
“It’s the Health-Care Costs, Stupid!”: Ideas, Institutions, and the Politics of Organized Labor and Health Policy in the United States

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In 1978, organized labor formally abandoned its longstanding commitment to public-sector solutions to achieve universal health care. Over the following fifteen years, it embraced private-sector solutions premised on a government mandate that would require employers to pay a portion of their employees health insurance premiums. In many respects, this about-face on the part of organized labor is neither remarkable nor puzzling. After all, labor’s prior commitment to national health insurance¹ had coexisted with its deep and abiding attachment to the private welfare state of job-based benefits dating back to the 1940s.² American labor unionists have tended to be

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1. The term national health insurance has many meanings. As used here, it refers to health-care reform proposals modeled on the Canadian experience in which the government replaces private insurance with its own public insurance system, thus eliminating the commercial health insurers. Commonly referred to as “single-payer” plans today, proposals for national health insurance can vary enormously on important details like financing, budgeting, taxation, and the role of individual states.

2. Donna Allen, *Fringe Benefits: Wages or Social Obligation?* (Ithaca, NY: Cornell University Press, 1964); Joseph W. Garbarino, *Health Plans and Collective Bargaining* (Berkeley: University of Cali-

fornia Press, 1960); Raymond Muntz, *Bargaining for Health: Labor Unions, Health Insurance, and Medical Care* (Madison: University of Wisconsin Press, 1967); Beth Stevens, “Labor Unions, Employee Benefits, and the Privatization of the American Welfare State,” *Journal of Policy History* 2 (1990): 233–60; and David Rosner and Gerald Markowitz, “Hospitals, Insurance, and the American Labor Movement: The Case of New York in the Postwar Decades,” *Journal of Policy History* 9 (1997): 74–95.

3. Indeed, some analysts characterize labor’s relationship with the Democratic party as a “barren marriage” or “abusive relationship.” Mike Davis, *Prisoners of the American Dream: Politics and Economy in the History of the U.S. Working Class* (London: Verso, 1986), 52; and Joel Rogers, “The Folks Who Brought You the Weekend: Labor and Independent Politics,” in *Audacious Democracy: Labor, Intellectuals, and the Social Reconstruction of America*, ed. Steven Fraser and Joshua B. Freeman (Boston: Mariner, 1997), 255.

The outstanding question remains why labor stuck by an employer-mandate solution over the next fif-

teen years despite a drastically changed political and economic environment. Paradoxically, as the bond between employer and employee frayed beginning in the late 1970s with the rise of the contingent work force, organized labor's commitment to the private welfare state of job-based social benefits became more intense. What appeared at the time to be a pragmatic concession in the face of labor's (and the Democrats') constrained political circumstances in 1978 ended up having far-reaching and enduring political consequences, many of them unforeseen by organized labor. Labor's latter-day support for the employer mandate significantly shaped the debate in the United States over how to provide universal and affordable health care. It also molded the stance unions took toward the deep restructuring of the U.S. economy in the last quarter of the twentieth century, and ultimately it affected labor's political efficacy on health care and other issues.

This article examines the origins and evolution of the idea of an employer mandate and labor's entanglements with the institutions of the private welfare state. These entanglements go far toward explaining why labor, after initially embracing the employer mandate in 1978, remained committed to this idea over the next decade and a half. It shows that labor's stance on health-care policy is not entirely derived from its longstanding pragmatism, or its waning political fortunes as the New Deal regime or "Democratic political order" began to shatter in the 1970s.⁴ The employer-mandate idea and the institutions of the private welfare state played a critical role in solidifying labor's attachment to private-sector solutions. Their effects were wide ranging. Together they molded labor's political choices and behavior and realigned its interests more closely with those of business. They also contributed to tensions within unions and between them and liberal-leaning public interest groups, impeding efforts to form an effective health-care reform coalition. These divisions, in turn, reinforced labor's general tendency to defer to the leadership of the Democratic party. The national leadership of organized labor became less willing to battle for national health insurance proposals that would greatly reduce or eliminate the role of the commercial insurers in health care and sever the connection between employment status and health benefits once and for all. Labor ended up tying itself to certain ideas and institutions that seriously impeded its ability to forge a winning political strategy and coalition that could secure universal and affordable health care over the long haul.

