and Kingdon (2003) emphasize the importance of the chief executive in setting the agenda. Although both of these studies focused on the role of the president in the national political scene, their suppositions are applicable to the role
of the governor in setting the state political agenda. Like the president, the Governor has institutional resources that enhance his ability to shape the policy agenda. The power of the veto is one resource that can be used by the executive as a negotiation strategy to prompt policymakers to consider issues of the governor’s concern (or, risk gubernatorial veto of those proposals the legislature wishes to accomplish). In addition, the governor has the ability to command public attention through use of the bully pulpit. Often, this results in the imposition of public pressure on other elected officials to address the issues raised by the governor.

Since new policy generally requires the government to enact new or amend existing legislation, the political stream is a primary determinant of whether policy change will occur when and if a window of opportunity emerges. However, politics alone do not dictate when policy change will occur, as government must be aware of and in agreement on which problems to address and which policies to consider for resolving them.

C. Policy Stream

Just as in the problem stream and the political stream, there are actors both inside and outside of government developing policies in hopes that they might ultimately reach the decision agenda. Policy entrepreneurs are defined by Kingdon (2003) as “advocates who are willing to invest their resources – time, energy, reputation, money – to promote a position in return for anticipated future gain” (p. 179). These “advocates” are located in diverse venues; they might be elected or appointed governmental officials, interest groups, or research organizations. Moreover, the type of “gain” policy entrepreneurs hope to earn varies. Some have material interests, where a direct personal gain is at stake, as the
motivation for promoting a policy. Other policy entrepreneurs have broader, more
purposive incentives such as a desire to promote certain values through policy proposals.
Finally, others entrepreneurs are active because of the solidarity benefit of being part of a
group and enjoying the advocacy process.

Though policy entrepreneurs may react to changes in the problem and political
streams, they act largely independently of these two streams. Participants in the policy
stream are generally specialists in a policy area who are continually developing or revising
policy options in response to new research and ideas. Kingdon (2003) refers to the
numerous and varied policies floating around the policy community as the “policy primeval
soup.” He argues that ideas and policies often float freely throughout this soup, but that
policy entrepreneurs engage in strategic efforts or activities to “soften up” the public.
Since the public and government tend to resist major change, the objective behind
“softening up” or exposing the public to these policy ideas is to create familiarity with the
ideas and proposals of policy entrepreneurs. Ideally, this will enable public readiness for a
new policy when a time does emerge for pushing it onto the agenda.

As Kingdon (2003) indicates, the availability of a policy proposal in and of itself is
insufficient to ensure policy change. Policy communities always have numerous policies in
development and floating about the policy primeval soup. It is only when a specific policy
is coupled with a particular problem or political circumstance that it might emerge onto the
decision agenda and be considered for adoption.
D. Window of Opportunity: Convergence of the Streams

Generally, the governmental agenda is most affected by the problem and political streams, as government becomes convinced of a new public problem or political changes bring attention to new issues or initiatives. However, the likelihood of an item rising onto the decision agenda increases when all three streams, problem, political, and policy, converge; items cannot move onto the decision agenda without the availability of policy options designed to address the issue or initiative that has surfaced.

Policy entrepreneurs assume a large role in orchestrating the joining of the streams in order to take advantage of policy windows. A policy option floating in the policy stream is quickly “coupled” with or “hooked” to a prominent problem or event in the political stream by policy entrepreneurs, elevating the policy to consideration in a context broader than the policy community. According to Kingdon (2003) these policy windows are fleeting and therefore require prompt and skillful action by entrepreneurs. Moreover, other players including government officials, interest groups, the public, research organizations, and consultants may try to shape the alternative policy proposals considered by government. Nonetheless, if the streams can be aligned, the possibility of major policy change does exist.

II. Health Care Reform: Emergence on the Agenda

A. Problem Stream

In the fall of 2004, the Blue Cross Blue Shield Foundation hosted a summit entitled the Roadmap to coverage: A summit on access. This summit was part of an initiative launched by the Blue Cross Blue Shield Foundation designed to “inform the debate about how to
provide health coverage for the uninsured in Massachusetts and generate a practical roadmap for achieving that goal” (Blue Cross Blue Shield Foundation 2004). Attending the summit were more than three hundred health, business, labor, and government leaders, including Senate President Robert Travaglini. Coinciding with this event, the Blue Cross Blue Shield Foundation released a report addressing options for expanding coverage to everyone in Massachusetts and analyzing the cost implications of those options. The summit served as a focusing event for the problem of the uninsured in Massachusetts, generating new attention to the issue of the uninsured in Massachusetts among those both inside and outside of government. In looking back on the process and factors that led to health care reform in 2006, one interview participant representing a large business organization in Massachusetts explained,

I would credit the BCBS Foundation…they provided, set the stage, through this whole Roadmap project that they embarked on. So, not only did they do a lot of good research and get the debate going; how can we expand access? Then they provided platforms for…they had three big events: one in the fall of 2004 and two in 2005 with hundreds of people at the Kennedy Library. And who are the main speakers? The first was Senator Travaglini who announced in November of 2004 we’re going to cut the uninsured in half to wild applause. (Interview 13)

A sample of newspaper articles published after the summit illustrates the growing attention on this issue and its presentation as a public problem. One editorial published just after the summit stated,

Senate President Robert E. Travaglini and the Blue Cross Blue Shield of Massachusetts Foundation put the issue of health coverage for the uninsured squarely on the agenda of state government yesterday. They are right. It is time for the Legislature and Governor Romney to devise a plan that covers hundreds of thousands of state residents who go without this necessity of modern life. (“Healthcare leadership” 2004, November 17)
In addition to this blatant call for legislative attention to the issue of the uninsured, other articles more subtly suggested that the issue of the uninsured was a growing problem. For example, Stone (2002) asserts that numbers are often used in policy debates to convey stories of decline or decay. This rings true in examples excerpted from this time period; numbers were used to support the supposition that the problem of the uninsured was worsening over time. One article indicated that “the number of uninsured increased between 2002 and 2004,” while another argued more powerfully that the number of uninsured residents in Massachusetts “has grown twenty-five percent since 2000” (Greenberger 2004, Dec 6; Kowalczyk 2004, November 16).

Numbers and survey results were also used to define this issue as one that was large in scope (Rochefort & Cobb 1994). Routinely cited in newspaper articles were estimates indicating the total number of uninsured residents ranged from 450,000 to 650,000, depending on the data source consulted. Interestingly, these numbers represent between seven and ten percent of the Massachusetts population. When assessed from this perspective, Massachusetts is among states with the lowest percentage of uninsured. However, rather than focusing on this interpretation of the numbers, newspaper articles instead presented the actual number of the uninsured. For most of the public, numbers like these loom large and reinforce the perception that this is a big problem.

In the fall of 2005 and the winter of 2006, several articles in the Boston Globe also focused on the erosion of employer sponsored insurance coverage and the increases in employee cost-sharing as a result of increasing health care costs. For example, one article titled “The health insurance meltdown” reported the results of a Kaiser Family Foundation study indicating that nationally the percentage of employers covering workers declined
nearly ten percent in five years from 69% in 2000 to 60% in 2005 (McDonough 2005, December 27). Later, the article cited a report from the Economic Policy Institute suggesting Massachusetts had the third largest decline in workers receiving employer-provided insurance (McDonough 2005, December 27). Other articles published during this time highlighted employers’ frustration with rising health care costs, and described the tendency among employers to increase cost-sharing for employees in response. Richard Lord, the President of Associated Industries of Massachusetts explained to a reporter, “five years of double digit [premium] increases has created a tremendous burden. Most [employers] are trying to continue to offer coverage. Some are sharing more of the cost with their employees” (Krasner 2005, September 15). A study published by Mercer Health and Benefits Consulting Firm confirmed these comments; according to their survey of employers, most employers responded to insurance cost increases by increasing deductibles and co-payments for employees (Krasner 2005, November 21).

Providing further evidence of the erosion of employer sponsored coverage and the trend toward reliance on employees to shoulder more of health care costs, in the winter of 2006 Friendly’s restaurant changed its health insurance plan dramatically in order to control costs. According to the Boston Globe, Friendly’s changes amounted to “slashing” health benefits for full-time workers and shifting workers to limited benefit or mini medical insurance plans (Krasner 2006, January 25). These trends, the decline in the provision of employer sponsored insurance and the increasing cost-sharing required of employees, reinforced concerns regarding the status of the health insurance system in Massachusetts.
B. Politics Stream

As events in the problem stream prompted attention to the issue of the uninsured, political circumstances both inside and outside of government reinforced the placement of this issue on the governmental agenda. First, key participants on the inside of government drew attention to this issue through their own actions. For example, Kingdon (2003) argues that members of the legislature can draw attention to an issue by sponsoring a bill, holding a hearing, or delivering a speech; these actions are generally covered by the press and communicated to the public. As indicated in the passages highlighted above, Senate President Travaglini’s announcement at the Blue Cross Blue Shield Foundation event that he intended to devise a plan for covering at least half of the uninsured by the end of 2006 was captured in several news articles following this event (Greenberger 2004, November 17).

Interestingly, just after Senate President Travagalini’s announcement, Governor Mitt Romney and House Speaker Salvatore DiMasi also declared their desire to make the issue of the uninsured in Massachusetts a primary focus in the next legislative session (Greenberger 2004, November 17; Romney 2004, November 21; Greenberger 2004, December 6). To counter the press coverage Senate President Travaglini’s announcement acquired, Governor Mitt Romney submitted an editorial to the Boston Globe indicating his intention to address health insurance reform (Romney 2004, November 21). The sudden combined interest in this issue represents the start of a “turf” battle among three of the more powerful elected officials in Massachusetts (Kingdon 2003). Each of these three leaders hoped to claim credit for raising this issue and hopefully responding to it by prompting the state legislature to pass legislation addressing the problem of the uninsured.
In addition to these actors inside government, political circumstances and actors outside government also focused attention to the problem of the uninsured. Illustrative of public interest and engagement in this issue, beginning in the spring of 2005, a group known as the Affordable Care Today (ACT!) Coalition began the process of collecting sufficient signatures to file an initiative petition requiring state health reform by November 2006. By the fall, ACT! had collected well over the requisite 112,000 signatures required to place this petition before the General Court (Little 2007; Interview 10). This process, as was intended by advocates, heightened legislative attention to health care reform.

The Greater Boston Interfaith Organization (GBIO) was a religious organization that became a very active and prominent member of the ACT! Coalition. Several interview participants cited the importance of this group in focusing the legislature’s attention to the problem of the uninsured. When asked about the role of GBIO and the ACT! Coalition in bringing the issue of health care reform to the political agenda, an interview participant who was an active member of both highlighted the importance of GBIO in illustrating that even among diverse groups, there was consensus on the need to address the issue of the uninsured. In his words,

It was GBIO’s ability to speak for Temple Israel, Old South, and Roxbury Presbyterian at the same time. It was the recognition that there’s an organization that is bringing together people who have not ever spoken in one voice. It’s not so much what they were saying, it was that there was finally one voice being heard loud and clear, that crossed a lot of weird different spectrums – faith, economic – it was amazing that they were able to agree on these issues. So I think process wise it’s that that existed…we got through taking to them [politicians] about power and morality. You know, about what’s the right thing to do here. (Interview 32)

Collectively, political circumstances both inside and outside of government indicated the public “mood” was focused on the issue of the uninsured in Massachusetts.
The problem stream was focused on the need to address the growing number of uninsured residents. At the same time, as will be described below, numerous policies to address this issue were floating through the policy stream.

C. Policy Stream

Numerous ideas and proposals designed to address the issue of the uninsured were floating through the “policy primeval soup.” As part of the Roadmap to Coverage initiative, the Blue Cross Blue Shield Foundation developed a variety of non-partisan policy options for covering the uninsured in Massachusetts. In describing the importance of this initiative to policy development and health care reform generally, an interviewee working as the research director for a majority leader in the state legislature explained,

They [the Blue Cross Blue Shield Foundation] had this plan of we’re going to set this stage for moving forward. What was valuable was they put all these policy options on the table that didn’t have anybody’s fingerprints on them…Legislative bodies don’t have policy resources so when you have an organization of the quality of the Blue Cross Blue Shield Foundation they’ve got an econometric model, they’ve ran the projections, it’s really good analytical data, you know we can run with that. We don’t usually have that kind of stuff. So, that was critically, critically important. (Interview 23)

The Roadmap to Coverage initiative included various activities to “soften up” the policy community and engage the interest of others beyond the traditional policy community. For example, the Foundation held several summits coinciding with the publication of major policy reports. As mentioned above, the first of these summits was held in November of 2004, and the subsequent two summits were held in June and October of 2005. Each of the three summits provided a forum for discussion of the policy options presented in the Blue Cross Blue Shield Foundation reports and their implications.
for the state. Senate President Travaglini, Governor Mitt Romney, and House Speaker DiMasi served as the keynote speaker at each of these events. Clearly, the Blue Cross and Blue Shield Foundation strategically used these summits to encourage political engagement in the issue of the uninsured and expose prominent and powerful political leaders to the policy alternatives it had devised.

In addition to the policy options developed by the Blue Cross Blue Shield Foundation, the ACT! Coalition also developed a detailed plan for increasing health insurance coverage. The main provisions of this initiative included: expansion of the MassHealth program to adults earning up to 200% of the Federal Poverty Level (FPL) and to children under the age of 21 earning up to 300% of the FPL; establishment of a new program to assist individuals earning up to 400% of the FPL with health care costs; expansion of the Insurance Partnership program to assist small businesses and low income workers in the provision and purchase of health insurance; establishment of a payroll tax on employers to ensure that employers contribute to employee health insurance costs; restoration of dental and eye glass benefits to the MassHealth program; revisions to MassHealth provider payment rates; and a sixty cent cigarette tax increase. News coverage of the ACT! Coalition campaign ensured considerable public attention to this plan (Greenberger 2005, May 26). In addition, the expediency with which advocates collected signatures for this initiative also prompted policymakers to become attentive to the plan that would be before them in the spring.

Finally, as each had promised, Governor Romney, Senate President Travaglini, and House Speaker DiMasi each developed a proposal for reform. Both Governor Romney and Senate President Travaglini formally filed their proposals in the spring of 2005, while
Speaker DiMasi filed his plan in the fall. Though each of the three plans included provisions designed to increase access to health insurance, some of the details and mechanisms to do so varied across the three proposals. Many of the policy elements included in Governor Romney’s and Senate President Travaglini’s proposals were derived from the research and analysis conducted as part of the Blue Cross Blue Shield Roadmap to Coverage project, while Speaker DiMasi’s plan incorporated many of the features of the policy proposal developed by the ACT! Coalition.

One of the primary features of Governor Romney’s proposal included the development of a health insurance “Exchange” or “Connector” designed to offer health insurance plans to individuals and to employees in small firms with 50 or fewer employees. According to Romney’s plan, employees would be able to purchase a health insurance plan through this “Exchange” with pre-tax dollars. In addition, the Governor’s plan included a program that would provide individuals whose employers do not provide coverage with income based sliding scale subsidies for the purchase of health insurance. Finally, the Romney proposal also included an individual mandate, requiring all individuals in the state to purchase health insurance. Individuals failing to comply with the mandate would be fined at tax filing (Holahan & Blumberg 2006; Massachusetts General Court 2005a; Massachusetts General Court 2005b).

The individual mandate represented the emergence of a relatively new policy tool. This method for increasing insurance coverage had been supported by the conservative think tank, the Heritage Foundation for more than a decade, and Governor Romney had worked with this organization in developing his health reform plan (Tanner 2006). A report published by the Blue Cross Blue Shield Foundation as part of the Roadmap to
Coverage initiative also identified an individual mandate as a policy option for reform (Blumberg et al. 2005). However, this report indicated an employer mandate must be coupled with an individual mandate in order to reach universal health insurance and the inclusion of the employer mandate was in contrast to Governor Romney’s political ideology.

Like Governor Romney’s policy, Senate President Travaglini’s plan also included the establishment of the “Commonwealth Care Health Insurance Exchange;” this entity would merge the small and non-group insurance markets and make commercial insurance plans available to individuals and small groups of 50 or fewer employees for purchase with pre-tax dollars. However, unlike Romney’s plan, rather than implementation of an individual mandate, the Senate proposal recommended a feasibility study of the mandate. The Senate plan included Medicaid eligibility expansions and the restoration of dental and eye glass benefits to the Medicaid program. In addition to Medicaid eligibility expansions, the Senate plan proposed an expansion in the income guidelines for the Insurance Partnership, a program allowing low-income workers to acquire state subsidies to offset employee premium contributions for employer sponsored insurance. The plan also developed a “Free Rider Surcharge” to be applied to employers whose employees utilize health care services through the Uncompensated Care Pool (UCP). Finally, Senate President Travaglini’s bill included a provision to allow provider rate increases in the Medicaid program (Pulos 2005; Holahan & Blumberg 2006; Massachusetts General Court 2005c).

Last, in November 2005, several months after Governor Romney and Senate President Travaglini filed their health care proposals, Speaker DiMasi filed a health care
proposal. As mentioned above, his proposal was heavily influenced by lobbying from the ACT! Coalition. The plan incorporated the individual mandate subject to an affordability provision, as well as the development of an insurance Connector. Like the Senate President’s plan, Speaker DiMasi also proposed Medicaid eligibility expansions and rate increases. Similar to the ACT! Coalition proposal, the House policy included the development of the “Commonwealth Care Insurance Program” to offer sliding scale premium assistance to individuals earning up to 300% of FPL and a payroll tax on employers. Employers received credit toward their payroll tax liability for contributions made to employee health insurance.

Following the first Blue Cross Blue Shield summit on access in 2004, the number of policies aimed at increasing health insurance coverage in Massachusetts seemed to gradually increase. Having also become increasingly prominent in the problem and politics stream, the issue of the uninsured was certainly one that had captured the attention of people both inside and outside of government. However, suddenly, in 2006, political circumstances made this issue the primary focus of the governmental decision agenda and a window of opportunity for major policy change emerged.

III. Capitalizing on a Window of Opportunity: A Political Economy Perspective

As Kingdon (2003) theorized, in this episode the problem, the politics, and the available policies converged, opening a window of opportunity. Though convergence of these three streams may provide an opportunity for policy change, it does not guarantee it. In fact, the political system favors the status quo. However, in Massachusetts in 2006, policy entrepreneurs took advantage of this window’s opening and seized the opportunity
for major policy change. Application of Kingdon’s theory of convergence of the streams and the political economy perspective provide insight into the way in which the interactions of key political and economic circumstances influenced the content and outcome of this policy initiative.

A. Problem Stream: Agreement on the Need to Prioritize the Issue of the Uninsured

Kingdon (2003) suggests that windows can be opened when a new problem captures the attention of government officials and those around them. As illustrated in the previous section, the problem of the uninsured initially gained the attention of many state policymakers, research institutions, and advocacy organizations in 2004.

The Blue Cross Blue Shield Foundation’s first summit on access served as a focusing event that brought attention to the issue of the uninsured. Subsequently, the prominence of press coverage highlighting the continued growth in the uninsured population created additional pressure on the legislature to address the issue of declining health insurance coverage. In addition to the three prominent policy leaders who developed proposals to address this issue, the ACT! Coalition, an advocacy organization dedicated to increasing access to health insurance, had also drafted a reform plan.

Though the mechanisms recommended for addressing the problem of the uninsured differed, the development of policy proposals to address this issue illustrated consensus that the issue of the uninsured was a serious and pressing problem that had earned governmental attention. Government has countless issues competing for its
attention; prioritization of this issue above all others contributed to this policy window’s opening.

B. Politics: Federal Waiver Renewal

Certain formal requirements, such as when sunset provisions in legislation require re-authorization or the budget cycle requires updating may provide a predictable policy window opening (Kingdom 2003). However, what is or is not done with the window’s opening is discretionary; that is, renewal may involve a simple extension of existing policy, elimination of the existing policy or program, or considerable alteration of what has previously been in place. In Massachusetts, the need for renewal of the 1115 Medicaid waiver initially implemented in 1997 qualified as such a circumstance, prompting a policy window opening.

As described in chapter three, Massachusetts passed authorizing legislation, chapter 203 of the acts of 1996, to implement a Section 1115 waiver that would allow the state to waive some of the federal Medicaid regulations pursuant to the Medicaid program. The waiver was implemented in 1997, and sought to expand the number of individuals covered through the Medicaid program by mandating enrollment in managed care plans for most of the MassHealth population. The Medicaid waiver enabling these expansions was renewed intact by the federal government in 2002 for three additional years (McDonough et al. 2006).