This article focuses specifically on the politics surrounding labor's decision to pursue universal health care through an employer mandate rather than

through a national health insurance program rooted in the public sector. The first section sketches the "backstory," locating the origins of the employer-mandate idea in the Nixon years and analyzing labor's embrace of the idea in 1978.⁵ Originally labor leaders opposed the employer mandate because, they argued, it would perpetuate many of the inequities of the existing job-based system of health benefits. But soon they became an important carrier of this idea. The backstory reveals that even prior to its reverse in 1978, labor was taking incremental policy steps in this direction that would have important consequences for the debate over health-care reform. In making these incremental shifts, labor helped to redefine the health-care crisis as largely an economic issue rather than a social one that revolved around questions of equity and social justice.

The second section takes up labor's steadfast commitment to an employer-mandate solution over the next fifteen years despite employers' dogged quest for a more flexible labor market and the most sustained assault on labor by employers and conservative legislators since the 1930s. The analysis shows how the idea of an employer mandate began to take on a life of its own and to cause groups to rethink their interests and form new alliances.⁶ The idea helped to reconfigure the coalitions around the health-care issue, aligning labor more closely with employers and insurers.

Ideas take on a life of their own when they "fit" perceptions of a problem. The carriers help to create that fit. They use their available resources to convince others that the idea they advocate meshes with the existing environment and can solve, or is relevant to, the problem at hand. As such, carriers, like any political actors, present a selective picture of the political and economic situation. In the case of the employer mandate, labor, as an important carrier, attempted to show how this idea, while a departure from its longstanding commitment to national health insurance, in other ways fit neatly with the demands of the existing environment.

How good the fit is, so to speak, is not merely a function of the carrier's political imagination, skills, and resources, however. It also depends on two other factors. First, objective reality sets some limits on the carrier's license to interpret. Beyond that, the institutional context can serve as an important and additional independent variable, providing fertile soil for certain ideas to take root and not others. Thus, we need to place ideas in a political as well as historical context, paying particular attention to the contours

5. The term "backstory" comes from Sheri Berman, "Ideas and Culture in Political Analysis," paper presented at workshop on "Ideas, Culture and Political Analysis," Princeton University, May 15–16, 1998, 4.

6. For a development of this point, see Peter A. Hall, "Conclusion: The Politics of Keynesian Ideas," in *The Political Power of Economic Ideas: Keynesianism Across Nations*, ed. Peter A. Hall (Princeton: Princeton University Press, 1989), esp. 369.

4. Stephen Skowronek, *The Politics Presidents Make: Leadership from John Adams to Bill Clinton* (Cambridge, MA: Harvard University Press, 1997), esp. chap. 7, pt. 3; and David Plotke, *Building a Democratic Political Order: Reshaping American Liberalism in the 1930s and 1940s* (Cambridge: Cambridge University Press, 1996), 71–72.

of the institutional landscape.⁷ As argued in the second section, three specific institutions, notably the Taft-Hartley health and welfare funds, the Employee Retirement Income Security Act (ERISA), and labor's longstanding modes of discourse about labor-management relations, provided hospitable soil for the employer-mandate idea to flourish. While the employer-mandate solution was compatible with these institutions, in other ways it was out of sync with a new political economy and rising business interest in a flexible or contingent work force.

The third section examines several of the key assumptions about the U.S. political economy that labor slowly but surely promoted as it pushed the idea of an employer mandate. The view of the economic world that labor helped to legitimize molded both its stance on health-care reform and its political strategies, notably the allies it sought and the way it pitched the health-care issue to its rank and file and the wider public. These assumptions were just that – assumptions. Yet organized labor treated them as a set of uncontestable facts. A sustained and independent questioning of these assumptions might have revealed their contingency and highlighted that they were “propositions” rather than “truths.” As will be shown, labor's tacit endorsement of these assumptions had important political consequences.

Given organized labor's historical role in establishing the health-care system,⁸ in negotiating and defending the U.S. welfare state,⁹ and, more broadly, in

7. Karen Orren, “Ideas and Institutions,” in “Polity Forum: Institutions and Institutionalism,” *Polity* 28 (1995): 97.

8. Labor established some of the first prepaid group practices and health maintenance organizations, was the leading voice for national health insurance up until the 1970s, and was decisive in the passage of Medicare. Monte M. Poen, *Harry S. Truman versus the Medical Lobby: The Genesis of Medicare* (Columbia, MO: University of Missouri Press, 1979); Martha Derthick, *Policymaking for Social Security* (Washington, DC: The Brookings Institution, 1979); Theodore R. Marmor, *The Politics of Medicare* (Chicago: Aldine Publishing Co., 1973); Lawrence D. Brown, *Politics and Health Care Organization: HMOs as Federal Policy* (Washington, DC: The Brookings Institution, 1983); Ivana Krajcinovic, *From Company Doctors to Managed Care: The United Mine Workers' Noble Experiment* (Ithaca, NY: Cornell University Press, 1997); and Alan Derickson, *Workers' Health, Workers' Democracy: The Western Miners' Struggle, 1891–1925* (Ithaca, NY: Cornell University Press, 1988).

9. Labor has been instrumental in shaping a number of major social programs, including Social Security and the Great Society. Graham K. Wilson, *Unions in American National Politics* (New York: St. Martin's Press, 1979); J. David Greenstone, *Labor in American Politics* (Chicago: Chicago University Press, 1977); Richard B. Freeman and James L. Medoff, *What Do Unions Do?* (New York: Basic Books, 1984); Dudley W. Buffa, *Union Power and American Democracy: The U.A.W. and the Democratic Party, 1935–1972* (Ann Arbor, MI: The University of Michigan Press, 1984); Jill Quadagno, *The Transformation of Old Age Security: Class and Politics in the American Welfare State* (Chicago: University of Chicago Press, 1988); Kevin Boyle, “Little More Than Ashes: The UAW and American Reform in the 1960s,” in *Organized Labor and American Politics, 1894–1994: The Labor-Liberal Alliance*, ed. Kevin Boyle (Albany: SUNY Press, 1998); and Alex Hicks, Roger Friedlander, and Edwin Johnson, “Class Power and State Policy: The Case of Large Business Corporations, Labor Unions, and Governmental Redistribution in the American States,” *American Sociological Review* 43 (1978): 302–15.

creating modern liberalism and expanding democracy in the United States,¹⁰ the activities of labor unions remain critical to any discussion of social welfare provision in this country. An important part of this discussion is why certain segments of organized labor have – or have not – been able to forge meaningful political alliances with other interest groups and mobilize effectively on behalf of the public welfare state in a political climate dominated by calls for retrenchment. By understanding how the private welfare state of job-based benefits developed over time, and, in particular, the political history of the employer-mandate idea, one can make better sense of shifting interest-group alliances and the ways in which the institutional context has conditioned organized labor's interests and political strategies.

I. THE ORIGINS OF THE EMPLOYER MANDATE

In his 1994 State of the Union address, President Bill Clinton declared that his proposed Health Security Act built upon “what works today in the private sector to expand employer-based coverage.” At the heart of his proposal was a requirement that employers pay a portion of the health insurance premiums for their workers. Clinton hastened to add that mandated employer-based health insurance had been proposed two decades earlier by then-president Richard M. Nixon, whom he singled out by name in his address. “It was a great idea then, and it's a better idea today,” implored Clinton.¹¹

This was a remarkable moment in the health-care debate in the United States. Two decades earlier, organized labor and leading Democrats had battled the Nixon plan, charging that it would perpetuate most of the injustices of the existing system of employment-based health insurance. When the Nixon administration first introduced the idea of an employer mandate in 1971, organized labor was a fierce opponent. Yet by 1978, labor leaders, in an abrupt about-face, endorsed an employer-mandate solution and essentially abandoned their longstanding commitment to national health insurance. Together with President Carter and Sen. Kennedy, organized labor viewed the adoption of the employer-mandate idea as a compromise that could broaden political support over the short run without sacrificing the ultimate goal of universal health-care coverage.¹² It mistaken-

10. Karen Orren, “Union Politics and Postwar Liberalism in the United States,” *Studies in American Political Development* 1 (1986); Karen Orren, “Organized Labor and the Invention of Modern Liberalism in the United States,” *Studies in American Political Development* 2 (1987); Joseph A. McCartin, *Labor's Great War: The Struggle for Industrial Democracy and the Origins of Modern American Labor Relations, 1912–1921* (Chapel Hill, N.C.: University of North Carolina Press, 1997); and Plotke, *Building a Democratic Political Order*, esp. chaps. 4–8.