In light of the transition from a fee-for-service to a managed care reimbursement system, the original waiver negotiated with the federal government also authorized the state to make “supplemental rate payments” to Boston Medical Center (BMC) and Cambridge
Hospital. These two “safety net” hospitals, identified as such because of their provision of care to a disproportionate share of low-income and uninsured individuals, developed hospital based Medicaid Managed Care Organizations (MMCOs) in response to the waiver requirements. In addition to the capitation rates paid to these hospitals for those Medicaid members enrolled in their respective MMCOs, each hospital received a supplemental payment to offset the high medical claims cost of the population they served. Section 29 of chapter 203 of the acts of 1996 stipulated the use of an intergovernmental transfer (IGT) system to make these supplemental payments to BMC and Cambridge Hospital. In short, this system enabled the state to use IGTs to provide the supplemental payments to the hospitals, without any net cost to the state (Massachusetts Medicaid Policy Institute 2005). Though it seemed a small aspect of the health reform legislation and Section 1115 waiver when the waiver was initially negotiated, the provision allowing “supp payments” through IGT provided the impetus for major health reform in 2006.

The waiver Massachusetts had implemented in 1997 and renewed in 2002 was set to expire July 1, 2005. Therefore, the state began to work with federal officials on the renewal of a Medicaid waiver in 2004. At that time, the state was informed that the federal matching funds for supplemental payment to the MMCOs at BMC and Cambridge Hospital would not be renewed. By 2005, these supplemental payments had grown to nearly $385 million in federal funds (Holahan & Blumberg 2006). Rather than continuing to fund institutions treating a disproportionate share of the low-income uninsured, the

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18 Using the IGT system, the state would make a payment to the local Public Health Commission affiliated with each of these hospitals. The state would then claim 50% reimbursement for this payment from in federal matching funds. The Commission would provide 50% of the payment to the MCO and reimburse the state for 50% of the payment.
Centers for Medicare and Medicaid Services (CMS) desired that federal funding be dedicated directly to individual insurance subsidies. Therefore if the state did not revise the existing structure of the waiver, it could lose up to $385 million in federal funding. An interview participant who was the leader of a large advocacy organization acknowledged the importance of these circumstances. In his words, “the feds were saying we were going to have to redo the waiver which definitely, well, nothing sharpens the attention of the legislature like the potential for losing four hundred million dollars” (Interview 9). Though the state was granted a provisional extension of the waiver in January 2005, it was contingent upon Massachusetts submitting a plan that addressed these concerns and increased individual insurance coverage (Wielawski 2007). Thus, both political and economic circumstances prompted a policy window’s opening as the state was forced by the federal government to consider policy alternatives (or lose hundreds of millions of dollars in federal funds). Still, as Kingdon (2003) suggested, what this opening would mean remained to be determined.

Turf battle

In addition to the federal waiver renewal requirement, the “turf” battle that arose among Governor Romney, Speaker DiMasi, and Senate President Travaglini, who all desired to be credited with increasing access to health insurance, enhanced the likelihood of reform. As Kingdon (2003) explains, competition among policymakers enhances the likelihood of serious consideration of a problem and policy movement. Moreover, all three of these entrepreneurs were motivated by material incentives, the political benefits that leading the state to health care reform might provide.
Perhaps swayed by events that had occurred in the problem stream and by the attention this issue had garnered among the general public, the issue of the uninsured had clearly captured the interest of Senate President Travaglini. Several interview participants suggested Senate President Travaglini viewed this as an issue that could serve as a defining accomplishment of his tenure as Senate President. Consequently, Travaglini was the first elected official to announce his intention to address health care reform in 2004. As highlighted above, the very public announcement of this undertaking was critical in shaping the policy agenda and prompting the opening of a policy window. Over the course of the next two years, his attention to this issue never wavered because of the political pressure to deliver on his 2004 promise to “cut the number of the uninsured in half within two years” (McDonough et al. 2006). As a policy leader on the inside of government, Senate President Travaglini’s endorsement of this issue promptly elevated it on the legislature’s agenda (Kingdon 2003). Subsequently, the political struggle for ownership of this problem and the policy to address it helped maintain health care reform at the top of the agenda.

Governor Romney and his advisors began to draft a health reform plan for Massachusetts in his first year in office with the intention of introducing it to the legislature in January 2005. However, Senate President Travaglini’s announcement in November 2004 prompted Romney to expedite the release of his reform plan (McDonough et. al 2006). Interestingly, just after he assumed the office of governor, rumors began to surface (and were later confirmed) that Romney was hoping for the Republican nomination for president in 2008 (Greenberger 2004, November 21). Being credited with the development and passage of an innovative reform plan would certainly enhance Governor Romney’s candidacy. Motivated by this potential political gain, Romney submitted an
editorial providing the details of his health reform plan only days after Senate President
Travaglini’s announcement. This tactic was designed to protect his “turf” on this issue and
illustrate his position as an early leader on health reform.

Speaker of the House of Representatives, Sal DiMasi, assumed his position in
September 2004, following the resignation of Speaker Finneran. Following his ascension
to the role of Speaker, there was some skepticism as to his ability to serve as such a high
level policymaker (Jonas 2005, December 11). This cynicism may have, in part, served as
the political motivation to sponsor a health reform proposal, illustrating to the public and
his colleagues his dedication and ability to handle complicated policy issues. Furthermore,
like Governor Romney and Senate President Travaglini, Speaker DiMasi sought to be
recognized as the policymaker who addressed the issue of the uninsured. This
accomplishment would certainly assuage concerns among colleagues and the public as to
his policymaking capabilities, build credence in his leadership skills, and serve as a defining
accomplishment during his term as Speaker of the House.

Threat of a ballot initiative

The internal “turf” battle over the issue of the uninsured resulted in a strong
commitment among high level policymakers to passage of health reform. The possibility
of a ballot initiative addressing health reform was an external political pressure that also
focused the attention of the legislature. The ACT! Coalition, led by Health Care for All
(HCFA) and the Greater Boston Interfaith Organization (GBIO), completed the first
round of signature-gathering necessary to present this issue to the General Court in the fall
of 2005. One interview participant who led the advocacy efforts explained, “we collected 140,000 signatures to demand that something happen” (Interview 10).

Because of their ability to mobilize the general public, HCFA and GBIO, two leaders of the ACT! Coalition, were able to exert strong pressure for policy action on not only actors inside government, but also stakeholders outside of government who might be affected by reform. If major reform were to pass, legislators and dominant structural interests would prefer to develop the reform plan, dictate its content, and receive credit for its passage. With this knowledge, advocates used the threat of an initiative to force action.

To explain the importance of the ballot initiative in prompting action on health reform, one interview participant who is a senior level administrator at a large provider organization commented,

The role of consumers, while important in ’88, was even more important in 05-06 because the potency of HCFA and GBIO was really striking and everyone knew, the legislative leaders and the business community knew, that absent agreement on something the ballot initiative was going to take the decision out of the hands of all of these different groups and that was a somewhat scary prospect for people. People wanted to find something that would be acceptable to HCFA and GBIO because the ballot initiative left a lot less room for nuance and negotiation. (Interview 34)

These advocates publicly expressed that they were “prepared to go to the ballot” unless the legislature passed a law designed to expand coverage (Helman 2006, March 1; Phillips 2006, March 4).

The ballot initiative in combination with other political circumstances described above, were critical factors that increased the likelihood of policy change during this window. An interviewee who is the leader of a non-partisan think tank that conducts research on the Massachusetts’ economy explained,
you had an advocate community [the ACT! Coalition] that was pushing it [the issue of the uninsured] and organized well…They put together a broad coalition including the religious community [GBIO] which was sort of the new kids on the block around healthcare and playing a role that was very important. And then they went ahead and they did this deliberately as a shtick, got the signatures for the ballot question and that was critical…Another was the combination of the three leaders: Romney, DiMasi and Travaglini. And the other is the federal waiver and the potential loss of $385 million over two years. (Interview 28)

The chief of staff for a legislative leader during the 2004-2006 health care debate echoed many of the same ideas in describing the circumstances that enhanced the prospects for health reform. He stated,

I think first we cannot neglect the fact that you had three principals in state government committed to getting something done. Romney, the Senate president for pragmatic reasons, something had to be done as part of his agenda, and the Speaker did believe in it; it was something he felt was part of his legacy. Three people very engaged, very committed to getting something done – number one. Number two, you had an amazing grassroots organization in Health Care for All (HCFA), GBIO I believe, the religious faith organizations were very active and they had an amazing press operation to the point where every week people were getting updates. Here’s where we are, here’s what is happening. They had a very well organized machine. Number three, members were coming up to a political campaign year and they knew they had to deliver something for their constituencies by way of healthcare. Very powerful forces had come together. (Interview 24)

As these comments indicate, the coupling of the political and problem streams propelled the issue of the uninsured onto the forefront of the decision agenda. The convergence of these two streams with the policy stream, in which there was already an abundance of policy options floating and available for consideration, meant the opportunity for dramatic policy change was ripe.
C. Policy Stream: Pressure for Policy Preferences

Policy entrepreneurs develop and sponsor policy. Because of the work of several policy entrepreneurs, the Massachusetts legislature had numerous policy options to consider. The policies proposed by Romney, Travaglini, and DiMasi addressed the problem of the uninsured, while also satisfying the federal government request that existing “supp payments” would be eliminated and that federal funds would instead be directed toward individual insurance subsidies for the uninsured. However, in addition to policy development, successful policy entrepreneurs must also be ready to take advantage of a policy window’s opening and broker a policy solution. Given the ability of political and economic power elites to obfuscate or control the direction of reform initiatives, this latter characteristic, the ability to take advantage of a policy window and negotiate a policy that could survive, became critically important (Alford 1975).

Though three legislative leaders had issued proposals addressing the uninsured, progress in reaching policy agreement was stymied as the House and the Senate were unable to reach agreement on a proposal. In November 2005, the House and the Senate passed widely different health reform proposals, and a Conference Committee with appointed members from each branch was set up to negotiate legislation that might garner approval from both governmental branches (State House News Service 2005, December 12). Two striking differences between the reform plans passed in each chamber were the inclusion of the individual mandate and the payroll tax on business included in the House plan. In describing how the House created its reform plan, an interview participant who was involved in developing it argued, “the simplest way I could characterize what we did is that I think we took the basic template for the governor’s plan and we shaped it with
typical democratic values” (Interview 23). Conversely, another interview participant who was actively involved with GBIO and ACT! Coalition advocacy efforts suggested, “…Romney proposed a plan and then what happened is the House plan pretty much became our initiative petition in response” (Interview 32). In actuality, the House plan incorporated features from both; the individual mandate had been included in Romney’s health reform proposal, and the employer mandate had been a prominent feature in the ACT! Coalition’s initiative petition. The inability to reach agreement on these two provisions was the primary cause of deadlock amongst policymakers.

Tension among and pressure on state policymakers intensified considerably at the outset of 2006, as conferees were still unable to develop a compromise reform proposal. In order for the state to avoid the loss of the $385 million in federal assistance, the state needed to provide the Centers for Medicare and Medicaid Services (CMS) with their revised health reform plan imminently. The existing waiver was set to expire as of July 1, 2006, and CMS required 120 days to review the state’s proposed alternative. The chance that the state might lose considerable federal financial investment seemed a real possibility. Tim Murphy, the Secretary of Health and Human Services at this time, was quoted in the Boston Globe stating, “Even if an agreement [among conferees and then the House and Senate] were reached this week, I think it’s fair to say that the ability of the Commonwealth to put all that in place by July 1 would be Herculean” (Greenberger 2006, February 14).

Ironing out differences over the individual mandate

The use of an individual mandate as a policy tool to increase access to insurance coverage represented an interesting political paradox and opportunity; a House controlled
by Democrats and a Republican Governor independently devised reform plans with this policy tool. For the House and other liberals who supported the individual mandate, proposing the individual mandate in conjunction with an employer mandate, a new government program for the low-income uninsured, and an affordability provision represented a unique way to provide universal insurance coverage. This design would maintain or expand the existing employer sponsored insurance system and also encourage those eligible for public programs but not enrolled to acquire insurance. Moreover, many studies suggested that an individual mandate might actually decrease health insurance premiums by spreading risks and costs (Appleby 2005).

The foundation for Governor Romney’s support for the individual mandate was the premise that a significant percentage of the uninsured were earning enough to purchase insurance but had chosen not to; these individuals ultimately receive free or subsidized medical care when it is needed because by law they cannot be turned away (Romney 2006). In light of these circumstances, Governor Romney suggested the individual mandate represented an opportunity for individuals to assume “personal responsibility” for their health care costs (Klein 2005). Though the rationale for supporting the inclusion of an individual mandate differed, the concept of an individual mandate revealed the promise of bipartisan support. These divergent rationales appealed to both liberals and conservatives ultimately swaying the Senate into allowing the inclusion of this element in the reform plan.

Negotiating with business

Though the individual mandate was certainly a contentious aspect of the health care reform debate, even more controversial was the payroll tax on employers. Though the
House was committed to a payroll tax on employers, neither Governor Romney’s proposal nor the Senate President’s proposal incorporated a requirement that business make a defined contribution to health insurance for employees. However, Speaker DiMasi and the House conferees refused to support a plan without an element requiring employers to assume some responsibility for the provision of health insurance to their workers (Greenberger 2006, February 15). Governor Romney was dedicated to passage of health reform, but adamantly opposed to any new taxes or “assessments” that might be viewed unfavorably by the business industry or by political conservatives. One interview participant who was working as a senior staff member at a prominent health care research institution during this time argued,

The employer piece took the longest to settle. The Conference Committee thought, and that’s because it was very much linked in the minds of, I think, the Speaker and the ACT coalition, that you couldn’t have an individual mandate unless there was a role or responsibility for employers…The employer responsibility took the longest to come to agreement on. It almost fell apart over that a number of times. (Interview 9)

Similarly, news articles routinely cited the payroll tax as the major “sticking point” in developing a compromise plan (Vennochi 2006, February 9; Phillips 2006, March 4; LeBlanc 2006, March 6).

Further complicating this situation for state policymakers were powerful lobbying activities waged by dominant structural interests to refine or block certain policy elements. Because of the growth in the number of uninsured, reliance on funding through the UCP had grown. Since funding for the pool is derived in part through surcharges on health insurance premiums, many employers were once again (as was the case in 1988) concerned with the increase in uncompensated care and interested in health care reform that would
help in controlling these costs (Holahan & Blumberg 2006). However, the payroll tax on employers proposed in the House bill was not a mechanism employers supported in reaching this end.

In response to the element of the House plan recommending a payroll tax on employers, many of the arguments waged by business in 1988 reverberated in 2006. Business expressed concern that an employer mandate would be a burden on business and would put Massachusetts employers at a competitive disadvantage in comparison to other states (LeHigh 2005, December 6). Shortly after the Conference Committee formed to develop a compromise bill a new advocacy group called Massachusetts Businesses for Real Health Care Reform began advertising in opposition to the employer payroll tax. Their ad campaign succinctly explained business opposition, emphasizing that the payroll tax was “bad for business, bad for job growth, and bad for the economy” (Rowland 2006, January 18).

In addition to businesses publicly expressing their concerns associated with a payroll tax, interview participants and news articles indicated business representatives also met privately with elected officials in hopes of defeating this provision and designing an alternative health care reform plan. Jack Connors, the Chairman of the Board of Directors at Partners Health Care19, and Peter Meade, the Executive Vice President of Blue Cross Blue Shield of Massachusetts were cited in both interviews and in newspapers as actively involved in blocking the payroll tax and devising a different policy option that would be

19 Partners Healthcare system includes primary care and specialty physicians, community hospitals, the two founding academic medical centers (Brigham and Women’s Hospital and Massachusetts General Hospital), specialty facilities, community health centers, and other health-related entities.
responsive to the House’s call for employer responsibility and be supported by the business community.

The participation of these players is interesting. They became involved in negotiations as representatives of the business community. However, as health care organizations, they also would be directly impacted by many other details of the health reform proposal. This distinctive circumstance was explained by an interview participant who represents a small business association in the following way:

one of the things that is unique about Massachusetts in terms of its business community is the – I don’t want to say domination – is the importance of healthcare and insurance in the business community. Just look at the importance of healthcare and insurance in the Boston business community! (Interview 31)

Another interviewee working as a senior staff member for a leader in the state legislature echoed similar sentiments. When asked to identify the major players in influencing the outcome of the health reform proposal she responded,

So, big players are obviously Partners, Blue Cross Blue Shield. I don’t think that a lot of advocates get that a lot of the reasons for the power of these folks is as employers. It’s a little subtle, but it gets to the point of why these people are influential is the worry about eroding jobs and the fact of good employers moving out of state. The increase, like I’ve just seen from being here before and now back again that hospitals are more powerful, Partners is more powerful, as an employer. So, I think there’s a lot of anxiety about jobs in Massachusetts and so that gave the business community a lot of clout. (Interview 23)

Finally, a Boston Globe article also described how these health care industry leaders represent major employers in Massachusetts. According to the article,

The private healthcare industry provides 11.5 percent of the jobs in Massachusetts, about 367,300, making it the state’s top employer. Partners and Blue Cross are the biggest companies in the sector, each with annual revenues of more than $5 billion, enough to rank them among the state’s 10 largest corporations. (Rowland 2006, March 13)
The impact of these dominant interests was profound. Just prior to their participation in negotiations a *Boston Globe* headline stated, “Hopes fade on reform in healthcare” but a week later a headline reported, “Legislators end stalemate on healthcare” (Helman & Phillips 2006, February 26; Phillips 2006, March 4). This situation illustrates the role of interest groups and players outside of government in shaping policy alternatives. Moreover, this situation is an example of an interest group attaching their own alternative to agenda items and policies that others made prominent (Kingdon 2003).

The deal that was ultimately brokered by these representatives to “end the stalemate” on health reform with respect to the contentious employer piece was a requirement that businesses with eleven or more Full Time Equivalent (FTE) employees would be required to make a “fair and reasonable” contribution to their employees’ health insurance coverage. If an employer did not meet this requirement, it may be required to make a fair share contribution (FSC) to the state of up to $295. This amount was developed based on an analysis that considered the cost of uncompensated care provided to workers whose companies do not provide health insurance (Phillips 2006, March 4).

The plan also required employers with eleven or more FTEs to offer their workers a Section 125 plan. A Section 125 plan, sometimes called a “cafeteria plan” or a “premium only plan,” refers to the section of the federal tax code that allows employers to offer employees a choice between taxable income and certain benefits, like health insurance. Employers would be required to provide Section 125 plans even if the employer does not provide a health insurance premium contribution, enabling employees to purchase health insurance on a pre-tax basis. Employers required to set-up a Section 125 Plan who failed to do so would risk imposition of a “free rider” surcharge.
This compromise could satisfy both the House and Senate leaders, while protecting the state’s business interests; these employer responsibilities were less onerous than the payroll tax initially proposed in Speaker DiMasi’s plan. In explaining the perspective of business during these negotiations, an interview participant who represented one of the state’s largest business associations and was intimately involved in negotiations with state policymakers in 2006 explained,

We were opposed to the House bill that had a new payroll tax on employers. We just thought that wasn’t the way to go and would put us at a competitive disadvantage but we ended up supporting the new assessment in the final law that will assess $295 per year per employee where the number wasn’t just pulled out of the air. It was basically saying alright, employers here who provide health insurance also pay a surcharge to cover the uninsured, people who show up in emergency rooms. So, at the very least, why not require all employers to at least contribute to that and at the end of the day, we went with that because there was a sense of some fairness. It didn’t appear to us to be too burdensome. (Interview 13)

The $295 fair share contribution (FSC) was not included in any of the initial proposals designed by Governor Romney, Senate President Travaglini, or Speaker DiMasi. In describing the origins of this plan feature, an article in the Boston Globe stated,

Connors, Meade, and representatives of business groups devised a plan to impose a $295 per employee levy on businesses that have 11 or more workers and do not provide healthcare coverage…Business groups say the healthcare executives’ intervention in the bill was not a one-time show of muscle. The industry is deeply embedded in the state’s economic structure and its political influence will continue, they said. (Rowland 2006, March 13)

The inclusion of this element in the final reform plan provides evidence of both the power of dominant structure interests in controlling the direction of policy and the willingness of policy entrepreneurs to become more flexible in bargaining when an issue has a serious chance of legislative action (Alford 1975; Kingdon 2003).
Negotiating with the hospitals

The need to revise the existing “supp payment” system seemed critical to Massachusetts’ receipt of the federal waiver renewal. For BMC and Cambridge, elimination of this arrangement could mean the loss of hundreds of millions of dollars. Consequently, these two hospitals actively sought to influence policymakers to ensure they would not be adversely affected, economically, by a new reform proposal. These hospitals urged state policymakers to replace lost federal funding to these hospitals with state support (McDonough et al. 2006). The debate as to if these hospitals should receive funding, and if so how much, quickly became extremely contentious.