11. Bill Clinton, “State of the Union,” *Vital Speeches* 60 (February 15, 1994): 258.

12. Tom Wicker, “The Health Insurance Minefield,” *The New York Times*, December 20, 1977; and Max W. Fine, letter to George

ly viewed the employer-mandate idea as a "focal point" that could unite important segments of business, labor, and the state on the health-care issue.¹³ Over the next decade and a half, labor and state actors, most notably the Clinton administration, repeatedly overestimated the breadth of business support for an employer mandate and underestimated the ideological hostility of business to mandates.¹⁴

For years, labor and other advocates of national health insurance had denounced employer-mandate proposals, charging that they would perpetuate and deepen the inequities of the existing multi-tiered system of job-based health-care benefits in the United States.¹⁵ Labor and other critics argued that an employer mandate, if enacted, would reshape the labor market in undesirable ways by providing employers with an incentive to replace their full-time workers with part-timers, to rely more on compulsory overtime rather than hire new workers, and to discriminate against older and sicker employees, all in an effort to avoid having to pay for health insurance.¹⁶

Buoyed by the resignation of President Nixon in August 1974 and the Democratic sweep in the midterm elections that November, labor's opposition to employer-mandate proposals appeared steadfast.¹⁷

Hardy, May 30, 1978, UAW Washington Office: Stephen Schlossberg Collection (hereafter, UAW Schlossberg Collection), Walter P. Reuther Library, Wayne State University, Detroit, MI, Box 56, Folder 43, "S.E.I.U., George Hardy"; and CNHI, report sent to members of the technical committee, Apr. 13, 1978, Committee for National Health Insurance (CNHI) Collection, Walter P. Reuther Library, Wayne State University, Detroit, MI, Box 15, Folder 20, "Technical Committee, memos, 1975-79."

13. For more on "focal points," see Geoffrey Garrett and Barry R. Weingast, "Ideas, Interests, and Institutions: Constructing the European Community's Internal Market," in *Ideas and Foreign Policy: Beliefs, Institutions, and Political Change*, ed. Judith Goldstein and Robert O. Keohane (Ithaca, NY: Cornell University Press, 1993); and John Kurt Jacobsen, "Much Ado About Ideas: The Cognitive Factor in Economic Policy," *World Politics* 47 (1995): 283-310.

14. For a development of this point, see Marie Gottschalk, *The Shadow Welfare State: Labor, Business, and the Politics of Health Care in the United States* (Ithaca, NY: Cornell University Press, 2000), chap. 5.

15. Richard Lyons, "Nixon's Health Care Plan Proposes Employers Pay \$2.5-Billion More a Year," *The New York Times*, February 19, 1971, 1; and Sen. Edward M. Kennedy, "National Health Insurance Proposals," U.S. House, Committee on Ways and Means, 92nd Cong., 1st Sess. (Oct.-Nov. 1971), Part 13, 2959. See also Leonard Woodcock, "Health Care Crisis in America, 1971," U.S. Senate, Subcommittee on Health of the Committee on Labor and Public Welfare, 92nd Cong., 1st Sess., Mar. 1971, Part 1, 103-25; and Louis B. Knecht, executive vice-president, Communications Workers of America, "National Health Insurance Proposals," Part 7, 1467.

16. See, for example, Melvin Glasser of the UAW, U.S. House, Committee on Interstate and Foreign Commerce, Subcommittee on Public Health and Environment, "National Health Insurance Implications," 93rd Cong., 1st and 2nd Sess., Dec.-Feb. 1974, 363-70. See also U.S. House, Committee on Ways and Means, "National Health Insurance," 93rd Cong., 2nd Sess., April-July 1974, 1144, 1361-68, 3041-44, and 3511; and Gary M. Fink, ed., *AFL-CIO Executive Council Statements and Reports, 1956-1975* (Westport, CT: Greenwood Press, 1978), 2480, 2481, 2489.

17. Sven Steinmo and Jon Watts, "It's the Institutions, Stupid!" *Journal of Health Politics, Policy and Law* 20 (1995): 353.

Its refusal at the time to endorse any compromise legislative proposals caused a rupture with some of its leading Democratic allies, notably Kennedy.¹⁸ But labor's own hopes for a legislative breakthrough on national health insurance were dashed soon after the 1974 election. President Gerald Ford vowed in his 1975 State of the Union address that he would veto any new spending legislation and proposed instead a tax cut to spur the sullen economy.¹⁹ The moratorium on new spending applied to health care, and the administration refused to reintroduce a compromise health-care reform proposal it had unveiled soon after Ford had assumed the presidency.²⁰ This resulted, beginning around 1975, in a shift in the way organized labor, legislators, and other political actors viewed health policy, leading to labor's belated embrace of the employer-mandate idea.

The debates about health care in the first half of the 1970s were not dominated just by concerns about escalating medical costs, but also about huge gaps in the U.S. health-care system that left many Americans unable to obtain quality health care.²¹ But as the recession of 1973 lingered on into 1975, economic concerns became paramount in a way that they had not been before. In particular, legislators and other policy makers began to link more explicitly their health-care prescriptions with specific analyses of the U.S. economy's ills. This changed the debate over health care in subtle but important ways. Increasingly, the health-care issue was subsumed in questions of economic performance. The immediate catalyst for this shift was the Ford administration's expressed determination to cap federal spending. A more fundamental cause was rising concern, especially among labor leaders, about the plight of laid-off workers whose health benefits were at risk.

As the unemployment rate inched toward a postwar high of nearly 9 percent in the spring of 1975, alarm grew among labor leaders that more and more Americans were losing not only their jobs, but also the health benefits they had received through their employers. While organized labor remained rhetorically supportive of national health insurance, it began to put more of its energy into developing emergency

18. Bert Seidman, memo to George Meany and Lane Kirkland, Dec. 16, 1974, re: Meeting of Executive Committee, Committee for National Health Insurance, AFL-CIO Department of Legislation Collection, George Meany Memorial Archives, Silver Spring, MD, Box 25, Folder 39, "Health Insurance, 1974."

19. George J. Lankevich, *Gerald R. Ford, 1913-: Chronology, Documents, Biographical Aids* (Dobbs Ferry, NY: Oceana Publications, Inc., 1977), 126-31.

20. Frank Carlucci, Memorandum for the President, Aug. 29, 1974, re: Health Insurance Legislation, AFL-CIO Department of Legislation Collection, Box 25, Folder 39, "Health Insurance, 1974."

21. See, for example, U.S. Senate, Committee on Labor and Public Welfare, "National Health Insurance," Part 1, 91st Cong., 2nd Sess., Sept. 23, 1970; "Health Care Crisis in America, 1971," Part 6; and Evan M. Melhado, "Economists, Public Provision, and the Market: Changing Values in Policy Debate," *Journal of Health Politics, Policy and Law* 23 (1998): 215-63.

health insurance legislation targeted at the unemployed. In doing so, organized labor made two significant but subtle political and policy shifts that would facilitate its eventual endorsement in 1978 of the idea of an employer mandate. First, with its newfound focus on how to provide relief for a specific group of people – that is, recently laid-off workers – labor took an important step toward sanctioning an incremental approach to health-care reform based on employment status. Previously, there had been an ironclad belief among labor officials that the most important lesson to be drawn from the experience of Medicare (the health-care program for senior citizens) was that it was not possible to reform the health-care system in a desirable direction through incremental steps, such as expanding coverage to include certain population groups or specific medical services.²² Second, labor took a major step away from the principle of universalism. It argued for a program, paid for by the federal government, that would provide unemployed workers with the identical package of medical benefits they had been receiving from their employers prior to being laid off.²³ Thus, just as the health benefit packages varied greatly amongst workers, they would vary greatly among the unemployed.

At the time, the business community remained divided over the question of health insurance for the unemployed. The U.S. Chamber of Commerce supported amending the Social Security Act so as to provide the unemployed and their dependents with a basic and universal package of health benefits funded out of general revenues. However, a spokesman for the Chamber warned that before the nation could enact any kind of comprehensive health insurance reform, it needed to resolve several more pressing economic problems.²⁴ The National Association of Manufacturers (NAM), on the other hand, stood firmly with the Ford administration, which was implacably opposed to legislative proposals to provide health insurance for the unemployed. Like the administration, NAM began to derive its views on health benefits for the unemployed from its larger analysis of the nation's economic woes. This prominent business organization echoed the administration's conviction that any special provision for the unemployed would add to the budget deficit, which would dry up

22. See, for example, the remarks by Leonard Woodcock in CNHI Collection, Box 20, Folder 20, "Executive Committee Minutes and Members."