Several interview participants suggested part of the conflict in determining whether hospitals should continue to receive public assistance stemmed from divergent opinions as to the initial intent of the “supp payments.” One interview participant who worked as a high level government administrator in the 1990s and who was closely involved in negotiating the details of the initial waiver provided his perspective on the origins and intent of these supplemental payments. According to his recollection,

We proposed that we start up managed care plans at the two hospitals [BMC and Cambridge] with the intent being to allow them to hold onto the people they were serving who were being funded by the uncompensated care pool. And, we would develop these plans and pay them a Medicaid capitation rate like we paid other plans and that rate would be supplemented. For every enrollee they would get a supplement at full federal expense, not state expense, which would be the difference between what they were getting paid in the uncompensated care pool and what Medicaid would pay them as a capitation rate and that would last for a four year period and would decline and be eliminated at the end of the four year period [emphasis added]. It’s that supplement that was the key issue of the renewal at this time [2006]. (Interview 15)
This interviewee’s standpoint is consistent with that of many others interviewed. That is, that the “supp payments” were designed to serve as temporary aid to assist BMC and Cambridge as they transitioned from reimbursement through the uncompensated care pool to a capitation rate for those enrolled in their MMCOs. Another interviewee, working as the research director for a high level state policymaker in 2006 referenced the lack of agreement as to the intent of these “supp payments” as a major dispute in deciding whether funding should be provided as part of the 2006 reform plan. As this interview participant explained,

In the '97 reform, BMC and Cambridge became health plans. So Medicaid gave supplemental rates to help them create these organizations…this is a mystery. People who were there and negotiated those agreements said it was explicitly a short term rate to achieve this goal. These are now healthy, well run plans that are fully established. The BMC and Cambridge people will look you straight in the eye and say that is not our understanding. We were promised that these were ongoing supplements…and we need them. (Interview 23)

Regardless of the original intent of the “supp payments,” the safety net hospitals were not willing to lose this funding without a fight. From the perspective of the hospitals, loss of this money would have dire economic consequences that would hinder their ability to continue to provide care for the low-income populations they served. The hospitals argued that even if the reform plan passed, there would still be a residual pool of people to whom they would still need to provide care because these individuals would not be eligible for any other public insurance programs after reform was implemented (Holahan & Blumberg 2006; D’Angelo & Haislmaier 2008). From the perspective of advocates and some policymakers, continued funding of these hospitals would undermine the reform, as funding would be better allocated to Commonwealth Care, the insurance program included
in the proposal that would provide subsidized insurance to low income Massachusetts adults.

Initially, there was not extensive newspaper coverage on the negotiations between these two hospitals and policymakers. An editorial published in February 2006 advocated for continued supplemental funding for BMC and Cambridge, if the state transitioned to a new health coverage system (“Beyond the health pool”, 2006, February 15). About a month later, another Boston Globe article identified this conflict between the hospitals and policymakers explaining,

another aspect of the battle [developing a health reform proposal] is that House Speaker Salvatore DiMasi is resisting efforts to continue Medicaid funding for Boston Medical Center and Cambridge Hospital, according to those negotiating the bill. Senate President Robert Travaglini has advocated that the two hospitals should get the lion’s share of the $385 million in a so-called Medicaid waiver from the federal government because they serve a major portion of the poor, negotiators say. (Phillips 2006, March 29)

Despite a lack of press coverage detailing these negotiations, numerous interview participants expressed strong opinions as to the implications of the hospitals’ lobbying activities in shaping policy.

Expanding on the ideas mentioned in the excerpt above, when asked if there were any actors that influenced the policy process the chief policy advisor to a leading policymaker in 2006 explained in an interview,

I would say one of the biggest drivers was BMC and Cambridge…And BMC is based in the Senate President’s district which was very serendipitous. They were not going to lose that money on his watch. I would say they were at the top of the list. (Interview 18)

Another interviewee working as the director of a large non-profit research organization expressed similar sentiments. From her perspective, “Boston Medical Center and
Cambridge were huge players here. Figuring out how much money they were going to get and in what form they were going to get it” was a fundamental component of the reform negotiations (Interview 9).

Ultimately, the lobbying activities of these hospitals resulted in the inclusion of $287 million of additional funding for BMC and Cambridge in Fiscal Years 2007, 2008, and 2009. The reform plan also included a requirement that from July 1, 2006 through June 30, 2009 the Connector established by the reform plan to administer the new insurance program would only be able to contract with MMCOs operating in Massachusetts. This provision guaranteed BMC and Cambridge, the two largest MMCOs in Massachusetts, a large market share of those who would be newly insured through the Commonwealth Care program.

Though there may not have been extensive press coverage detailing the negotiation process, the details of the final agreement that was reached were certainly the subject of much public criticism. One article in the Boston Globe began with the headline, “Care bill may be a hospital bonanza: New revenues of $270M seen” and later quoted Alan Sager, director of the Health Reform Program at Boston University, arguing “powerful hospitals and insurers did a better lobbying job than access advocates” (Phillips 2006, March 29). Later, another article in the Boston Globe began with the headline “Bill aids two hospitals that assist poor” (Rowland 2006, April 11). Referencing the two provisions detailed above, this article argued,

\[\text{20 M.G.L. 176Q § 122.}\]
\[\text{21 M.G.L. 176Q § 123.}\]
The hospitals lobbied intensely for special provisions, which are buried in the 145-page measure awaiting Governor Mitt Romney’s signature. They guarantee Boston Medical Center and Cambridge Health Alliance hundreds of millions of dollars in Medicaid funding and market rights to a large segment of new insurance business for three years. (Rowland 2006, April 11)

Interview participants expressed strong frustrations with the impact that hospital lobbying had on the content of the reform plan. One interview participant who was a state legislator in the 1980s and a lobbyist for several private health care organizations in 2006, cynically stated, “Part of this whole thing [health care reform] is the tension between BMC and Cambridge. In many respects, a lot of health care reform is a sort of cloud under which BMC and Cambridge have guaranteed themselves a market share” (Interview 6). Another interview participant who represented a research organization advocating for reform expressed concerns that,

we were not well served by the safety net hospitals. I think they serve an incredibly important function and I think we need a strong safety net. I worry that they’ve gotten too much of the money in reform and that’s going to come back to bite us in the long run and I think that happened to some extent in ’96 and then I sort of viewed it as a buy-in cost. (Interview 9)

Just as the $295 FSC by business was not an element of any of the initial reform proposals, neither was $287 million in continued funding for BMC and Cambridge Hospital nor was the provision that the health care plans participating in the Commonwealth Care program had to be MMCOs. As the interview participant above suggested, including this piece was likely necessary to get “buy-in” from the hospitals and policymakers representing them. With the CMS deadline fast approaching, pressure on policymakers to develop a reform proposal intensified, making them more open to adoption of this provision if it would allow the plan to move forward. Interestingly,
neither newspaper reports nor interviews with those involved in these negotiations explained why the federal government would be willing to allow continuation of these supplemental payments since this was one of the major problems with Massachusetts existing arrangement. One interview participant working in the state legislature at the time as a high level staff member to a leading policymaker responded to this question. She explained,

We were so up against a deadline, we were over the deadline. Kennedy [U.S. Senator Edward Kennedy] basically let us know that he didn’t think he could win it [convincing the federal government to approve the reform plan with the supplemental payments included]. Now, but then somehow the $287 million is still there. And I don’t know if that’s Kennedy, I don’t know if that’s Elaine Ullian [President and Chief Executive Officer of Boston Medical Center], who is an incredible lobbyist and who has other friends that we don’t. I don’t know the source of her power. Some people assume it was Kennedy, but I certainly don’t know that personally. (Interview 23)

Though the reason state (and ultimately federal) officials were willing to keep this provision was not revealed in this study, it is illustrative of the strong influence these hospitals had on the policymaking process.

D. Policy Passage

After nearly a year of debate in the legislature and nearly four months of stalemate while the Conference Committee sought to develop a bill and negotiate with dominant interests, on April 3, 2006 Senate President Travaglini and Speaker DiMasi hosted a Statehouse news conference to formally reveal the details of the health care reform bill. The bill was designed by the Conference Committee with the “help” of the dominant structural interests who weighed in during this process (LeBlanc 2006, April 3).
The compromise bill incorporated some elements or variations thereof from the plans initially proposed by Governor Romney, Senate President Travaglini, and Speaker DiMasi. It was designed to cover 90-95% of the uninsured within the next three years. Its major components included: an individual mandate for adults to purchase insurance if an “affordable” option is available; a FSC and free rider surcharge on employers failing to adequately contribute to the health insurance of their employees; the development of the Commonwealth Health Insurance Connector Authority for the management of a subsidized program available to adults earning up to 300% FPL, and a commercial program available to what would become the newly merged small and non-group health insurance market; expansions in MassHealth, and Medicaid rate increases, among others (including the provisions for hospitals described above). Since both chambers had already passed earlier versions of the bill, the House and the Senate would only be able to support or oppose the legislation, without changing its content.

Speaker DiMasi and Senate President Travaglini were two policy entrepreneurs dedicated to passage of this reform. Their efforts to garner political support of their colleagues enabled prompt passage of this legislation. Only a day after receiving the health care reform bill, the House indicated its overwhelming support for it with a vote of 154 in favor and only two opposed. Subsequently, on the same day, the bill received endorsement of the Senate with a unanimous vote of 37 in favor and none opposed. Though it had been a tumultuous process, the commitment of these policymakers allowed them to take advantage of a policy window’s opening and enabled passage of landmark health reform for the state.
Illustrative of the historical significance of adopting this legislation, a ceremony was held in Faneuil Hall in Boston on April 12, 2006. Governor Romney signed the health care bill into law, with bipartisan leaders from the State legislature and U.S. Senator Edward Kennedy at his side. On either side of the podium were banners waving “Making History in HealthCare” as with passage of this reform Massachusetts became the first state to require most residents to acquire and maintain health insurance (Helman & Kowalczyk 2006, April 13) (see Figure 3 below).

![Figure 3: Signing of Massachusetts “landmark” Health Care Reform, April 12, 2006](image)

Governor Romney did veto several sections of this bill, most notably the establishment of the employer FSC to illustrate his opposition to any new taxes or assessments. However, his vetoes were easily overridden by the legislature.
Shared responsibility

Adherence to the concept of “shared responsibility” seemed critical to the passage of Massachusetts health reform. One of the persistent themes of the political economy approach is the tension surrounding where the line should be drawn in determining public versus private responsibilities. In this case, the cornerstone of the reform is a mandate that adult residents maintain health coverage that meets a minimum standard of value and coverage. However, government and employers are also required to assume responsibilities as part of the reform. This arrangement represents a compromise between government and employers with respect to their associated responsibilities for the provision of health insurance. Employers are expected to make a “fair and reasonable” contribution to health insurance for their employees (or face the FSC or a “free rider” surcharge), and government will increase access to insurance through the development of a new program providing subsidized insurance to the low income uninsured. Articles and commentary from policymakers point to the importance of this concept in enabling the reform.

In describing the process that led to the concept of “shared responsibility” an article in the *New England Journal of Medicine* explained, “Advocates were not happy with the individual mandate, and the business community was not happy with an employer mandate. All sides, however, believe they can live with the compromise, and the result will be increased coverage for the uninsured” (Altman & Doonan 2006). Similarly, shortly after the reform passed, Speaker DiMasi described it as “a carefully designed combined

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22 Pursuant to M.G.L. 111M § 1, to satisfy the requirements of the individual mandate, individuals with affordable insurance available to them must acquire and maintain a health insurance plan that meets minimum creditable coverage standards.
approach of Medicaid expansion, state insurance subsidies, employer contributions, and a requirement for individuals to purchase insurance if it’s affordable” (Feller 2006, p. 1). DiMasi suggested that this reform should result in near universal coverage, but he cautioned that “it will only work if it is part of an overall package of shared responsibility” (Feller 2006, p. 1). In accordance with Speaker DiMasi’s assessment of the reform, Senate President Travaglini described it as a “delicate balance between providers, consumers, state, and federal governments” (Feller 2006, p. 1).

The notion of shared responsibility was critical to gaining support for the reform from policymakers and dominant interests. Implementation of the law requires the Connector Board and many other state agencies to develop the details of certain elements of the law. Continued support for reform will largely depend on how these elements are defined, and whether major stakeholders feel the definitions are consistent with the notion of “shared responsibility” that they agreed to in shaping the law.

Bailing on the ballot initiative

To show their support for the new legislation, advocates who had initially sponsored the ballot initiative announced on July 5th that though they would not file the additional signatures necessary to put the initiative on the ballot in November 2006. From their perspective, the law represented a true effort to expand health insurance coverage to those lacking it.

John McDonough, Executive Director of HCFA, explained the purpose of the ballot campaign was to send a message to the legislature that Massachusetts consumers want health care reform. If legislators did not on their own address the issue of the
uninsured, advocates would resort to the ballot initiative. However, instead, advocates put their support behind the law and invested their efforts in implementation. According to McDonough “We [the advocacy groups that comprised the ACT! Coalition] are all obsessively involved in the hard work of implementing the healthcare reform law. The ten groups that make up the coalition, including several labor unions voted unanimously to drop the ballot question” (Krasner 2006, July 6). Having reached a bipartisan compromise, which earned the support of consumers, employers, and hospitals, the state officials now faced the next challenge of implementing the plan they had passed.

IV. Implementation

A. Implementation Approaches

After government has passed new legislation, the next stage of the policy cycle is the translation of policy into action. Policymakers have made some major decisions regarding the shape of the policy during the policymaking process, but there are generally many elements that must still be determined to operationalize it (Howlett & Ramesh 2003). There are several different approaches for explaining and evaluating the implementation process.

Until the 1970s, many researchers did not extend the study of policy analysis to the implementation stage. Rather, public policy scholars concluded that after completing the difficult process of passing legislation, government easily embarked on the task of putting the new policy in place (Howlett & Ramesh 2003). However, published in 1973, Pressman and Wildavsky’s book, Implementation, served as a pivotal study initiating attention to the field of implementation analysis. Their study, evaluating the failure of a federal program
designed to create jobs for unemployed inner-city residents in California, prompted researchers to pay closer attention to the factors that impact government's ability to carry out a given policy and accomplish its stated policy objectives (Mazmanian & Sabatier 1989).

Following the publication of Pressman & Wildavsky’s (1973) study, implementation studies were characterized by what became known as a “top down” approach. Researchers argued that for implementation to be effective, a strong chain of command was necessary to ensure those implementing the policy or program were doing so consistent with the intentions envisioned during the policy design stage (Parsons 1995; Howlett & Ramesh 2003). This approach focused on the need for legislative clarity and a strong system to exert control over each stage of the implementation process, from policymakers’ initial passage to the “street level” as bureaucrats actually put policy into practice (Lipsky 1980).

In time, many researchers studying the implementation of public policies criticized the “top down” approach, suggesting it relied on an unrealistic level of order pervading the governance structure (Peters 1999). In addition, scholars argued that the “top down” approach failed to consider the role of outside actors in influencing the implementation process. From these criticisms emerged a new model for evaluating the implementation process known as the “bottom up” approach. One of the fundamental premises of this model was that even in the presence of a strong chain of command system for policy implementation street level bureaucrats may exercise discretion in how they choose to apply policy. A considerable amount of bargaining or negotiating among implementers and other actors in the political environment influences the process of implementation for those adhering to the “bottom up” approach (Parsons 1995).
Eugene Bardach (1979) expanded on the concepts inherent in the “bottom up” approach to develop yet another framework for evaluating implementation. Bardach (1979) concurred with the concept of bargaining and negotiation among actors inherent in the bottom up approach. However, most researchers using the “bottom up” approach envisioned that the different actors negotiating at the implementation stage all shared the same policy goals. Conversely, Bardach (1979) suggested that rather than sharing policy goals, actors who become involved during implementation are motivated by their desire to influence the implementation process so as to best achieve their own self interested goals and objectives.

According to Bardach’s (1979) model,

the bargaining and maneuvering, the pulling and hauling of the policy adoption process carries over into the policy implementation process. Die-hard opponents of the policy who lost out in the adoption stage seek, and find, means to continue their opposition when, say, administrative regulations and guidelines are being written. Many who supported the original policy proposal did so only because they expected to be able to twist it in the implementation phase to suit purposes never contemplated or desired by others who formed part of the original coalition. (p. 38)

In short, Bardach (1979) characterized the politicking that ensues during the implementation process as a “game”. Bardach (1979) writes that in order to assess how a program will fare during the implementation process it is necessary to “look at the players, what they regard as the stakes, their strategies and tactics, their resources for playing…” (p. 56). Bardach (1979) identified four general types of adverse effects on policy implementation that can result from the “games” associated with this aspect of the policy process. These four effects include: the diversion of resources, especially money, which ought to be used for certain program related elements; deviance from the policy goals
stipulated in the initial legislation; resistance to administrative efforts to control or modify behavior; and investment of personal and political time and energy in game-playing activities that might otherwise be used for constructive program action (p. 66). Ultimately, the extent to which the “games” of dominant interests seeking to influence the implementation process produce these adverse results will determine how effectively a new policy or program is carried out.

Having studied the different approaches for evaluating the process of implementation, the framework developed by Mazmanian & Sabatier (1989) represented a synthesis of ideas across different implementation models. In developing their approach, they created a framework that could be used by both political scientists and practitioners to determine the likelihood that a program will achieve its intended objectives. According to Mazmanian & Sabatier’s (1989) framework, a policy decision designed to create substantial change from the status quo will be successful, if the following conditions are met. These include:

- The enabling legislation or other legal directive mandates policy objectives which are clear and consistent or at least provide substantive criteria for resolving goal conflicts;

- The enabling legislation incorporates a sound theory identifying the principal factors and causal linkages affecting policy objectives and gives implementing officials sufficient jurisdiction over target groups and other points of leverage to attain, at least potentially, the desired goals;

- The enabling legislation structures the implementation process so as to maximize the probability that implementing officials and target groups will perform as desired. This involves assignment to sympathetic agencies with adequate hierarchical integration, supportive decision rules, sufficient financial resources, and adequate access to supporters;
• The leaders of the implementing agency possess substantial managerial and political skill and are committed to statutory goals;

• The program is actively supported by organized constituency groups and by a few key legislators (or a chief executive) throughout the implementation process, with the courts being neutral or supportive; and

• The relative priority of statutory objectives is not undermined over time by the emergence of conflicting public policies or by changes in relevant socioeconomic conditions which weaken the statute’s causal theory or political support. (p. 41)

Mazmanian and Sabatier (1989) acknowledge that it is unlikely to attain all six of these conditions at the outset, particularly for a policy that represents substantial change. However, these scholars argue that if the objectives of the initial policy are to be accomplished, these conditions must be met.

Though there are numerous different frameworks for studying this process of implementation, a few common ideas are repeated across these different approaches. Moreover, there is some consensus as to the conditions or factors that facilitate or constrain the implementation of public policy. These approaches emphasize the importance of clarity in the initial authorizing legislation and the goals or objectives the policy intends to accomplish (Parsons 1995; Howlett & Ramesh 2003; Mazmanian and Sabatier 1989). Policymakers must have had sufficient information and knowledge of the problem when drafting the authorizing legislation. To develop policy that will address a specific problem, it is first necessary to understand the causal linkages between what and how certain circumstances correlate to the resultant problem or issue under consideration (Peters 1999; Mazmanian and Sabatier 1989).
From a practical and operational standpoint, effective implementation of policy requires communication and cooperation among agencies or organizations involved in the implementation process (Peters 1999; Howlett & Ramesh 2003; Parsons 1995). Adequate time and sufficient resources are also critical factors in determining how effectively a new policy or program will be implemented (Mazmanian and Sabatier 1989; Bardach 1979; Parsons 1995).

Finally, broad political support for the new policy or program is essential to successful implementation. One way of assessing political support is to consider the way in which the involvement of various stakeholders in the “implementation game” illustrates efforts to undermine the policy or program or results in outcomes that are inconsistent with the initial intent or objectives of the law. In addition, political support from the administration and legislators is also crucial to successful implementation of a new policy or program (Mazmanian and Sabatier 1989; Bardach 1979; Parsons 1995).

B. Implementation of Massachusetts’ Health Reform: Political Pressures

Two years have passed since Massachusetts enacted chapter 58, An Act Providing Access to Affordable, Quality, Accountable Health Care, and implementation of health reform is well underway. In the two years since passage of health reform, nearly 340,000 additional people have acquired health insurance. This growth in insured lives has been the result of increased enrollment in both public and private health insurance. As of August 2008, nearly 180,000 adults were enrolled in the state subsidized Commonwealth Care program established as part of chapter 58. In addition, enrollment in MassHealth, an existing insurance program for categorically eligible low income individuals and families,
grew by approximately 50,000 since implementation of reform. Enrollment in private insurance plans has also increased by approximately 110,000 lives.

Despite a reduction in the number of uninsured in Massachusetts, the process of implementing health reform has not been without challenges. As Mazmanian and Sabatier (1989) suggest, for a policy that represents substantial change from the status quo (as does the 2006 health reform in Massachusetts), considerable time is necessary to complete implementation and accomplish the objectives included in the law. Nonetheless, it is possible to evaluate the way in which the factors described above have impacted the implementation of health reform in Massachusetts to date. Furthermore, consideration of political and economic circumstances can provide insight into the forthcoming obstacles that may be encountered in sustaining this reform.

Politicking around the “details”

Reaching agreement on many of the provisions included in the reform legislation was contentious and involved considerable negotiation and bargaining. Just as Bardach (1979) suggested, this “bargaining and maneuvering, pulling and hauling of the policy- adoption process” did carry over into the policy implementation process. In fact, Chapter 58 assigned determination of many of the policy and regulatory “details” associated with reform to the Connector, the agency created by the law to lead in its implementation, as well as other state agencies (p. 38). Many of the stakeholders affected by these “details” actively sought to influence regulations and other practices pursuant to the implementation of reform.
Numerous articles published after the health reform law passed highlighted the importance of this aspect, determination of many of the particulars of the reform, to the implementation process. For example, in an article published by the National Conference of State Legislatures John McDonough, the Executive Director of HCFA during the law’s passage, remarked that “the law is short on details, which will be hammered out in the coming months, but it lays out the basic components of a reform program” (Feller 2006, p. 29). Similarly, two scholars writing about Massachusetts health reform in the New England Journal of Medicine argued, “the devil as always, is in the details…and many of the details of the Massachusetts plan still need to be worked out” (Altman & Doonan 2006, p. 2094).

Finally, to explain the anticipated effort of numerous stakeholders to influence the implementation process, an article published in the Boston Globe about a month after the reform’s passage suggested, “there’ll be lobbying at all levels of the executive branch, from the governor to his key aides to the secretary of health and human services to the agencies with key implementation responsibility” (Krasner 2006, May 24). Consistent with these predilections and the assertions of Bardach (1979), the experience in the months after chapter 58 passed illustrated how involved dominant interests would be in influencing these “details” and how critical this stage of the policy process would be in shaping the outcome of the reform.

Players involved in the implementation game: Business

Two aspects of the law that were of great interest to the business community following the law’s passage included determining how the “free rider” surcharge would be calculated and the definition of what would constitute a “fair and reasonable contribution”
to health insurance (necessary for businesses to avoid the potential FSC). According to the law, the “free rider” surcharge was to be applied to employers with 11 or more workers who failed to set up Section 125 plans and whose workers utilized publicly funded health care services. Additional rules and regulations were necessary to provide clarification for small employers with part-time and contract help as to if they would be subject to this requirement, and subsequently to determine how much the surcharge could be. Similarly, regulations were necessary to clarify what would constitute a “fair and reasonable” contribution to health insurance for their employees. Establishment of these regulations was delegated to the Division of Health Care Finance and Policy (DHCFP).

Illustrative of the importance of the implementation process in shaping a law’s outcome and of the influence of vested stakeholders in this process, Rick Lord, leader of a the largest business association in Massachusetts explicitly acknowledged to a Boston Globe reporter,

We feel our work only just began on April 12 when the governor signed the bill. The next twelve months are going to be key as to how this actually works…I’m sure everybody is doing what we are, which is advocating for our position. (Krasner 2006, May 24)

As these comments illustrate, the business community’s effort to influence the content of these regulations was not furtive. The article went on to explain,

Businesses are trying to influence many facets of the healthcare reform. At the top of their list are the rules that will determine which employers have to pay a $295 annual assessment for each employee if they do not offer a ‘fair and reasonable’ premium contribution to workers…The rule making process will be central to the success of the legislation. Everyone is eager to get in on the act. (Krasner 2006, May 24)

In fact, numerous employers offered comments to DHCFP. These remarks were welcomed by the Division and considered in developing regulations. In the words of Amy
Lischko, Commissioner of the DHCFP, “the law is broad and sometimes vague…the regulations are supposed to be crystal clear…we’re taking all of the comments [from employers] into account. Employers are not a homogenous group” (Krasner 2006, June 29). Just as the business community influenced the policy formation stage, so too did they influence policy implementation.

As described above, the concept of “shared responsibility” was critical to enabling the law’s passage. Maintaining a careful balance in this division of responsibility also proved a critical component in implementing reform. For example, employers felt that they “compromised” by agreeing to the inclusion of the free rider surcharge and the FSC in chapter 58. As the rules pertaining to these two facets of the law were developed, businesses made it clear that if the rules resulted in what they perceived as an undue burden, businesses’ political support for the law might recede. This was certainly one pressure felt by DHCFP in crafting these regulations. Indicative of this not-so-subtle pressure to draft regulations that would be met with approval by the business community, the President of Associated Industries of Massachusetts explained, “if the regulations don’t recognize the contributions employers are now making, it could create some ill will” (Krasner 2006, June 29).

In the end, the regulations issued by DHCFP reflected the influence and lobbying activities of the business community and are illustrative of what Bardach (1979) characterizes as the “keeping the peace” strategy used by political leaders in the implementation game (p. 93). According to this strategy, players who were very active in the policy adoption stage (i.e., business) expect to have a voice when the program is being carried out. The goal of political leaders is to keep this part of the implementation game
from getting out of control. To “keep the peace” with business, the regulations adopted by DHCFP stipulated that employers with 11 or more full time employees who fail to set up a Section 125 plan and who have an employee receive care that is funded through the state subsidized Health Safety Net Fund (the program replacing the uncompensated care pool to reimburse hospitals and community health centers for uncompensated care), are required to pay between 10-100% of the costs of the care, depending on the employer size and the cost of care provided.\(^\text{23}\) Advocates argued that these rules are so lenient that it would be difficult to even trigger the penalty. From their perspective, this represented a “forfeit” of the attempt to hold business accountable to health care reform (Health Care for All 2006, December 27). With respect to the FSC, employers were deemed to be providing a “fair and reasonable” contribution to health insurance so long as at least 25% of the firm’s full-time workforce obtains company health insurance or the company contributes at least 33% of employees’ health insurance.\(^\text{24}\) Early estimates suggest that these latter regulations would only require about two percent of Massachusetts employers to pay the FSC (Brodkin 2006, July 1).

\(^{23}\) An employer may be subject to the free rider surcharge if they are required to set up a Section 125 plan, have failed to do so, and if one of their employees (or the dependents of an employee receives health care services paid for as free care on three or more occasions during any hospital fiscal year), OR if there are 5 or more occurrences of health care services paid for as free care by all employees in aggregate during any fiscal year, AND the total costs of such free care is $50,000 or more. These regulations, 114.5 CMR 17.00 Employer Surcharge for State Funded Health Costs, are available at the following, http://www.mass.gov/ecoohs2/docs/dhcfp/g/regs/114_5_17.pdf.

\(^{24}\) These regulations, 114.5 CMR 16.00 Determination of Employer Fair Share Contribution, are available at the following, www.mass.gov/ecoohs2/docs/dhcfp/g/regs/114_5_16.doc.
Advocates

Other important “details” of the law that were to be determined by the Connector as part of the implementation process included establishment of the premium contribution requirements for individuals enrolled in the new subsidized insurance program, Commonwealth Care, and the development of an affordability schedule used for determining application of the individual mandate. Chapter 58 specified that for those with income of 100% FPL or less, the premium contribution for Commonwealth Care would be the same as that for individuals of this income enrolled in MassHealth programs (currently $0). However, the Connector had to establish the benefits packages and premium contribution schedules for those in this program earning above 100% FPL and equal to or less than 300% FPL.

The advocate community demonstrated their support for the new law by foregoing the ballot initiative, however, their political involvement in health care reform continued. Just as the business community weighed in to influence the regulations pertaining to the free rider surcharge and FSC, advocates became involved in the implementation “game” in an effort to influence the Commonwealth Care premium contribution guidelines and the affordability schedule.

Just after announcing that they would not pursue the ballot initiative Reverend Hurmon Hamilton, pastor of Roxbury Presbyterian and a member of GBIO conveyed the coalition’s intention to remain active as the state crafted additional rules and regulations influencing healthcare reform (Krasner 2006, July 6). Rabbi Jonah Pesner, another member of GBIO and the ACT! Coalition, concurred. He explained, “when the Connector comes out with its criteria [for premium contributions and affordability], we're
going to hold it up against real people’s lives” by surveying residents (Kowalczyk 2006, June 4).

During the summer of 2006, the Connector developed and proposed a sliding scale premium contribution schedule for individuals eligible for the Commonwealth Care program. This schedule garnered considerable attention from advocates and policymakers who were involved in crafting the law. The development of the Commonwealth Care premium and affordability schedule were representative of what Bardach (1979) characterized as program or policy elements that were “up for grabs” (p. 90). In this implementation game, different groups seek to shape the policy or program in ways that are congenial to their interests; one tactic for accomplishing this is to educate or inform bureaucrats who assume power on the aspects of the program the group seeks to control (Bardach 1979). In this case, GBIO, Health Care for All, and other members of the ACT! Coalition participated in public hearings on the proposed Commonwealth Care premium contributions and attended Connector Board meetings addressing this topic (Health Care for All 2006, November 19). As Rabbi Pesner promised, individuals belonging to GBIO provided personal testimony describing their personal hardships and their inability to pay for the proposed Commonwealth Care premium contributions. In addition, state Senator Richard Moore, co-chair of the Joint Committee on Health Care Financing, drafted a letter to the Connector arguing that the premium contributions proposed by the Connector should be reconsidered (Krasner 2006, August 31).

The premium contribution schedule adopted by the Connector Board in September 2006 reflected the influence of these actors. The premium contribution schedule initially proposed required premium contributions between $0 and $118 per month depending on
the enrollee's income. However, the Board of the Commonwealth Connector Authority adopted a schedule which lowered premium contributions and resulted in a range of between $0 and $106 per month, depending on an enrollee’s income.

In the spring of 2007, the Connector Board began the task of devising the affordability schedule for the state. The affordability schedule would be used to identify the maximum monthly premium amount considered “affordable” to an individual, couple, or family, based on their income. This schedule would help to determine if an adult resident would be subject to the individual mandate (requiring purchase of health insurance, if an affordable option is available). Under this schedule, an adult will be considered able to purchase affordable health insurance if the monthly contribution to employer sponsored insurance or the monthly premium for the lowest cost insurance plan available through the small and non-group market (as indicated by the plans for sale through the Commonwealth Choice program, the Connector’s new commercial program for the newly merged small and non-group market) does not exceed the corresponding maximum monthly premium for his income bracket. Connector staff recommended a draft affordability schedule to the Board in April 2007, and then participated in a series of statewide hearings throughout May 2007.

Like the Commonwealth Care premium contribution schedule, determination of this aspect of reform was also extensively debated. The proposed affordability schedule outlined premium prices considered affordable for those earning up to approximately 500% FPL. For those falling in the 0 – 300% FPL categories, affordable prices were in alignment with the Commonwealth Care contribution schedule and contributions were adjusted incrementally by income up to 500% FPL. At approximately 500% FPL, the
schedule deemed insurance affordable, indicating individuals above this income threshold should be able to purchase insurance.

Nonetheless, advocates who were strongly opposed to the mandate argued for exemption from the mandate for those earning up to 500% FPL (Raymond 2007). In addition to the information presented by stakeholders during the hearing process, the Connector Board also charged Connector staff with providing the Board recent data and analysis on what insured and uninsured people spend on health care at different levels of income. While the Board wanted to be sensitive to the concerns of the advocates, there were also concerns that too loose a standard of affordability might erode employer-based coverage, and drive up government spending for subsidies, thereby undermining reform (Raymond 2007).

In June 2007, the Board approved an affordability schedule for use in determining application of the individual mandate for those filing taxes in 2007. However, as a political compromise to win the support of advocates, the Connector Board amended the Commonwealth Care contribution schedule (and therefore the affordability schedule) by eliminating monthly premium requirements for those earning 100.1 – 150% FPL (those earning up to 100% FPL were already not required to make a premium contribution). In addition, monthly premium contributions for those earning 150.1 – 200% FPL were lowered from $40 to $35 per month (LeBlanc 2007, April 12). Consistent with Bardach’s (1979) theory, the process for defining the “details” of the health care reform law illustrated the involvement of dominant interests in shaping certain aspects of policy as part of the implementation game.
Explaining the new law to the public was another important element of implementation. Given the inclusion of the individual mandate and the possibility of financial penalties for adult residents who do not obtain insurance (if an affordable plan is deemed available to them), ensuring public awareness of the law became critical. If Massachusetts residents were first exposed to the law because of the need to pay a penalty for being uninsured, political support for the reform would dissipate quickly (Dembner 2007, July 7).

Even before the law’s passage, education and outreach were recognized as critical determinants of its future success. Advocates and others working with low-income populations emphasized the need to allocate sufficient public funding to inform the public of the law, its implications, and the insurance options available. As one article in the Boston Globe explained,

Those working on the front lines with the state’s low-income residents say education is key to the program’s success. Lester Holtzblatt helps run a free weekly clinic at Congregation Beth El in Sudbury. Holtzblatt said many people who come to the clinic are unaware of the pending changes in the state’s health care system. ‘It’s going to take a while for people to understand what this is and how it affects them’ he said. ‘There’s going to be a need for a lot of outreach’ (LeBlanc, 2006 April 8).

In the end, the health reform legislation passed in April included three million dollars in outreach grants for hospitals, clinics, and advocacy organizations that work directly with low-income people.

In the fall of 2006, however, Governor Mitt Romney proposed elimination of the funding dedicated to educating business and the public about the landmark law. Again, concerns arose that the inability to finance a public outreach and education campaign could
jeopardize the law’s success. “Healthcare reform is at a vulnerable stage of needing to 
communicate” argued Jon Kingsdale, the Executive Director of the Connector, “we’re 
facing a tsunami of ignorance and confusion” (Krasner 2006, November 16). The 
legislature restored state outreach grants, enabling numerous local non-profits to conduct 
extensive outreach campaigns and to enroll individuals in the newly developed 
Commonwealth Care program (McDonough et al. 2008, June 3).

The Connector also relied on paid advertising to inform the public of the health 
reform law and the new insurance options available (Kingsdale 2008). As part of the 
television marketing and advertising campaign, New England Sports Network (NESN) 
displayed the Connector logo during televised Red Sox home games in 2007. In addition, a 
sports broadcaster announced the partnership and the “cover your bases campaign” during 
the game. This informed the public of the need to obtain health insurance and directed 
individuals to the Connector for further information. Interviews with Governor Deval 
Patrick and U.S. Senator Edward M. Kennedy addressing the importance of health reform 
were also televised during Red Sox games.

Given the potency of the Red Sox in garnering media attention, and data indicating 
the average uninsured individual in Massachusetts is a 37-year-old male, this partnership 
was notable. The partnership included many different marketing and advertising 
opportunities for the Connector. In addition to the paid advertising purchased by the 
Connector, the Red Sox also offered additional pro bono advertising opportunities. For 
example, throughout the 2007 season, an insurance and health care information booth was 
situated at Fenway Park and administered by Connector staff at all home games. 
Brochures and pamphlets describing health reform and insurance plans available through
the Connector were available at the booth to provide interested individuals information on health insurance and the health reform law.

Recently, results from a survey of Massachusetts residents suggested outreach and education efforts have been effective (O’Brien 2007, May 1). As of June 2008, 94% of survey respondents were aware of the law, up from 80% in 2006. Perhaps more significant, given the importance of political support to effective implementation, support for the law also increased from 61% in 2006 to 69% in 2008 as has support for the individual mandate, increasing from 52% in 2006 to 58% in 2008 (Harvard School of Public Health and Blue Cross Blue Shield of Massachusetts Foundation 2008, June).

The Governor, his administration, and other public agencies

In addition to the support of the general public, political support from the administration and policymakers is also crucial to successful implementation of a new policy or program. As Mazmanian & Sabatier (1989) suggested, new policy may take many years to implement, and therefore continued support and dedication to the reform from administrators, policymakers, implementers, and stakeholders is necessary. This became a pressing issue for Massachusetts because of the gubernatorial election in November 2006. Governor Romney announced he would not run again since he would be making a bid for the Republican nomination for the presidency. Therefore, the governor of Massachusetts would be someone new, who had not been in office during the law’s crafting.

Many interview participants expressed the importance of the governor in shaping the success of reform. In the words of a senior staff member for a policymaker deeply involved in negotiating this legislation,
The challenge is going to be keeping the momentum going forward... So, I think the sense of keeping a sense of coherence and momentum is going to be critical... I think the Governor can make a huge difference and if he's willing to really, you know I'm sure he's got lots of other little things he would like to do. It's scary that there's a gubernatorial transition in the midst of this... he could totally make or break it if he's willing to put in enough. (Interview 23)

Echoing similar sentiments regarding the importance of the governor and also acknowledging the importance of economic factors in the implementation process, an advocate asserted, “I think implementation depends on who’s Governor and what happens to the economy” (Interview 8).

In November 2006, Democratic nominee Patrick won the election for governor of Massachusetts. Though he had expressed his support for the Massachusetts health reform during his campaign, his dedication to carrying out the law became apparent through his actions in the months following his inauguration. As will be discussed in the next section, Governor Patrick used his political influence to assist the Connector as it grappled with one of the first economic issues that could threaten reform's success (Krasner 2007, March 4).

In addition to the need for gubernatorial political support, implementation of reform has required cooperation and collaboration among many Massachusetts public agencies (Peters 1999; Howlett & Ramesh 2003; Parsons 1995). The willingness of other state agencies to assist the Connector, the agency charged with leading implementation of reform, with public education and outreach efforts illustrates the commitment of state bureaucrats to reform. There are numerous examples that provide evidence of these joint efforts.
For example, the Department of Revenue (DOR) assisted the Connector in the development of a postcard that was mailed to nearly three million Massachusetts taxpayers. The card informed residents of the requirements of the new law and the opportunities for accessing insurance through the Connector. Letters were also distributed to Massachusetts employers in the spring and fall of 2007, outlining ways in which they or their employees might be impacted by health reform. The Connector and the DOR also worked together to draft a letter to taxpayers who indicated they were uninsured on their 2007 tax return. These taxpayers were notified of the increased penalties for being uninsured in 2008, and the opportunities for accessing health insurance.

The Connector has also worked with the Massachusetts Bay Transit Authority (MBTA) to provide public messaging about health care reform. MBTA cars display posters addressing the health care law, and provide tear-away note cards for passengers who wish to follow up with the Connector to get additional information on health insurance programs.

In 2008, the Registry of Motor Vehicles (RMV) joined the Connector’s public outreach campaign. The RMV was helpful and important since many Massachusetts adults visit the RMV at some point during the year and many new Massachusetts residents visit the RMV. RMV locations use LED screens to display a message on the requirement that most Massachusetts adults need to be insured. Additionally, the Driver’s Manual distributed by the RMV now includes an excerpt on the health care reform law in Massachusetts and provides contact information for the Connector. In the future, the Connector and the RMV hope to develop a system that will deploy a letter on Massachusetts’ health reform law to any individual converting an out-of-state license to a Massachusetts license.
In addition to the public education and outreach examples highlighted above, Massachusetts state agencies have had to work together on various other aspects of implementation. For example, though individuals report health insurance coverage status to the DOR when taxes are filed, the Connector is responsible for hearing all appeals. Therefore, the DOR and the Connector have worked together to develop a system for processing appeals to the individual mandate. In addition, the Connector must work with the Division of Insurance (DOI) to make sure that all the commercial plans for sale through the Connector’s Commonwealth Choice program are compliant with state health insurance requirements and mandates. Implementation requires the continued political support and collaborative efforts of state bureaucrats across different state agencies.

C. Implementation of Massachusetts’ Health Reform: Economic Issues

A persistent theme in the implementation literature is the necessity of sufficient resources to carry out a policy or program. In this section, the focus will be on the importance of economic resources. Health reform relies on the concept of shared responsibility and promotes expansions in not only public, but also private health insurance programs. Consequently, the affordability of health reform to the state, individuals, and the business community is necessary for continued implementation of and political support for health reform.
Cost concerns for the state

Even as chapter 58 of the acts of 2006 was signed into law, the sustainability of the law was being questioned. Published just the day after the celebratory ceremony commemorating the signing of this legislation, an article in the Boston Globe explained,

healthcare specialists expressed concern that the plan could start losing money in three years...amid the wide grins and handshakes, questions surfaced about the cost and the sweep of the legislation, which makes Massachusetts the first state to try and insure nearly all of its residents through an individual mandate to buy insurance. A legislative staff analysis estimates that the groundbreaking healthcare plan would start losing money in two to three years, which could put pressure on lawmakers to spend more tax money, increase the fee on businesses or scale back the coverage of the sweeping bill. The analysis projects that the plan will be about $160 million short of its estimated cost of $1.56 billion in the fiscal year that starts July 1, 2008. (Helman & Kowalczyk 2006, April 13)

Expressing similar sentiments, a former policymaker who had led a previous health reform initiative in Massachusetts explained,

I think it’s a good bill, I think it’s a great step, more than one step forward, it’s a number of steps forward...The one thing I hear from everybody is this is going to cost a lot more money than everybody thinks. (Interview 35)

As these initial concerns forecasted, program costs for the newly created Commonwealth Care program, designed to provide subsidized insurance to those adults earning 300% FPL or less, would soon exceed initial estimates.

Referring again to factors necessary for successful implementation, scholars argue sufficient information and knowledge of the problem when drafting the authorizing legislation is essential (Peters 1999; Mazmanian and Sabatier 1989). Though policymakers did have a firm understanding of the circumstances and characteristics of the uninsured, varying estimates of the number of the uninsured (ranging from 450,000 to 650,000) made
it difficult to assess the true scope of the problem. Without this knowledge, it was difficult
to predict the number of individuals that might be eligible for state subsidized insurance,
which profoundly impacts the cost of reform to the state.

Excerpts from several newspaper articles, beginning in the fall of 2007, illustrate
the ironic implications of the reform’s success. One *Boston Globe* article began with the
headline “Success could put health plan in the red: Mass program may come up $147M
short” (Dembner 2007, November 18). The article went on to explain that due to a higher
than expected enrollment rate in the new subsidized health plan, the state could face a
funding gap as large as $147 million by the end of the fiscal year (Dembner 2007,
November 18). “It’s a good problem to have – people are getting insured and hopefully
getting care” argued Senator Moore of this situation (Dembner 2007, November 18).
However, over time the number enrolling in Commonwealth Care continued to exceed
initial projections, leading state policymakers to believe that the number of the uninsured in
Massachusetts was likely closer the higher end of the estimate range and exacerbating
concerns associated with the cost of health reform for the state. Hackey (1998) aptly
argues in *Rethinking health care policy: The New Politics of State Regulation* that a lack of resources
has often constrained state efforts to expand access to health care to underserved and
uninsured populations. Indeed, this could certainly be the case in Massachusetts; many
policymakers and analysts have begun to voice concerns that the long-term cost of the
health reform initiative may be unaffordable for the state (Dembner 2007, November 18).
Cost concerns for individuals

Since a primary pillar of health reform and reaching the goal of near universal health insurance is an individual mandate to obtain health insurance, the availability of affordable insurance products to individuals is crucial. As described above, the Connector is responsible for the development of the premium contribution schedule for the Commonwealth Care program. The objective in designing the premium contribution schedule was to ensure that state subsidies were sufficient, enabling low-income individuals eligible for this program to make their required contribution to participate in this insurance program. However, in addition, the state grappled with concerns as to the availability of affordable private insurance plans for those not eligible for publicly subsidized plans.

For individuals earning just above the eligibility threshold for Commonwealth Care, the affordability schedule indicated an insurance plan that would cost $150 or less in 2007 (or $165 or less in 2008) was considered affordable. Again, if a private plan was not available for this amount or less, these individuals would be exempt from the mandate. Concerns arose during the initial stages of implementation that insurance products in this price range may not be available to individuals purchasing through the newly merged small and non-group market (“Costs could derail Massachusetts health reform” 2006, April 22). If this were the case, a large numbers of individuals would therefore be exempted from the mandate, undermining the objective of reform.

In January 2007, the initial bids received from the health insurance carriers that would be offering plans to the small and non-group market through the Connector’s Commonwealth Choice program were priced considerably higher than expected. The premium prices would have likely exempted many individuals from the mandate.
requirement. However, demonstrating his commitment to health reform, Governor Patrick joined the Connector Board in exerting political pressure on state health insurance carriers to reconsider and resubmit bids for plans that would be more affordable for state residents. While the governor and the Connector desired for private insurance carriers to submit plans with lower premium costs, they were also cognizant of the importance of maintaining a robust medical benefit package. Another “detail” of reform delegated to the Connector was the development of Minimum Creditable Coverage (MCC) standards, or a level of value or standard of benefits that a plan must meet in order for it to satisfy the individual mandate requirement. As a result, the guidelines provided by the Connector to the carriers in submitting bids included strict guidelines as to the actuarial value of medical benefits that a plan must cover. The carriers were then faced with the difficult challenge of providing robust health insurance plans at “affordable” prices.

Six weeks later, at the beginning of March, insurance carriers submitted proposals with considerably lower rates that met the benefit standards devised by the Connector. Confirming the importance of the role of the governor in the implementation process, several of the Chief Executive Officers (CEOs) of the insurance companies cited the Governor’s intervention as a primary motivator for the reduction of prices in the renegotiated plan rates (Krasner 2007, March 4). Both state officials and health insurance carriers publicly expressed their satisfaction at the agreement reached; however, the cost of private health insurance and annual premium increases will be an ongoing challenge with which the state will be forced to grapple.
Cost concerns for businesses

In the months immediately following the law’s passage, the greatest cost concerns for business were those associated with the FSC and the free rider surcharge for failure to set up Section 125 plans. As a result of the influence of business in shaping these rules, many expressed concerns that the revenue garnered from these assessments to assist in funding health reform would be considerably less than anticipated.

Initial estimates suggested that the state would acquire a total of about $95 million in revenue from these assessments, with $45 million resulting from fair share assessments and $50 million resulting from the imposition of the free rider surcharge (McDonough et al. 2006; Dembner 2007, May 10). However, by the spring of 2008, the state had only collected about $6 million dollars in additional revenue through the FSC requirements; no employer had yet been required to pay a free rider surcharge (McDonough et al. 2008).

This circumstance is representative of what Bardach (1979) characterized as the diversion of resources, one possible adverse result of the implementation game. According to Bardach’s (1979) theory, the business community may not have actually been supportive of all aspects of the reform, especially the FSC or free rider surcharge, but the business community was willing to support the law because it expected to be able to twist it during the implementation phase to suit its purposes. In this case, as a result of the negotiating and politicking the business community engaged in during the initial stages of implementation, the rules surrounding these two reform elements were designed such that they would not affect as many businesses or result in as significant as expected costs for businesses. Consequently, money which was intended to be generated and used for the health reform initiative was “diverted” because of the “games” played by business.
V. Sustainability of Reform: Issues and Challenges

Mazmanian & Sabatier (1989) argue that effective implementation of a new program or policy requires seven to ten years. Just as political and economic circumstances have influenced the implementation of reform in the initial years following the law’s passage, these factors will also determine the sustainability of the reform in the years to come. Several critical issues must be resolved in order for the state to continue its objective of reaching near universal insurance coverage.

First, the impetus for the development of this reform plan was the need to acquire a renewal of Massachusetts’ Medicaid 1115 waiver. Now that waiver, which was renewed by the state in 2005, is again up for renewal. One of the complexities inherent in the negotiations between state and federal officials is that a primary objective of the renewal was to shift public funds from institutions to individuals. Though health reform does intend to make this transition through the development of the Commonwealth Care program, chapter 58 still provided supplemental funds to Cambridge Hospital and Boston Medical Center. This is viewed by federal officials as inconsistent with the basic principles embodied in the waiver (D’Angelo & Haislmaier 2008; Cheney 2008). In addition, federal officials also want to ensure that the expansions in public programs have not simply resulted in crowd-out (i.e., the substitution of publicly subsidized insurance where private coverage is available). State and federal officials are in the midst of negotiating the status of the waiver. In the interim, Massachusetts has been granted an extension, allowing implementation of the program to continue. However, continued federal support of Massachusetts health reform is critical to its success, as the state will not be able to support this effort without federal financial participation.
Since initial passage of health reform rested heavily on the concept of shared responsibility, reform’s success is dependent on the continued support – both political and economic - of government, business, individuals, and other affected stakeholders. In July 2008, Governor Patrick filed a supplemental budget to help address the funding shortfall associated with health reform. Included in his budget proposal were provisions that would require insurers, employers, and hospitals to provide additional money for health reform. Drawing on the concept that was crucial to the law’s passage, the Governor emphasized the concept of shared responsibility and the need for these stakeholders to “step up” and assist in funding health reform. Insurers were required to make a contribution from their cash reserves, the amount of which would be determined according to regulations developed by DHCFP. Analysts suggested this could result in an additional $33 million for health reform efforts. Also included in the proposal was a recommendation that DHCFP change to the rules governing the FSC on employers, requiring employers to provide coverage for 25% of their workers and pay 33% of premium cost, rather than the current regulations which consider an employer to be making a fair and reasonable contribution to employee health insurance by meeting either of these tests. Analysts suggested this change to the rules would also result in an additional $33 million in revenue from fines on employers that would not comply with these more stringent regulations. For acute care hospitals, the Governor’s proposal included a one-time assessment totaling $20 million dollars (LeBlanc 2008, July 18).

Surprisingly, public denunciation and strong opposition to this proposal from hospitals and insurers was lacking. Dr. Buyse, the President of Massachusetts Association of Health Plans, addressed a letter to policymakers arguing “taxing health care to pay for
health care makes no sense. We don't need more money in the system, what we need to do is control health care costs” (Bebinger 2008). However, this was about the extent of lobbying efforts from the insurance community. Perhaps more surprisingly, Lynn Nicholas, president and CEO of the Massachusetts Hospital Association, explained "the hospital association understands the financial circumstances under which the governor made his recommendations" (LeBlanc 2008, July 18). Her comments suggest hospitals’ acquiescence and willingness to accept this proposal. At the time of this writing, there is little information available that might help explain the lack of resistance on behalf of insurers and employers to what essentially amounts to a new tax. Some have suggested that hospitals and insurers have benefitted economically from reform as more individuals have purchased insurance and sought care, and therefore these assessments are modest in comparison to their gains.

In marked contrast, after the proposal was filed employers immediately voiced their opposition. A common argument from the business community was that this proposal ran contrary to the concept of “shared responsibility” that was central to the law’s passage in April of 2006. For example, Eileen McAnenny of the Associated Industries of Massachusetts argued,

employers are already doing more than their fair share by adding uninsured workers to company health plans. There are a whole host of ways that employers have stepped up to the plate and this notion that employers are not paying their fair share is troublesome to them. The coalition that has hung together in support of it [health reform] will be fractures [if this proposal passes]. (WBUR Blog 2008)

Other business leaders concurred that this proposal could have the adverse consequence of weakening political support for the law (LeBlanc 2008, July 18). On October 1, 2008,
DHCFP issued a press release regarding the adoption of new FSC regulations. Again, the influence of dominant stakeholders in shaping these rules was explicitly acknowledged; the press release stated, “the state’s final regulations were designed following input given by advocates, businesses, and consumers at a public hearing on September 5” (Kritz 2008, October 1). According to the new regulations, firms with 50 or more employees will be required to meet both tests: providing coverage for 25% of their workers and paying 33% of premium cost. However, this was not met with resistance as most large employees in the state are already in compliance with these regulations. Small employers, for whom this change would be more burdensome, will still meet the test by meeting either of these provisions.

These circumstances, the conflicting reactions of various stakeholders to new economic responsibilities associated with health reform, illustrate the delicate balance that will be necessary to maintain both economic and political support for the law. If these mechanisms do not garner sufficient funding for health reform, the state will have to be creative in considering alternative options for generating revenue.

One of the most pressing issues for all those vested in health reform is the need to slow the rise in health care costs. This has direct economic consequences for the state, employers, and individuals. Continuation of the current trend in cost increases will make it increasingly burdensome for both employers and the state to provide insurance coverage. Moreover, a lack of affordable insurance policies would result in growth among the number of individuals exempted from the mandate, undermining the objective of Massachusetts health reform.
Since the passage of health reform in 2006, an additional 340,000 people in Massachusetts have acquired health insurance. However, the continued success and sustainability of Massachusetts’ health reform initiative depends on if and how the state responds to the difficult political and economic challenges it now faces.
CHAPTER SIX
THE CHALLENGE OF HEALTH POLICY REFORM:
RECURRING THEMES AND PERSISTENT OBSTACLES

This longitudinal case study has examined the Massachusetts health policy reform experience over a twenty year period, beginning in the spring of 1988 and culminating in the spring of 2008. A political economy approach guided this analysis of four discrete health reform attempts. Several recurring themes were developed and highlighted throughout the episodes considered in this project. In this chapter, I summarize the ways in which these themes have been illustrated throughout this study. In addition, I identify the key conditions or factors emanating from this investigation that influence the health policy process, either consistently assisting or obfuscating a reform effort. Finally, I conclude with some thoughts on how the lessons from this study might contribute to broader analysis of health policy reform initiatives.

I. Political Economy and Health Care Reform in Massachusetts: Recurring Themes

According to the political economy approach, to understand the process and outcome of a health reform attempt it is critical to understand the political and economic context in which it emerged and developed (Armstrong et. al. 2001; Clark 1998). Consequently, in chronicling the health reform episodes considered as part of this study, attention was paid to the way in which political and economic circumstances impacted the content and outcome of each reform initiative. In addition to the importance of political and economic circumstances generally, there are a few themes derived from the political economy literature which were also developed in the four episodes considered as part of
this case study. These themes are explained fully in chapter one and are summarized below as an overview:

A. The tension between the public and the private sectors and the difficulty in discerning where to draw the line dividing the responsibilities of each sector is a central component of the political economy approach and a primary point of contention in health policy reform debates.

B. A pervasive trend characterizing health policy reform movements is the pattern of a recurring plot line. Generally, despite the initial enthusiasm for reform, there is ultimately a gradual decline of support for health policy change. Frequently, waning of support is a result of concerns raised during the debate regarding what ought to be the role of the state versus the market.

C. Political and economic power elites play an important role in blocking reform initiatives or shaping them to reflect their own interests.

D. Despite arguments that expanding or building upon the existing private employment based health insurance system is the most politically viable option for accomplishing health reform, efforts to do so – particularly through employer mandates - have generally been unsuccessful. Grappling with this conundrum, or “catch 22,” is often a key element of health policy reform debates.

E. Language plays an importance role in the policymaking process. Political discourse heightens attention to an issue and often influences the shape and outcome of a reform debate.

Though the degree to which these themes characterized the policy process in 1988, 1996, 2000, and 2006 varied, each of these ideas surfaced during these respective reform debates. In each episode, understanding how these themes played out is helpful in explaining the outcome of the reform efforts.

A. Resolving Responsibilities: Public vs. Private

Resolving what responsibilities would be assumed by the state and what responsibilities would be required of the private sector was a fundamental controversy
surrounding Governor Dukakis’s universal health insurance plan in the late 1980s. As described in chapter two, the business community was prompted to enter into this health care reform debate because of cost concerns and their growing liability associated with financing the uncompensated care pool. Business was receptive to the idea of health reform so long as the plan addressed their cost concerns. However, when details of the governor’s reform plan emerged, specifically the inclusion of an employer mandate, business became skeptical. Representatives of small businesses became very vocal in their opposition to the reform. They argued that imposing this requirement on the business community would have dire economic consequences for the state, forcing many businesses to close or relocate outside of Massachusetts.

While policymakers sought to maintain business support for reform, the hospital industry lobbied in response to some financial concerns it had with the health reform proposal. To maintain the support of the hospitals, one of the dominant stakeholders in health reform initiatives, policymakers adjusted the hospital revenue and reimbursement provisions in the legislation. This change aggravated the business community and weakened its already tenuous support for reform. From the perspective of the business community, the reform plan imposed a new requirement through the employer mandate, and because of the hospital revenue adjustment, now failed to address the underlying cost issue that had initially propelled business into this debate.

In order to mitigate business opposition to the reform plan the state agreed to a cap on business liability for uncompensated care pool costs. Employers were willing to accept the new mandate responsibility, in exchange for the state assuming responsibility for
all uncompensated care pool costs in excess of $325 million. As one interviewee who was a high ranking state administrator at the time of this reform explained,

People were having some concerns about some elements of the legislation and at various points along the way I think there was a sense that things were getting stuck… due to the kind of fluctuating nature of it [the reform plan] and kind of who was responsible for what. The agreement that…the Roundtable [the Massachusetts Business Roundtable] would support the legislation in return for a cap on the uncompensated care pool expenses that the private sector would have to bear - that’s an important element of the bill. That was one of the more important compromises that enabled us to move forward. (Interview 34)

As this interviewee explained, reaching this agreement, which imposed new economic responsibilities on both the private and the public sector, was critical to enabling passage of the Health Security Act in 1988. Lacking inclusion of a cap on uncompensated care costs for business and state assumption of costs beyond that cap, the business community would likely have throttled this reform effort.

Changing political and economic conditions in the 1990s caused businesses to question whether they and the state would be able to deliver on the respective responsibilities (i.e., to comply with the employer mandate and to fund uncompensated care costs in excess of the cap) agreed to as part of the 1988 health reform law. As a result of this concern, businesses support for reform dwindled. Ironically, while the business community’s agreement to a new health care responsibility - the employer mandate - enabled reform to pass in 1988, the state’s willingness to repeal the employer mandate was critical to gaining business support and enabling reform in 1996.

Another tension surrounding the 1996 reform debate with respect to dividing the responsibilities of the public and private sectors was the plan to impose a tax on cigarettes (a private industry) to fund public health insurance programs. In addition to the tobacco
industry, businesses located on Massachusetts borders expressed opposition to this tax. As highlighted above, however, inclusion of the repeal of the employer mandate passed in 1988 brought the majority of employers on board. Among those businesses opposed to the reform plan because of the increase in cigarette taxes, in the end, they chose the tobacco tax over the mandate. Though the content of the reform plan passed in 1996 was markedly different than that of 1988 or 2006, in each case the appeasement of the public and private sectors with regard to their respective responsibilities was a contributing factor to policy passage.

In contrast, the lack of specification as to what would be the role of the state and the market in the health care sector helps explain the failure of the health reform initiative in 2000. In this reform episode, issue framing was critical to enabling opponents to sway the public to a particular side of the debate prior to the vote in November. Opponents capitalized on public skepticism of government intervention and raised concerns as to the new role and responsibilities the state would assume in the health care sector if the ballot question passed.

Opponents sent the message that Question 5 “hands bureaucrats a blank check” and argued that “Question 5 would create two new government bureaucracies with broad authority over the development of a health care entitlement system” (Rochefort 2002). As an interview participant who was the president of a small business organization succinctly summarized, “Opponents presented the message that this was an expansion of government bureaucracy and of government overstepping its responsibilities. Question 5 didn’t specify the roles of the state or the market, and opponents used this to their advantage” (Interview 31).
In the 2006 reform episode, the concept of “shared responsibility,” or the notion that government, business, and individuals were each assuming some new responsibilities, was critical to enabling passage of chapter 58. At several points in time during the process of establishing where these lines should be drawn, and determining what these respective responsibilities should include, it appeared that agreement might not be reached and the opportunity for health reform might be evaded.

Perhaps the most controversial aspect of the health reform debate in 2005-2006 was determining businesses’ responsibilities with respect to the provision of health insurance. As described in chapter five, differing opinions on this issue caused deadlock in the health reform debate, nearly causing the state to lose the Medicaid waiver and millions of dollars in federal assistance.

With the help of some of the state’s prominent business leaders, a deal was brokered that met the satisfaction of policymakers as well as the business community. In addition to the free rider surcharge imposed on businesses whose employees utilize the free care pool, business was also required to provide a “fair and reasonable contribution” to employees’ health insurance coverage. If businesses failed to do so, they would be required to pay a Fair Share Contribution (FSC) to the state, which would be used to cover costs associated with the provision of free care. In explaining the rationale that led to this provision, the leader of a prominent research institute in Massachusetts involved in these negotiations explained,

So we say wait, it’s not fair for Employer A to pay the free care costs of Employer B because it [Employer B] did not provide healthcare coverage. I’m willing to carry my load. I don’t think you should force them, Employer B, to provide coverage because the market should decide whether he or she provides healthcare coverage. But it’s not fair for me to
pay the free care cost of his or her employees. So, the distinction between
the mandate and that point is what led to this compromise. (Interview 28)

These elements, the free rider surcharge and the FSC, assuaged both House concerns that
businesses not escape responsibility for health insurance, and business concern that the
payroll tax was too burdensome.

Resolution of this issue, businesses’ responsibility as part of the 2006 health reform,
was certainly the major sticking point in this reform episode. However, the state assumed
additional responsibilities in chapter 58. In addition to the expansion of MassHealth and
the development of a new subsidized insurance program known as Commonwealth Care,
the state was also required to increase Medicaid rates. As one interviewee who was the
leader of the largest business organization in Massachusetts explained,

We argued strongly in this reform that the state had to live up to its
financial responsibilities too. You can’t just keep expanding Medicaid and
pay inadequate rates and don’t think that it’s not going to have some ripple
effect on the system. So, we were happy that in this law, the state
acknowledged its responsibility and over three years we’ll bring up the
Medicaid rates closer to private sector payments so that was a good
thing...So, I think under this new law the state’s role is appropriately
changed and for the better. I think the law was a good mix, frankly, of
changing responsibilities on government, employers, and individuals.
(Interview 13)

From the employer perspective, this was an important element of the reform law.

Insufficient reimbursement from the state for services rendered to Medicaid patients
results in provider cost-shifting to the private sector, thereby increasing costs for
employers that provide employees health insurance.

In each episode considered as part of this study, resolving the tension between
public and private responsibilities was an important component in the development of and
agreement on a reform plan or in influencing the outcome of a reform initiative. An
interview participant who has worked as a leader in public administration and in the private health insurance industry reinforced the importance of this theme to understanding the process and outcome of health reform debates. In explaining this tension between the state and the market and the role it plays in health reform initiatives designed to increase access, he argued

The problems emerge with the how as opposed to the what. Unfortunately, I think when these reform bills are proposed, the early discussions focus on universal access and there’s no mention of the how or the trade-offs or anything else. And there’s a kind of general assumption that government is going to find some magic formula to make everyone able to access affordable health insurance and there’s never a discussion about well how is this going to be accomplished and what does this mean exactly? And when the chips are down, you know, so much of healthcare operates in a market based environment that the two facts collide. The market based healthcare system collides with the expectations of people that government is going to come up with some magical formula and when the magical formula involved dramatically affects the way the private market works, a huge number of business interests are affected, and a huge number of other interests are affected because of the way the existing market functions. We do a terrible job of reconciling those two things. And what happens is the well meaning and high ideals – the well meaning approaches and the high ideals in the early discussions - inevitably sort of crash against the realities…(Interview 15)

As this interviewee suggested and as these case studies illustrate, it is only when the stakeholders involved in a reform debate are able to “reconcile” the respective roles of the state and the market, and the way in which these roles will affect “existing realities” that policy passage is possible.

B. Health Care Reform: The Recurring Plot Line

Another theme analyzed in this dissertation was the notion of a recurring plot line. According to this idea, reformers as well as the general public often exhibit strong
enthusiasm for reform at the outset. However, over time this support fades. This trend is one that often emanates from the theme discussed above; as the debate regarding the role of government and the private sector becomes more inflamed and contentious, and the details of a reform plan emerge, major stakeholders quickly assume a stance on the reform plan. The public can be swayed by those on either side of the debate, often resulting in a loss of confidence in their previous convictions.

During the interview process, several interview participants made comments that reinforced the concept and existence of this pattern in health reform debates. Consistent with the theory outlined above, among those interview participants who commented on this idea, emphasis was placed on the importance of determining the role of the state versus the market. Also critical is the role of those on either side of the debate in shaping public perception of the impact on either of these sectors, if reform passed. For example, in describing the way in which the tension between government and business relates to this pattern an interview participant who has been the leader of a small business organization in Massachusetts for nearly a decade explained,

People are of two minds when it comes to health care reform. They want it to be less expensive and they want it more comprehensive, they want to have choice, but we know that if you limit choice then you can limit cost and make it more affordable. So, it’s a very complicated system… I mean it involves government, it involves the state government, it involves the federal government, it involves private health insurance paying for things. People just don’t understand it and it’s easily derailed…Trying to get them [businesses] to move from that they’ve done in the past is very, very hard. So I think that that’s you know, any change, change is hard. (Interview 31)

Not only is reaching resolution – and possibly agreeing on a change in the respective roles of business and government challenging - but explaining these details to the public is also
difficult. In many cases, it is the way in which a reform plan is translated to the public that causes a reform initiative to “derail.”

As illustrated in the reform episodes considered in this study, opponents of reform often use attack strategies to discredit a particular policy plan (Cobb & Ross 1997). Frequently, the result of the attack strategies is to heighten the concerns and fears of the general public as to the implications of passing this policy. Given the often complicated details associated with a reform plan, it is not difficult for the public to be swayed by these messages. Several interviewees suggested that fear of an unknown system and concern that change could result in a circumstance worse than the status quo were fundamental reasons for a gradual waning of support for health reform. One interview participant who served as a primary leader of one of the policy reform episodes considered in this study and who continues to be active in the Massachusetts health care industry explained this situation in the following way:

I think there is this combination of a fear of a government takeover which would take away one of these wonderful benefits most of us have, not all of us, but most of us have in this country and a fear of going too far. The other thing that makes these things [health care reform initiatives] fall apart, they’re so complicated. So, sometimes these things get so complicated they fall of their own weight. And the public says, ‘No, no, I’m doing fine. I’ve got mine and I’m okay and it may not be in the best system but it is a system and the other thing scares me.’ So, I think there’s this natural reluctance that works for most people for most of the time and where we think we get really great healthcare even if there are certain glitches and problems. (Interview 35)

Other interview participants offered similar perspectives on the impact of fear in causing public support for reform to wane. For example, one interview participant who has been an active proponent for universal health care in Massachusetts explained,
Healthcare is very expensive and so it’s easy to say that extending healthcare to the uninsured or whatever it might be is going to devastate the economy – so it’s a wide open target. In terms of what we’ll lose, I think it’s very easy to get the public message out there that this initiative will change your healthcare, will change your relationship with your doctor, will change your ability to go to the hospital of your choice, things like that and people don’t want to lose that. (Interview 17)

Similarly, another interview participant argued,

everyone’s more comfortable with the status quo and when push comes to shove they become a little fearful of rocking the boat and losing something they may have been perfectly happy with right now…Status quo in the political arena – I don’t care what the issue is – status quo is always the easiest outcome because of the fear of the unknown and change. (Interview 21)

In this study of four reform episodes in Massachusetts, evidence of this pattern emerged, though three of the reform efforts studied did ultimately pass. In these instances, it seems the public was not sufficiently dissuaded (in time) to prevent the reform’s passage.

For example, though the Health Security Act did pass in 1988 support for this reform plan changed dramatically from the initial announcement of Senator McGovern’s and Governor Dukakis’s reform plans in the spring and summer of 1987 to the legislature’s vote on a reform plan in April 1988. Newspaper articles initially suggested Governor Dukakis’s health reform proposal would sail quickly through the legislative process, but the detailed account of this reform episode in chapter two highlights just how tumultuous the process was (Black 1987, September 9). In the end, the Massachusetts General Court was fairly divided in its support for the reform as illustrated by the slim margins by which is passed, 81-72 in the House and 19-15 in the Senate (SHNS 1988, April).

Support for the reform diminished so much that implementation of a key element of the reform plan, the employer mandate, was continually postponed and ultimately
repealed as part of the package that enabled support for health care reform in 1996. Governor Weld’s closure of the Children’s Medical Security Plan (CMSP) in 1994, and the intentional framing of McDonough’s “Health Care Minimum Wage” by policy proponents as a plan that would benefit children prompted the base of support for this new reform plan to expand. A diverse group of stakeholders including Health Care for All (HCFA), the Massachusetts Teachers Association (MTA), the Massachusetts Medical Society (MMS), the Massachusetts Academy of Pediatrics, and the Success by Six Coalition came together to support this legislation because of their shared commitment to this objective (McDonough 2000). However, just as was the case in 1988, when the details of this plan emerged, other affected stakeholders actively lobbied against the plan.

Almost immediately after Representative McDonough formally released his plan, labor expressed their opposition to the plan because it repealed a minimum wage increase that had just passed. Support became tenuous as business actively expressed its opposition, citing many of the same arguments voiced in the 1988 episode with respect to the detrimental impact the reform would have on businesses and the economy. In addition, the cigarette tax increase included in the bill caused concerns for those business owners located on state borders, who loudly voiced their opposition to the bill. Even though Governor Weld filed for the 1115 waiver that prompted attention to reform and developed a reform plan that looked very similar to McDonough’s bill, he was forced to oppose McDonough’s plan because of a pledge he had made not to increase taxes.

The recurring plot line had begun to emerge. Simultaneously looming for business was implementation of the employer mandate passed in 1988. It was fear of triggering this mandate that rekindled support for health reform in 1996 and prevented dismantling of the
reform initiative. Representative McDonough was willing to drop the health care minimum wage portion of the reform plan and include an element officially repealing the 1988 employer mandate. In exchange, business switched sides on the debate in this issue, actively promoting its passage and swaying others to do the same.

This analysis highlights not only how the pattern of a recurring plot line can reappear in different reform episodes, but also how this pattern can transcend a single reform episode, with a major impact on subsequent policy decisions. This circumstance also provides evidence supportive of Morone’s (1990) argument regarding the importance of historical context in understanding and explaining contemporary politics and policy. As this longitudinal study illustrated, the content and process enabling health care reform in 1996 was largely the result of the reform plan that has passed in 1988.

The case of the 2000 ballot initiative most clearly exemplifies the pattern of the recurring plot line. Though public opinion polls suggested initial widespread public support for a reform, the arguments made by various stakeholders vested in the status quo and opposed to Ballot Question 5 ultimately caused supporters to doubt their initial convictions. In September 2000, nearly three quarters of voters indicated they would vote yes on Question 5, however, this initiative lost by a vote of 48% to 52% (Kowalczyk & Mishra 2000, October 7; Heldt Powell 2000, November 8).

As the detailed account of this episode in chapter four explains, those dominant interests opposed to this initiative launched a powerful and well financed campaign. Powerful rhetoric and various attack strategies were used to convince the public that this initiative could harm more than help the Massachusetts health care system. In contrast to the three other episodes considered in this study where specific details of a reform plan
caused support to fade, the lack of a clear, well detailed reform plan was used by opponents to erode public support for this initiative.

Tension emerged in the other reform episodes as the details assigning the division of responsibilities for the public and private sectors were released. Conversely, Ballot Question 5 did not specify the exact roles the state or the market would assume in carrying out the plan to provide universal health insurance. Opponents of Question 5 used this in their campaign to dissuade the public from supporting this reform. Recognizing typical American skepticism with government intervention, opponents of Question 5 raised concerns that this reform would assign too much control and responsibility over the health care system to government and result in wasteful spending. Fear of an unknown system and concern that change could result in a circumstance that was worse than the status quo were fundamental reasons for a gradual waning in support of health reform in 2000.

In 2005 and 2006, as different events and articles in the problem stream prompted attention to the issue of the uninsured and various different policies for addressing this issue floated throughout the policy stream, support for health care reform was strong. However, as the details of a reform plan emerged, support for reform and the likelihood of reform became increasingly uncertain.

Perhaps surprisingly, the possibility of an individual mandate requiring most Massachusetts adult residents to obtain health insurance did not result in major public outcry or opposition to reform. This was likely because the vast majority of residents in Massachusetts already had health insurance. However, both hospitals and business actively lobbied policymakers as reform plans were debated. It was the concerns raised by business, repeating the same arguments waged in 1988 and 1996 regarding the adverse
economic implications of a mandated health requirement on business, that most resonated with the public.

As described in chapter five, a group called Massachusetts Businesses for Real Healthcare Reform launched a campaign designed to convince the public that the health reform proposal, specifically the possibility of a payroll tax on business, would be detrimental to the Massachusetts economy. The President of the Massachusetts Taxpayers Association, Michael Widmer wrote an editorial arguing, “With a payroll tax on employers, we’d all be ailing,” to persuade both the public and policymakers to oppose that element of health reform (Widmer 2006, January 5). Resistance to this aspect of the reform plan stagnated policymakers’ ability to progress in devising a reform plan. As a result, by March of 2006, the prospect for health reform seemed dismal.

In an effort to salvage the opportunity for reform and the federal funding at risk, policymakers and representatives from the business community were able to broker a deal. Paralleling the situation in 1996, this reform episode illustrated the emergence of the recurring plot line pattern, but the ability of policymakers to negotiate a reform plan with business backing again enabled passage of reform.

C. Shaping the Content and Direction of Reform Initiatives: The Power of Political and Economic Elites

The role of political and economic elites in controlling the direction of reform initiatives is the most dominant theme emerging from this case study. Repeatedly, this analysis illustrated ways in which “dominant structural interests” intervened in the political process to ensure the reform plan was in line with their interests (Alford 1975). In fact,
when asked about the players or actors involved in the policy process, one interview participant candidly remarked, “You see it too often in public policy that the people that really are deemed the experts and have a whole lot of influence in what the final outcomes are, are the people that are most affected economically” (Interview 21).

The business community had powerful influence on the content and outcome of the policy initiative in all cases. Supporting this assertion, when asked about the dominant interests in the health policy arena in Massachusetts, an interviewee who has been involved in Massachusetts health reform in various capacities over the past two decades commented that “nothing has passed, no major law has passed that has had solid business community opposition” (Interview 10). The 1988, 1996 and 2006 health reforms also illustrated the power of the hospital industry in health care reform debates, which, in all three cases ensured that the provisions of reform were to their direct economic advantage. According to an interviewee with extensive involvement in the health care policy arena in Massachusetts over the last two decades, “the hospitals have always been central players in all of this [health reform debates], both in supporting access and demanding their pound of flesh to make something happen” (Interview 10). Consistent with Gordon’s (2003) assertions, in the case of the 2000 reform initiative, when it was not possible to shape the policy or plan to their liking (because the ballot initiative could not be modified, but required a yes or no vote), political and economic elites suppressed the reform effort entirely.

In the late 1980s, economic circumstances prompted both business and hospitals to become interested in health care policy. For business, the costs associated with the uncompensated care pool were becoming increasingly burdensome, while for hospitals an
expiring hospital financing law caused financial concerns to mount. However, when Governor Dukakis’s reform plan was revealed, neither of these dominant stakeholders were supportive of the plan.

Anticipating pressure from the hospitals as a result of cuts in reimbursement for Medicare and Medicaid rates, the Administration’s plan included rate limits that would enable hospitals to receive up to $190 million more in revenue (than in 1987) in the upcoming year. However, the hospital industry was not satisfied with this stipulation.

Similarly, when Governor Dukakis’s proposal was released, businesses began to reconsider their stance on health care reform. Small business organizations, in particular, felt threatened by the possibility of a mandate requiring them to provide health insurance to their employees and voiced strong concerns as to the economic implications of this plan.

This circumstance presented a conundrum for policymakers. Support from both of these dominant interests was crucial to enabling policy passage, but their respective objectives – curtailment of liability for rising health care costs for the business community and adequate revenue for hospitals – seemed contradictory. After months of debate and intense lobbying from both of these dominant interests, policymakers crafted a universal health plan which clearly reflected the influence of both business and hospitals. The plan cap on responsibility for uncompensated care pool costs, as well as the phase in of the employer mandate was included to satisfy business. An interview participant who has been an active advocate for health care reform suggested, “the hardest community is always business. In 1988, there was interest by business because of the costs of health care. The deal they got was a capped pool” (Interview 5).
Hospitals also got the financial provisions they were seeking, including an additional $50 million in state funding. One interviewee who has been involved in the health policy arena in Massachusetts in various capacities over the past two decades commented frankly on the need to “buy” the support of dominant interests. From her perspective, “the hospitals are always powerful. There’s a buy-in cost in every health reform and it’s usually more money for the hospitals. It’s always been more money for the hospitals. So, in ’88 that was a very huge piece of it” (Interview 9). Offering a similar viewpoint on the ability of the hospitals to control the policy process, another interviewee who has worked as an advocate for universal access to health reform for many years, said of this reform, “the hospitals were powerful in terms of the final outcome and also holding hostage until they got what they wanted” (Interview 14). As described in greater detail in chapter two, inclusion of these provisions was critical to gaining sufficient legislative support for this reform plan and reflected the influence of dominant interests in shaping policy development.

In light of the changes in Massachusetts’ political economy from the late 1980s to the mid 1990s, the political acceptability and economic feasibility of the health reform agreement passed in 1988 greatly diminished. Policymakers like Chairwoman Buell and Representative McDonough, who were dedicated to health reform recognized that the employer mandate was at risk, used postponement of the mandate (from 1992, to 1995, to 1996) as a strategy to ensure that health care reform would remain an item on the legislative agenda. In the spring of 1995, the Administration’s request for a Medicaid Demonstration Waiver was approved. As a result, the Governor needed to acquire the legislature’s support for a reform plan. Together these circumstances, the pending
implementation of the employer mandate and the prospective 1115 waiver heightened policymakers’ attention to health care reform.

Governor Weld appointed members to the Special Commission Established for the Purpose of Making an Investigation and Study of Methods for Achieving Universal Health Coverage for Residents of the Commonwealth ("the Commission"), which was charged with reviewing the 1115 waiver and the original reform plan devised by the Weld Administration. After completing its review, the Commission was to make recommendations as to the health care reform plan that should be implemented (Committee on Health Care, Massachusetts General Court 1995). Unfortunately, though the Commission agreed on the need for health care reform, they could not reach agreement on a plan.

Not willing to forgo this opportunity for health reform, in October of 1995, representative McDonough introduced the Health Care Minimum Wage bill. This bill, which included many of the provisions included in the plan Weld had developed as part of the application for the 1115 waiver, was named for its “minimum” requirement (not included in Weld’s plan) that employers offer health insurance to employees, and pay at least 50% of the cost. At the time, McDonough thought this might be better received by the business community than the employer mandate, which required employers to offer health insurance or pay a fee of $1,680 to the state. Included in McDonough’s plan was also a repeal of the employer mandate passed in 1988. The business community supported repeal of the 1988 employer mandate, but they opposed the “health care minimum wage” provision of the bill, citing the same arguments as in the late 1980s and early 1990s with respect to the adverse economic implications this would have on business.
Illustrative of the influence of the business community on the policy process, Representative McDonough dropped the health care minimum wage provision of this bill. He has described this decision as “political pragmatism.” According to this rationale, McDonough argued it would have been politically impossible to pass the bill with the health care minimum wage provision, but by dropping that piece, it became possible to pass a reform that still enabled significant improvements in health care access (McDonough 2000).

By dropping this piece and maintaining repeal of the mandate, business groups went from actively opposing to actively supporting this legislation. Weld received the approved plan from the General Court in July 1996. Inclusion of a cigarette tax in this plan forced Weld to oppose the plan since he had pledged not to raise taxes, despite many of the other elements having originated from the plan he has proposed when seeking the 1115 waiver. Weld could delay action on the bill, thereby preventing it from becoming a law if he vetoed it but did not submit it back to the legislature in time for an override prior to the conclusion of formal legislative session. Again illustrating their role in the policy process, business lobbied the Governor to promptly act on this legislation because they wanted to ensure its passage, preventing imposition of the employer mandate. Though its passage did repeal the major mechanism designed to provide universal access in 1988, in July 1996 another health reform designed to increase access to health insurance passed. And once again, the business community served as a dominant interest in shaping the reform plan and controlling the policy process.

Though there was not considerable coverage of it at the time, the 1996 reform plan also included provisions designed to meet the economic interests of the hospitals,
particularly Boston Medical Center (BMC) and Cambridge Hospital. Part of the waiver included a transition from a fee-for-service to a managed care reimbursement system for services provided to Medicaid patients. As part of the waiver negotiations, the federal government authorized the state to make “supplemental rate payments” to BMC and Cambridge Hospital. These two “safety net” hospitals, identified as such because of their provision of care to a disproportionate share of low-income and uninsured individuals, developed hospital based Medicaid Managed Care Organizations (MMCOs) in response to the waiver requirements. In addition to the capitation rates paid to these hospitals for those Medicaid members enrolled in their respective MMCOs, each hospital received a supplemental payment to offset the high medical claims cost of the population they served. Though there was little attention or focus on this aspect of the health reform legislation in 1996 it illustrates the role of hospitals as a dominant structural interest. Special considerations were drafted and included for them because of their special status as safety net hospitals serving a predominant share of the uninsured.

In 2000, dominant interests were unable to shape the content of the ballot initiative, but they still managed to control the direction of the health care reform debate. Feeling threatened by the potential implications of this reform on their economic livelihood, dominant stakeholders first sought to control the debate by deterring proponents from moving forward with their campaign. Representatives from Health Maintenance Organizations (HMOs) worked alongside some of the supporters of Question 5 to promote and shepherd an alternative legislative proposal (supported by the insurance industry) through the policy process. This bill, which became known as the Patients’ Bill of Rights, was passed by the General Court and addressed some of the issues of concern
among those who had initially filed the petition for Ballot Question 5. This strategy fragmented the coalition dedicated to Ballot Question 5 as some of the initiative’s supporters stopped campaigning as a result of passage of the Patients’ Bill of Rights. However, many of the original sponsors of this initiative felt the bill did not sufficiently address the issue of universal health care access and therefore they waged ahead with their campaign.

Initial poll results suggested there was strong popular support for Question 5. Proponents sought to build additional support for the reform by focusing on the moral imperative to ensure all citizens access to health care. In contrast, those opposed to Question 5, especially the insurance industry and the business community, sought to heighten public concern as to the impact of passing Question 5. Aided by their economic resources and cultural clout, these dominant structural interests radically changed the public’s perception of this reform plan.

A prominent theme pervading many of the advertisements and arguments of the No on 5 Coalition was that passage of the ballot question would exacerbate rather than improve current problems in the health care system. Opponents were skillful in using alarming discourse and rhetoric to ensure this message resonated with the public. For example, an editorial submitted to the Boston Globe on this initiative suggested, “the doctors’ plan [Ballot Question 5] would only make matters worse, sending the state’s economy into a competitive tailspin of soaring insurance premiums” (Warsh 2000, January 8). Another article stated, “opponents of Question 5 argued that it would so disrupt the system that HMOs would face financial crisis, the state government would be hit with huge health bills, premiums would skyrocket, and more people than ever would ultimately be without...
insurance” (Mishra 2000, November 8). Other articles more bluntly suggested passage of Question 5 would cause “holy hell” and “chaos” in the Massachusetts health care system (Knox 2000, April 7; Mishra 2000, September 17). In addition to these public messages, some insurers personally reached out to members to persuade them to vote against Question 5. Blue Cross Blue Shield, the insurance company with the largest membership in Massachusetts, sent letters directly to members. One interview participant recalled that the letter he received indicated passage of Question 5 would dramatically increase his insurance premium (Interview 36).

With significantly greater economic resources, those opposed to Question 5 used radio, mail, and television advertisements to ensure broad dissemination of their message to the public. Several news articles commented on the dramatic discrepancy in campaign spending, with one article suggesting this debate might represent the most lopsided spending in a political campaign to date (Mooney 2000, October 18). This enabled those opposed to Question 5 to monopolize coverage of this issue and present it from their perspective. By November 7th, those vested in the status quo had sufficiently persuaded the public to their side of the debate. Question 5 lost by a vote of 48% to 52%.

The analysis of the 2006 reform suggests the role of BMC and Cambridge Hospital as dominant interests has become well entrenched. Even though the federal government’s request for termination of this supplemental payment arrangement was a major impetus prompting health reform negotiations, BMC and Cambridge hospitals managed to maintain supplemental payments as part of the 2006 health reform.

The waiver which prompted passage of the reform plan in 1996 was renewed in 2002 for three years. In discussions regarding this renewal, state officials were informed
that the federal matching funds for supplemental payment to the MMCOs at BMC and Cambridge Hospital would not be renewed. By 2005, these supplemental payments had grown to nearly $385 million in federal funds (Holahan & Blumberg 2006). Instead of these institutional based subsidies, the federal government preferred funding be allocated for individual based subsidies.

When it came time to finalize the details of the 2006 health reform plan, the hospitals argued that if the reform plan passed, there would still be a residual pool of people to whom they would still need to provide care (because these individuals would not be eligible for any other public insurance programs) after reform was implemented (Holahan & Blumberg 2006; D’Angelo & Haishmaier 2008). According to them, loss of this money would hinder their ability to continue to provide care for the low-income populations they served.

There was not extensive press coverage of these negotiations while they were unfolding. However, several news articles published after the law’s passage and comments offered by interview participants reinforced the role of these hospitals as dominant economic interests with profound influence on the policy development process in 2006. The provisions for hospital included in the legislation speak for themselves; despite the federal insistence on removing direct institutional subsidies chapter 58 included $287 million of additional funding for BMC and Cambridge in fiscal years 2007, 2008, and 2009. Providing further evidence of the influence of these vested interests in shaping policy, the reform plan also included the requirement that for the first three fiscal years of

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25 M.G.L. 176Q § 122.
the Commonwealth Care program (the subsidized health insurance program administered by the Connector for those with earnings of 300% FPL or less), the Connector would only be able to contract with MMCOs currently operating in Massachusetts. This exclusivity further protected the economic interests of BMC and Cambridge, the two largest MMCOs in Massachusetts, guaranteeing them a large market share of those who would be newly insured through the Commonwealth Care program.

As was the case in 1988 and 1996, the process leading to the 2006 reform also revealed the business community’s role as a dominant stakeholder with the ability to control the policy process. The inability to reach agreement on businesses’ responsibility for health insurance caused deadlock for policymakers. Many feared this “sticking point” would cause the state to lose substantial federal funding, if they were unable to reach agreement on a plan for the Administration’s review prior to expiration of the existing waiver.

While the business community was strongly opposed to the payroll tax provision included in the House reform plan, it recognized the economic ramifications that would reverberate throughout the entire Massachusetts health care sector if the state lost such substantial federal health care dollars. In addition, the business community was aware that a number of leading policymakers were committed to requiring business to assume at least some form of responsibility for health insurance coverage. As a result, business became directly involved in shaping the content of the reform plan. Several prominent Massachusetts business leaders worked and negotiated with policymakers in an effort to devise a mutually agreeable provision pertaining to employer responsibility for health

26 M.G.L. 176Q § 123.
insurance. In the end, the deal brokered by business representatives and policymakers included the “fair and reasonable” contribution requirement and the Section 125 plan requirement. This compromise satisfied policymakers, but was considerably less burdensome than the employer payroll tax proposed in the House bill. With this “deal” reached, the reform plan passed both branches of the legislature with strong support and was signed by Governor Romney. Without business intervention in these negotiations, it is uncertain as to if or how state policymakers would have reached agreement on a reform plan by the imposing deadline.

As each of these four cases has illustrated, dominant economic and structural elites have a powerful role in shaping the content and/or controlling the direction of health reform initiatives. In 1988, 1996, and 2006, the reform plan passed was dramatically different in content than that which was initially proposed, reflecting the interest of dominant interests. In 2000, lacking the ability to alter the reform plan’s content, dominant interests defeated the initiative entirely.

D. The “Catch 22” of the Employment Based Health Insurance System

Some have described the employment based health insurance system, through which the majority of the nonelderly population in the United States receives health insurance, as a historical accident (Blumenthal 2006). This system first emerged in the 1940s when the Stabilization Act of 1942 limited employers’ ability to use wages to compete for workers, but allowed employers to expand other benefits offered to employees. In the midst of labor shortages, an increasing number of employers began to offer health insurance in an effort to attract and recruit workers. In the 1950s, a ruling by
the Internal Revenue Service to treat health insurance contributions provided by employers as non-taxable income resulted in a considerable tax benefit for both employers providing and employees receiving health insurance through this arrangement.

This system for providing insurance has grown substantially, and there are several dominant interests vested in its preservation. As a result, reform proposals which threaten this arrangement or seek to dramatically alter it are met with great resistance. At the same time, reform initiatives which seek to build on this existing structure by imposing new requirements or mandates are also met with strong opposition. This circumstance represents the “catch 22” of the employer based health insurance system. While building on this system seems the only politically viable option for reform, efforts to do so are highly contentious and often unsuccessful, especially if they threaten the existing mode of providing insurance. Each of the four reform episodes considered as part of this case study illustrated this “catch 22” in some capacity. In fact, this analysis suggests that in order to pass, a health reform proposal must find the right balance between what is perceived as moving “too close” to a public system or imposing what are perceived as overly burdensome mandates or requirements on stakeholders in the existing system.

Concerns associated with the costs of health care propelled business into the health care reform debate in 1988. Most of the business community expressed support for health care reform. However, when the details of a reform plan emerged, including an employer mandate as the primary mechanism for providing universal insurance, business support for reform began to wane. Businesses argued that this requirement was too burdensome and would have dire economic consequences, causing small businesses to either lay off workers (in order to fall below the threshold of six employees which triggered the mandate
requirement), to go out of business, or to leave the state. Despite these protests, chapter 23 of the acts of 1988 passed by a narrow margin, intimating the conundrum of the “catch 22” was resolved. However, as described in this longitudinal case study, this predicament would persist, playing an important role in setting the stage for and enabling passage of health reform in 1996.

As the date for implementation of the mandate approached, business opposition and calls for its outright appeal grew louder. Deteriorating state economic conditions, a Republican governor opposed to the mandate, and an increase in Republican representation in the General Court also made it increasingly unlikely that the state would move forward with the imposition of the mandate as planned. Recognizing this, Representative McDonough sought to delay implementation of the mandate which temporarily assuaged business concerns and provided him the opportunity to develop an alternative reform plan for consideration when this issue again arose on the legislative agenda.

Using the pieces of the plan developed by Governor Weld in his application for the 1115 waiver as the foundation for a plan, Representative McDonough also included several other features including a tax on tobacco to fund a public health insurance program and the health care minimum wage requirement. In order to get business support for reform, however, McDonough ultimately dropped the health care minimum wage requirement, but maintained repeal of the employer mandate passed in 1988.

The 1996 reform expanded existing public insurance programs, but it did not affect the existing private, employment based arrangement. By developing a plan that represented an “acceptable” mode of building on the current system (from the perspective
of dominant structural interests), policymakers were able to successfully navigate the “catch 22” associated with the employer-based health insurance system. Conversely, in 2000, fear that the reform plan might dismantle the private health insurance system prevented proponents from circumventing this “catch 22.”

For example, in 2000, the director of a small business association suggested the sponsors of Question 5 “were just going to shift it [the provision of health insurance] all over to government and we couldn’t see that as getting us anywhere” (Interview 31). Initiative sponsors intentionally used vague language in the petition, laying out the principle that all residents should have insurance, but not detailing the plan to reach that end. The ballot question did not actually define the role for government or other existing stakeholders. However, this lack of an explicit plan caused those dominant structural interests vested in the existing system to feel threatened by the possibility of a shift to a different arrangement for providing insurance. As a result, they relied on numerous strategies to convince the public of the futility and perversity of passing this initiative and shifting the health care system to what they characterized as a “big government” system. In actuality, the true motivation for blocking this reform initiative was the concern that it would create a system that deviated too greatly from the existing arrangement.

The “catch 22” of the employer based health insurance system surfaced again in the 2006 health reform debate. As one interviewee explained of this reform episode, “the employer piece took the longest to settle. The employer responsibility took the longest to come to agreement on. It almost fell apart over that a number of times” (Interview 9).

Though Governor Romney was politically opposed to the House plan requiring a payroll tax on employers, another argument for not including this provision in the health
reform plan was the possibility that it could be a violation of the Employee Retirement Income Security Act (ERISA) of 1974. This Act does not require an employer to provide insurance but does regulate a health benefit plan if an employer offers one. ERISA preempts any state laws that relate to employer benefits, and therefore passage of a state law requiring employers to provide health insurance benefits or contribute a percentage of payroll toward such benefits might be challenged as a violation of ERISA if these regulations are considered “relating to” an employee benefit plan (Denison 2006, April 9).

Beyond these political and legal concerns was clear opposition and strong lobbying from the business community opposing this provision for economic reasons. Just as in 1988 and in 1996 businesses argued that this stick was too onerous and would be a major burden on business, putting Massachusetts employers at a competitive disadvantage in comparison to other states. Policymakers were in the precarious position of trying to strike the right balance in building on the existing employer based system. As the deadline by which the state needed to provide the federal government a reform plan for continuation of the 1115 waiver approached, pressure on policymakers intensified. If agreement on this aspect of the reform plan could not be reached, the state could lose substantial federal funds.

Confronted with this possibility, policymakers worked directly with business representatives to develop a provision that would not be opposed by the business community, but that would satisfy the House’s desire for business to assume some new responsibility for the provision of insurance. As described earlier in more detail, business representatives and policymakers agreed to the inclusion of the Fair Share Contribution (FSC) requirement and the Section 125 requirement. Employers required to meet these
responsibilities and failing to do so would be fined and the assessments would be used by the state to fund health care services.

Because policymakers worked with business to devise a plan for building on the existing employer based insurance system that was politically viable (and not overly economically burdensome for employers), health reform prevailed in 2006. However, many of the details and regulations associated with the 2006 reform were delegated to other state agencies to be developed after policy passage. Currently, in implementing many elements of the law, state officials continue to grapple with how those stakeholders with a vested interest in the employer based insurance system will react to reform regulations. The most recent debate regarding the regulations defining a “fair and reasonable” employer contribution are illustrative of this challenge.

Reflecting the “catch 22” of the employer-based health insurance system, dominant structural interests resisted the reform initiative in 2000 because of concerns that it might result in a shift toward a publicly run health insurance system. However, in 1988, 1996, and 2006, the business community’s resistance to the imposition of new requirements that would expand the existing private employer sponsored insurance system nearly throttled each of these reform attempts.

Though the “catch 22” of the employer based system manifested itself in different ways in each of the reform episodes considered here, it was a central tension in each of these health reform debates. Even if the employer based insurance system emerged through historical accident, it has become a system that many dominant structural interests are vested in preserving.
The majority of large employers in Massachusetts and the United States provide health insurance. Small employers, however, are considerably less likely to provide health insurance than large employers and are more likely to oppose mandates requiring them to do so (DeVaney & Anong 2007). Though this circumstance suggests a potential source for division in the business community, large and small business interests have generally aligned to present a united front in response to health reform initiatives. Few analysts or policymakers refute the claims of small businesses that the imposition of health insurance requirements would be economically burdensome, but the question as to why larger businesses are willing assume the costs (through surcharges to fund the uncompensated care pool, cost-shifting, etc.) of their non-insuring counterparts remains. Why hasn’t there been a more prominent rift in the employer community over the issue of health reform? Perhaps one reason for this collective front is preference for the status quo – among large employers - in the face of fear of the unknown. Though there are many problems with the current employer sponsored system of providing insurance, employers have also come to appreciate the benefits it provides in terms of tax advantages and recruitment and retention of employees. Transitioning to a new system might address some of (mostly large) businesses’ concerns with the costs of the current health care system, but it could also dismantle the advantages that exist for many large employers under the current arrangement. As a result, it seems a fundamental tension in health reform debates is striking the right balance in building on the existing system, without imposing what are conceived as overly arduous responsibilities on vested stakeholders.
E. Role of Language in Political Conflict

In each of the reform episodes considered as part of this study, rhetoric was an important factor in the policymaking process. Political discourse was used to heighten the public’s or policymakers’ attention to an issue, thereby elevating it on the governmental agenda, or was relied upon to persuade the public or policymakers to a certain side of the debate. This study corroborates Stone’s (2002) argument regarding the importance of numbers. In all four episodes, numbers were relied upon to illustrate the scope and severity of the issue of the uninsured and to convey a “story of decline” with respect to access to health insurance.

In 1988, in addition to the use of numbers to emphasize the incidence of the uninsured, newspaper coverage of this issue included stories profiling the uninsured. One article presented the circumstances of a working mother with three children who indicated she was forced to stop purchasing health insurance for her family because in her words, “It was either paying for that [health insurance] or putting food in my kids’ mouths” (Reynolds 1987, March 2). Articles like this personalized this issue and enabled the public to empathize with those in this predicament. Furthermore, the language used in describing those lacking insurance characterized this population as one that did not deserve their plight. For example, another article in the Boston Globe began, “The Wests – hardworking, solid citizens who pay their bills [emphasis added]– have no coverage for medical expenses” (Knox 1987, October 4). Press coverage increased the proximity of the issue of the uninsured for the public and policymakers and presented the population afflicted with the problem of a lack of insurance as one that deserved assistance. Consistent with the arguments offered by Rochefort & Cobb (1994), the way in which the “problem
population” is defined strongly influences the public’s and policymakers’ attitudes regarding government intervention. The positive image of the uninsured population increased pressure on government officials to develop a public solution for this problem. After this issue arrived on the governmental agenda, proponents relied on normative rhetoric arguing there was a moral imperative to address this issue and that reform was “the right thing to do” to persuade others to support policy passage (SHNS 1988, February).

The 1996 reform episode provides a powerful illustration of the use of language to shape public attitudes. In this case, strategic use of rhetoric helped garner support for McDonough’s health care plan. Though elements designed to aid children and the elderly were only part of this reform plan, proponents recognized the political appeal of these populations and they became the primary focus of advocates’ commentary. One editorial in the Boston Globe summarized McDonough’s plan by stating, “the bill…would expand Medicaid to include tens of thousands of children and set up a program to help needy elderly buy medicine…two groups especially deserving of support” (“Two worthy bills” 1996, June 16). Later, as the debate unfolded, this conflict was characterized as a struggle between “good,” those wanting to provide assistance to children and the elderly, and “evil,” or those who were opposed to the reform because of the cigarette tax. The following excerpt from a Boston Globe editorial highlights the way in which language was used to mobilize support for reform. The author argued, “On the one hand we have needy children – sweet, innocent, little children without health insurance. On the other hand we have the tobacco lobby – evil defenders of that nasty, dirty habit, smoking. Good cause vs.
bad cause. Good guys, bad guys” (Cohen 1996, June 26). By breaking the contest down in this fashion, it was difficult to justify opposing the reform plan.

The chronicle of the ballot initiative in 2000 underscores the importance of the rhetorical contest in shaping the outcome of reform efforts. Though there were several factors that contributed to the demise in support for the petition, the discursive debate that unfolded in the months just prior to the vote likely had the most profound influence on public support for this question. Proponents of Question 5 sought to engage public support to their side of the debate by focusing on the universal care provision of the petition and framing the issue as one of basic social rights. The Yes on 5 campaign also used language to argue that siding with it represented the “morally correct path” (Goldberg 2000, June 11). The rhetorical campaign waged by those opposed to Question 5 was designed to heighten the public’s fear as to the implications passage of this petition would have on the health care system. Opponents suggested that Question 5 could “absolutely destroy the health coverage of most people in this state” and that if it passed “premiums would skyrocket and more people than ever would ultimately be without insurance” (Knox 2000, April 7; Mishra 2000, November 8). Armed with significantly greater resources than proponents, the No on 5 campaign was able to dominate advertising and the messages conveyed to the electorate on this issue. Despite the morally compelling arguments offered by Question 5 proponents, the language used by the opposition heightened the fear of the public and persuaded more people to their side of the debate.

Like the reform episodes in 1988 and 1996, use of numbers in popular press articles leading up to the 2006 reform helped to draw attention to the issue of the uninsured and place it on the governmental agenda. In addition, in speeches on this topic,
prominent policymakers used language indicating health insurance is a “necessity,” helping to prioritize this problem over others (“Healthcare leadership” 2004, November 17).

Language was also strategically used in developing support for particular elements of reform proposals. For example, a major source of contention in the 2006 reform debate was the appropriate responsibility for business in the provision of health insurance. After lengthy deliberation, state policymakers developed a “fair share” contribution requirement. This element of the legislation was designed to encourage employers to provide insurance to employees or risk an assessment by the state of up to $295 per employee if they failed to do so. Selecting this language and framing the requirement in these terms reinforced the normative argument that businesses were at least partially responsible for providing insurance. Moreover, describing the penalty imposed on employers whose employees receive health care services through the state free care pool as the “free rider” surcharge also illustrates the use of political discourse in shaping perception of an issue. Selecting this term promoted the stigmatization of employers who are assessed this fine as they were choosing to “free ride” on the system, rather than to provide health insurance. This language helped in building support for a reform that included business responsibility for health insurance; in essence, these new burdens would only impact employers who were not already doing their “fair share” or who were “free riders” of the system.

II. Beyond the Original Themes: Other Important Influences on the Health Policy Process

This application of the political economy approach to the study of health reform initiatives in Massachusetts has highlighted the way in which the recurring themes identified at the outset of this chapter have pervaded each of the reform episodes
considered here. In addition to the importance of these themes in explaining the outcome of the health reform episodes, this study has highlighted some additional conditions, factors, and circumstances that play a large role in shaping the direction of a reform effort.

A. Sharpening Attention to Reform: The Role of External Forces

One conclusion emanating from this study is the potential for external forces to prompt legislative attention to or legislative action on health reform proposals. A major impetus for state health reform initiatives has been the possibility of acquiring additional federal funds or the threat of losing existing federal funds for health care programs. In 1996, the opportunity to acquire increased federal funding through a Medicaid waiver provided the encouragement state officials needed to tackle the complicated issue of health reform. Later, consistent with Kingdon’s (2003) assertions regarding the role of sun-set provisions or expiration of existing policy as creating a window of opportunity, the need for renewal of this waiver prompted attention to reform in 2006. An impending ballot initiative has also played a powerful role in focusing the legislature’s attention to health care reform, as evident by the 2000 and 2006 reform episodes. And finally, based on the reform experiences in 1988 and 2006, having a governor with presidential ambitions seems to increase pressure on policymakers to address the issue of health reform and increases the likelihood of policy passage.

The expiration of chapter 574, the existing hospital financing legislation, was one circumstance that forced the legislature to visit the issue of health reform in 1988. For hospitals, the longer it took policymakers to decide on a new financing plan, the longer they faced budgetary uncertainties; as a result, hospitals continually asserted pressure on
policymakers to devise a new hospital financing plan. This constant pressure from a
dominant stakeholder on an issue ensured its status on the agenda.

Governor Dukakis’s dedication to the issue of health reform and his status as a
presidential candidate also increased attention to the issue of health reform. For personal
and political reasons, the governor was dedicated to ensuring passage of a universal health
plan, even canceling presidential campaign trips to rally support for his plan in
Massachusetts. One interviewee who was working as an advocate at this time explained
the importance of this circumstance in the following way,

You had a governor running for president. It provided the political
imperatives for both the legislature and governor; the governor first and
then the legislature to do something on reform. He was running for
president. The uninsured was an issue, the democratic legislature certainly
wanted to see a Democratic president. If the reform had failed, it wouldn’t
have been helpful [to his candidacy]. (Interview 14)

Other interview participants offered similar comments, and several news articles published
during this time suggested that the governor’s involvement in the national political scene
heightened state policymakers’ attention to the issue of health reform (Knox 1987,
September 27; Loth, 1988, April 22).

Neither of these external circumstances directly impacted the content of the reform
plan, but they certainly played a role in focusing the legislature’s attention to health reform.
Moreover, both of these circumstances were time sensitive; that is, hospitals argued the
longer it took policymakers to pass a financing plan the more their economic position
would worsen, and Dukakis needed the legislature to pass a reform plan that he could use
on the presidential campaign trail. As a result, together these external variables pushed
health reform to the top of the legislative agenda and encouraged attention to it until a plan was passed.

In 1996, Weld’s decision to apply for an 1115 Medicaid Demonstration Waiver played a fundamental role in state policymakers’ attention to health reform. Though the Commission established to develop a reform plan was unable to do so, the federal government’s approval of an 1115 waiver sparked policymakers to action. The prospect of additional federal money encouraged policymakers to use their creativity and the flexibility granted by the waiver to devise a plan that would enhance access to public insurance programs. Though Weld was forced to veto McDonough’s plan because of the inclusion of a cigarette tax and his campaign promise not to raise taxes, ironically, he had opened the doors to enable this reform by filing for the 1115 Demonstration Waiver and developed many of the features included in McDonough’s plan. An interview participant who was very involved in negotiating with the federal government during this reform plan reinforced this analysis and summarized what happened in the following way:

People forget the bill was filed by Governor Weld. Even though he later vetoed the bill because it was returned to him with a tax included that he didn’t like. The bill he filed did not include any taxes and it was a proposal to reallocate existing funds to support the federal waiver that the administration had been successful in negotiating with the Clinton administration. So that bill, which reflected the terms of a Medicaid waiver that was negotiated, was really the impetus of health reform…the fact that the federal government was willing to provide Medicaid reimbursement for the entire scheme was very important. (Interview 15)

The 2000 reform episode represents an interesting case of the role of ballot initiatives in prompting legislative attention and action on an issue. Fearing the potential implications of Ballot Question 5, the insurance industry reached out to policymakers and some members of the advocacy community in an effort to negotiate an alternative reform
plan. The bill they created differed in some ways from the ballot initiative, most notably in the lack of a provision addressing universal health insurance access, but it addressed other objectives similar to those included in Ballot Question 5. The political strategy of the insurance industry and others opposed to the ballot initiative was to appease supporters of Question 5 with this legislation, thereby making passage of the initiative unnecessary. Although the legislation known as the Patients’ Bill of Rights passed, the initiative petition sponsors forged ahead in campaigning for Ballot Question 5 because of their commitment to pass reform targeted at improving access. Question 5 was not successful at the ballot, but it did prompt attention to health reform and motivated policymakers and dominant structural interests to reach out to reform advocates and work together to address some of their health policy concerns.

Several external forces aligned to prompt attention to and action on health reform in 2006. For starters, the Medicaid waiver the state had received from the federal government in 1996 and renewed in 2002 was set to expire. In order for the state to retain federal matching funds under the waiver, which now amounted to $385 million, the federal government required that the state develop a reform plan that increased coverage, but shifted the provision of subsidies from institutions to individuals. Describing the impact of this situation on the policy process an interview participant who has been active in the Massachusetts health policy arena throughout each of these reform episodes in different capacities argued,

You know, there was the feds saying we were going to have to re-do the waiver which definitely – nothing sharpens the attention of the legislature like the potential for losing $400 million. So without that this wouldn’t have happened. I mean, who knows whether it wouldn’t have...I think we
would have gotten some reform, but it wouldn’t have been as large as this. (Interview 9)

Clearly, none of the policymakers in office during this time wanted to be held responsible for the loss of this money and as a result, health reform became a primary legislative priority.

Just as was the case in 1988, Governor Romney’s potential presidential run heightened attention to the political scene in Massachusetts. Baumgartner and Jones (1993) argue that presidential involvement in a particular policy issue can be key to pushing issues high on the agenda. In this instance and in 1988, a governor with presidential aspirations seemed to be an important factor in initiating and maintaining legislative attention to the issue of health care reform. Shortly after Senate President Travaglini announced a promise to cut the number of the uninsured in half in November 2004, Governor Romney published an editorial in the Boston Globe indicating his commitment to health reform. Governor Romney recognized the political opportunity before him; if Massachusetts could pass a reform plan, like Governor Dukakis, he could use this as an important element of his presidential campaign platform. Therefore, with Speaker DiMasi and Senate President Travaglini, Governor Romney remained committed to reaching agreement on a reform plan.

Finally, the possibility of another ballot initiative requiring health reform by November 2006 also heightened legislators’ attention to health reform. Given the choice, policymakers and dominant structural interests would rather participate in the development of a reform plan than leave this decision to be determined at the ballot. By the fall of 2005, the ACT! Coalition had already collected more than the requisite signatures necessary to
place this petition before the General Court. In describing the importance of this in bringing attention to health reform, an interview participant representing small businesses explained, “the ballot initiative – you knew the proponents were going to go forward with it if the legislature didn’t pass something so that was a driver to pass something to prevent that really horrible proposal” (Interview 21). As this interview participant articulated, the ballot initiative provided another “stick” to motivate policymakers. As a result of these external factors: the potential ballot initiative, Governor Romney’s desire to pass a reform plan that would bolster a presidential campaign, and the need to maintain federal funding as part of the 1115 waiver, the political conditions were ripe for reform.

B. Medicaid as a Politically Viable and Successful Way to Expand Insurance Coverage

This analysis reinforced the notion that expansion of Medicaid programs is both a politically viable and practical mechanism for increasing access to health insurance. However, it is important to juxtapose this finding with the discussion presented in the section of this chapter on the “catch 22” of the employer based health insurance system. While Medicaid expansions may be effective policy options, they must be part of a reform package that incorporates the right balance between moving too far in the direction of a public insurance system and imposing too many responsibilities on stakeholders in the existing private system. More specifically, replacing the existing employer-based insurance system with a public system built on an expansion of Medicaid would not be politically feasible, but expanding Medicaid in a way that would not dismantle existing arrangements, but complement them, appears a viable option for reform.
The 1988, 1996 and the 2006 reform episodes are examples of this assertion. In all of these cases, Medicaid was expanded to include those individuals who lacked employer sponsored insurance and met income and other eligibility criteria. Interestingly, while the employer mandate passed in 1988 was repealed, other pieces of the 1988 reform package, including the CommonHealth program, Healthy Start and expanded Medicaid eligibility for pregnant women and children are still intact (Wielawski 2007). All of these programs were created by expanding the income or categorical eligibility guidelines of the Medicaid program.

In 1996, the Weld administration’s intent in applying to the federal government for an 1115 Medicaid waiver was to utilize managed care to control spending in the Medicaid program and therefore expand the number of people covered under the program. Though the cigarette tax to fund a Senior Pharmacy Program, the 1996 reform plan did not impose any new responsibilities on players in the private insurance system. More than a decade later, the state has been able to continually renew the waiver that enabled these expansions, and many of them are also still in place.

Like the 1988 reform initiative, the 2006 reform included both expansions to public insurance programs and new requirements on employers. Two years after passage of this reform, the Medicaid expansions and the new Medicaid program (Commonwealth Care) created under this law have effectively increased access to insurance for hundreds of thousands of individuals. Despite high public costs, support for maintaining these programs remains strong. At the same time, even with the imposition of new requirements on employers, employer support for health reform remains strong (Gabel et. al. 2007).
Perhaps one reason for this is because of the large role employers have had in shaping both the elements of the reform and the regulations (drafted after reform) that most affect them.

As of March 2008, data from the Massachusetts Division of Health Care Finance and Policy indicated a total of 439,000 individuals had acquired health insurance since reform’s passage. Of these individuals, about 248,000 were enrolled in Medicaid or Commonwealth Care and 159,000 new individuals had taken-up employer sponsored insurance (Kingsdale 2008). Though the difficult economic times now confronting Massachusetts will certainly test support for the reform, the initial evidence suggests it has been successful in increasing access to care, with the majority of individuals receiving coverage through public insurance program expansions.

C. Issue Framing Matters

Together, these reform episodes illustrate the importance of issue framing in influencing the outcome of health policy initiatives. When advocates or proponents of reform are able to construct a positive policy image, policymakers and the public are more easily persuaded to support the reform initiative. Conversely, negative images have the opposite effect, prompting the public to shun the reform proposal.

The 1988, 1996, 2000, and 2006 reform episodes all highlight the importance of policy image on the reform process. In order to be successful, the public and policymakers must “buy in” to the positive policy image reform proponents present. In 1988, proponents of reform emphasized not only how large the problem of the uninsured was, but also routinely cited its growing incidence. More importantly, those supporting health reform also stressed that the population that would benefit most greatly from reform were
hard-working families, deserving of assistance. In the late 1980s, newspaper articles frequently profiled individual families, explaining the reasons why they lacked insurance. Consistent with Rochefort & Cobb’s (1994) assertions, the way in which the “problem population” was depicted matters. Because those lacking insurance were considered “worthy” of assistance, it was possible to build support for reform.

The 1996 reform episode illustrates a more blatant example of the use of a positive policy image to build support for reform. In this case, those supporting reform were perceived as “good” because they were willing to side with children and the elderly, two populations who would benefit from the reform. Conversely, those who did not support the reform were labeled “evil” because opposition to the reform was construed as choosing to side with the tobacco industry (who was opposed to the legislation because of an increase in the cigarette tax) over children and the elderly. By depicting this debate in these terms, it made it very difficult for policymakers and the public to oppose the reform plan.

In 2000, advocates for Ballot Question 5 were unable to overcome the negative policy image the opposition created. By November, the public’s perception of the reform was in line with the negative image business and insurers had regularly presented. Rather than being compelled to follow the “morally correct path” and pass Ballot Question 5, the public was concerned that this reform would result in an overly bureaucratic and inefficient health care system. Images of doctors surrounded by red tape and money flowing freely out of a window successfully reinforced the opposition’s claims that that this reform would hurt more than help consumer experience with the health care system. In this case, the ability of policy opponents to construct a strong policy image that resonated with the public contributed to the reform’s demise.
Finally, in 2006 framing the health reform plan as one that required “shared responsibility” was crucial to enabling policy passage. Chapter 58 imposed new responsibilities on individuals, employers, and government. Individuals and advocates were not pleased with the individual mandate, and the inability to reach an agreement over the role of business in this reform plan nearly caused reform to be evaded entirely. Nevertheless, this plan represented a political compromise and was explicitly presented as such; if businesses were willing to do their part, advocates should be willing to as well (and accept the individual mandate). None of these stakeholders wanted the public shame of being the reason health reform (and hundreds of millions of federal dollars) was eluded.

D. The Importance of Relationships and Dedication to Health Reform

Though this may be special to the Massachusetts reform experience, individuals interviewed as part of this study suggested that longstanding relationships among individuals in the Massachusetts health care arena and a shared commitment to health reform have also been factors in enabling policy change. In conducting the initial research for this analysis and compiling the list of potential interviewees, it was apparent that many of the individuals identified as key players in one reform episode also had involvement in at least one or more of the other episodes. Interestingly, among interview participants involved in multiple reform episodes, most held different positions in each of the reform episodes. “It’s so funny” one interview participant began, “I look around these days and we’ve all been at this for so long wearing different hats. I mean it is like wow, we’ve all been here for a really long time working on this stuff” (Interview 13). Offering similar thoughts, another interview participant explained,
Actually, as I think about this, the cast of characters hasn’t changed much if you look at it...The players, all the people I’ve talked about have been around, are savvy, experienced, and many of them have worked in state, like myself, state government and we know each other and we understand it and I think have relationships so there was I think a key piece of all this success you know in '05 and '06...In '05-'06 a key part of the success was the experience of the players and all the individuals I mentioned are bright, savvy about the process. (Interview 28)

Finally, reaching this same conclusion, another interviewee stated,

…the kind of core team who worked on this in the Dukakis administration— we were involved at that time and are still involved. Our roles have changed but I think we’re still kind of pushing, we’re advocating for the same issues, but our roles have certainly changed. There is a group of I guess a dozen people who have just been with this for 20 years. (Interview 19)

For example, one interview participant who was extremely active in developing and promoting the 1996 reform plan later became the leader of one of the largest health care advocacy organizations in the state. Another interview participant who was a high level staff person during the 1988 reform later became the leader of one of the largest business groups in Massachusetts. Several interview participants commented on this circumstance and offered insight into the impact it might have on the health policy process in Massachusetts.

The comments of interview participants suggested that this situation has positively impacted the policy reform process. Interview participants suggested having past relationships with many of these individuals has enhanced the level of trust among those working on reform initiatives. One interview participant explained,

… we got so close [with the 1988 reform] and could kind of touch it and sense it and feel it. There was a sense of purpose and idealism that stayed and then I think those relationships were forged then and even as people moved into different organizations and had slightly different perspectives, they held onto that collegiality, sense of idealism, purpose, and felt like we
weren’t dropping this issue [health reform]. And we kept coming back to it and you know, we came back to it in 96…so I think those relationships were very important and there was a lot of trust built up and a sense that regardless of where you sat because some of these people moved from government outside of government…so you know, all these people and we’re all friends and we’ve been to each others’ events. So there is a strong connection among the dozen or so people… (Interview 19)

Offering similar sentiments, another interview participant offered,

One thing that struck me about the most recent reform [2006] is that a lot of the people who worked on it have been around for a while. And in fact a lot of us, this is the third reform that we have worked on. So people have very deep relationships and they have – there’s a lot of trust among people. There’s a lot of having gone through things together before and having seen what worked and I do think this time that was really quite important. That you could have people from different constituencies who have just done a lot of work together over the years and that was important I think…You have these people who can bridge constituencies. (Interview 9)

Again, case studies of the health policy arena in other states would be necessary to determine if and/or how unique this circumstance is. Regardless, the comments offered here suggest the longstanding involvement and relationships among key players in the Massachusetts health care arena have had a positive influence on the reform process in this state.

III. Lessons for Other States

Certainly, not all states in the United States are the same. Rather, each state is characterized by its own political, economic, and institutional arrangements and these influence the policy process. Despite these differences across state “laboratories,” the findings from this study of the Massachusetts health policy reform experience offer some
general lessons about the health policymaking process that may be applicable to health policymaking initiatives in other state or national venues.

First, the presence of a politically powerful and well organized advocacy community is critical to spearheading reform efforts and ensuring attention to health policy issues. By mobilizing other stakeholders to expand their support base and building diverse coalitions for reform, advocacy organizations are able to focus both public and governmental attention on a given issue. Moreover, the existence of an advocacy organization ensures political persistency and issue saliency, exerting political pressure on government officials to act.

Another important element in the health policymaking process is a policy entrepreneur dedicated to health policy change. Institutional arrangements alone make policy change difficult and the preference among vested interests to maintain the status quo exacerbates these circumstances. In addition, the debate, negotiation, and politicking that characterize the policy process often result in changes to the plan initially filed. These changes may result in a plan deviating greatly from its initial objectives. Consequently, a leader among policymakers dedicated to an issue and willing to shepherd a plan through the policy process is essential to enabling the possibility of policy change.

Given the varied political and economic circumstances across the states and the country, there are bound to be differences as to what industries or sectors represent the dominant structural interests in a given political arena. With respect to policy proposals impacting the health care system, however, it seems that the business community has a profound role and influence on the policymaking process - regardless of the political venue - because of the historic link between health insurance and employment. Efforts to change
the existing system will be met with strong resistance from the employer community; again, it seems only those options that represent the “right” balance of building on the existing system from the perspective of business will be politically viable.

It is difficult to assess the influence of public opinion on the policymaking process because it is not consistently measured or documented. Though policymakers often speak to broad public values in arguing for a policy initiative, these public claims cannot always be tied to existing poll data. Even if poll data were regularly reported, Stone (2002) emphasizes that public support is highly dependent on the way in which programs or policies are labeled. This relates to the previous discussion regarding the importance of problem definition and issue framing. Policy image is a significant factor in shaping the public’s and policymakers’ responsiveness to an issue.

Finally, despite the continued efforts of states to adopt innovative health reform policies, it is important to acknowledge that there are many difficulties associated with state-based reform initiatives and several arguments as to why this is not the best approach for health care reform. For example, Stone (1997) suggests that the Medicare program’s large share of health care costs handicaps the state’s ability to implement any reforms aimed at cost-containment. Lacking the ability to control costs, efforts to expand access will ultimately be futile. Moreover, she suggests that in general, state autonomy with the Medicaid program is limited and the process for implementing rule changes is slow. This makes it difficult for the majority of states to modify the program to best suit the needs of their population. In addition, Stone (1997) suggests that the permeability of state boundaries and the possibility for exit makes it very difficult for states to enact health reforms. In fact, it may be necessary to look to the federal government to assume
responsibility for health policy reform in a national welfare state. Still, the lessons from Massachusetts and other states that have experimented with health reform may inform and provide useful guidance for this policymaking process.

IV. Conclusion

Analyzing the Massachusetts health policy reform experience over a twenty year period has provided insight into the way in which political and economic factors influence the outcome of health care reform initiatives. This study supports the utility of the political economy approach in explaining the outcome of health care reform initiatives. Moreover, this study has also identified the importance of external forces in prompting attention to health reform, and illustrated the importance of issue framing and policy images in garnering support for reform. Finally, this study has reinforced the value of Medicaid expansions as a mechanism to expand access to insurance, so long as this does not threaten the existing, private, employer based insurance system.

The completion of this study comes at an interesting time as researchers and policy analysts consider the application of the Massachusetts health reform model passed in 2006 to other states and the nation. The findings from this dissertation, not only with respect to the reform passed in 2006 but pertaining to the policy process and the conditions that assist or obfuscate reform efforts generally, may provide useful guidance in considering the likelihood of health care reform in other venues.


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APPENDIX A: DRAFT of INTERVIEW PROTOCOL

While there are a number of general questions that will be asked of all interview participants, each interview will also include some questions that are tailored to each interview given the role the respective participant had in the reform episode under consideration. Below is a general protocol that will be followed for each interview.

GENERAL INTERVIEW QUESTIONS:

- Why don’t we begin with you telling me a little bit about yourself? Please describe your current job. How did you first become involved in health policy reform/health care industry (if applicable)?

- Now, I’d like to ask you to think back to ________ (insert appropriate timeframe). Through my research and interviews, I have identified you (or have been referred to you) as someone who played an active role during the ____________ (fill in the appropriate reform episode). I was wondering if you could tell me a little about how you viewed that reform episode and the role you played during that time…

  o To begin, what is the ____________ (insert name of organization/group)? What do they do? What was/is your position there?

  o What was the reaction of ____________ (insert name of organization/group) to the ____________ (insert name of reform episode under consideration)?

  o How important an issue is health care reform to ____________ (insert name of organization/group)? How would ____________ (insert name of organization/group) have been affected by the reform?

  o What are some of the positive and adverse effects of the reform for the organization you work for/represent?

  o Were/Are there any reform proposals/mechanisms (a particular piece of legislation?) that you, as a representative of ____________ (insert name of organization/group), supported/support?

  o What are some additional concerns beyond ____________ (insert concern of particular group/stakeholder) that ____________ (insert name of organization/group) have with the existing h/c system?

  o What would have been the ideal provisions set forth in health care legislation for ____________ (insert name of organization/group)? If
___________ (insert name of organization/group) could draft a piece of health care reform legislation, what provisions would they insert?

- How would you characterize what happened during this reform movement? What enabled the reform to be successful or what caused the reform to fail?
  - Were there any particularly powerful messages, advertisements, or events that stood out to you as influencing how this reform movement was perceived by the public or in the media?
  - Who supported the reform movement? Opposed it? Are there any organizations or individuals that stand out in your mind as being particularly powerful in their sentiments towards the reform movement?
  - What was the source of the biggest tension in the reform movement? If you had to identify one factor that was most controversial in the debate surrounding this reform episode, what would it be?
  - Overall, how would you rate each of the following groups or individuals—lawmakers, the governor, health industry groups, other interest groups, the public, local media—in determining the outcome of this health policy proposal?

- Now I’d like to ask you some general questions about health policy reform in Massachusetts.

  - What is your assessment of the politics of health care reform? Who are the main players? Have these changed since _______ (timeframe of reform episode person was involved in)?
    - If so, how?

  - From your perspective, what has or has not worked thus far in the health care system, or with reform initiatives, and what changes are necessary? What type of compromises do you think would have been/are necessary for all involved in order for health reform to occur? Has this changed over time?
    - If so, how?
Despite apparent support for comprehensive health care reform, generally, reform initiatives have been unsuccessful. Why do you think this is the case?

Do we have enough information available to make good decisions about the status of the health care system in Massachusetts? If so, on what information are we relying?

Do you think the latest Massachusetts reform plan will be successfully implemented? What impact do you think it will have? Why?

Finally, I’d like to ask you a few questions that relate to your opinion on the goals of health care reform and how health care reform options might be structured.

How would you rank the importance of the following three goals of health reform: universal coverage, cost-containment, and improving quality?

Who should be responsible for attaining these goals?

What responsibilities do you think business has/should have in attaining these goals? Explain.

Would you favor an employment-based approach for expanding health insurance coverage? Explain.

What responsibilities do you think government has/should have in attaining these goals? Explain.

Should the process of health reform involve a larger or smaller role for government in the health care arena? At the state level? At the federal level?

What responsibilities should individuals have in attaining these goals?

Do you think some groups have become too powerful in controlling the process of health policymaking in Massachusetts?

My goal is to gain insight into the atmosphere shaping a series of reform movements. One of the best ways to do that is to speak with people, like you, who were actively involved in the reform episodes I am considering. With that in mind, is there anyone that you would recommend I try to contact for an interview for this project?