23. Leonard Woodcock, U.S. House, Committee on Ways and Means, Subcommittee on Health, "Health Insurance for the Unemployed and Related Legislation," 94th Cong., 1st Sess., Mar. 1975, 90–110.

24. Roger C. Sonnemann, "Health Insurance for the Unemployed and Related Legislation," 127; and Roger C. Sonnemann, U.S. House, Committee on Interstate and Foreign Commerce, Subcommittee on Health and the Environment, "National Health Insurance, Major Proposals," 94th Cong., 1st Sess., Dec. 8–10, 1975, 203–15. See also, U.S. House, Committee on Ways and Means, Subcommittee on Health, "National Health Insurance," Part 3, 94th Cong., 1st Sess., Nov.–Dec. 1975, 2.

capital, saddle business with higher labor costs, hurt the overall job picture, and thus slow the economy's recovery.²⁵

Legislation to provide some kind of health insurance for the unemployed never made it to the floor of either the House or the Senate, in large part because of jurisdictional disputes.²⁶ Nonetheless, the 1975 debate over health insurance for the unemployed was significant for it helped to recast the wider debate over universal health care, tying it more directly to macroeconomic concerns. When legislators and other policy makers started talking about health care, they were now more likely to talk about the health of the economy at the same time.

The following year Congress held sporadic hearings on health insurance, at which labor officials reaffirmed their fierce opposition to the employer mandate.²⁷ These hearings are noteworthy because, for the first time, individual corporations began to focus in a concerted fashion on the issue of how rising health-care costs were reportedly hurting the international competitiveness of American products. A spokesman for General Motors warned legislators that if the auto giant had to increase the price of its subcompact cars to cover rising employee health costs, "this could be particularly harmful" because these "models compete directly with imports."²⁸

Whereas organized labor inched toward a new position on health-care reform in 1975 and 1976, in 1978 it formally took a big step in a new direction. Deeply frustrated over the apparent stalemate on the issue of health-care reform, the Committee for National Health Insurance (CNHI), labor's main vehicle since the late 1960s for the development of health policy, devised a new plan based for the first time on the employer-mandate feature. Working in concert with Kennedy, CNHI also proposed that commercial insurers be allowed to stay in the health insurance business, but under the watchful eye of greater federal regulation. After making what they viewed as two major and difficult compromises, labor officials and Kennedy were disappointed by what they saw as the

25. For the administration's view, see Caspar W. Weinberger, "Health Insurance for the Unemployed and Related Legislation," 317–26; for NAM's view, see 389–90.

26. *Congress and the Nation, 1973–1976* (Washington, DC: Congressional Quarterly Press, 1977) 4:353–54; and Steinmo and Watts, "It's the Institutions, Stupid!," 354–61.

27. Melvin A. Glasser, U.S. House, Committee on Interstate and Foreign Commerce, Subcommittee on Health and the Environment, "National Health Insurance: Major Issues," 94th Cong., 2nd Sess., Feb. 1976, 241–46, and 254–55; and Wilbur J. Cohen, U.S. House, Committee on Interstate and Foreign Commerce, Subcommittee on Health and the Environment, "Maternal and Child Health Care Act," 94th Cong., 2nd Sess., June 16, 1976, 187.

28. Victor M. Zink, U.S. Senate, Committee on Labor and Public Welfare, Subcommittee on Health, "Inflation of Health Care Costs, 1976," 94th Cong., 2nd Sess., Apr.–May 1976, 127. See also the testimony of executives from Goodyear, Ford, and the Aluminum Company of America.

Department of Health, Education and Welfare's determined effort in the spring of 1978 to "do in" their new proposal.²⁹ In a tense meeting with labor officials at the White House in April 1978, Kennedy suggested that President Carter appoint a working group on health care that would include experts from labor.³⁰ Carter rebuffed Kennedy's suggestion.³¹

Carter was intent on subjecting proposals for health-care reform to a new White House decision-making process, the Presidential Review Memorandum (PRM), which sought to involve all Cabinet officers in major decisions by soliciting their formal comments on important policy proposals.³² In labor's view, these other departments and agencies, which concerned themselves primarily with economic matters and had little expertise in health policy, were fueling the administration's already significant fears about the effect comprehensive health-care reform would have on inflation and the federal budget.³³ Thus, economists, who had already established themselves as the "intellectual gatekeepers" for fiscal policy, were able to become important gatekeepers for social policy as well.³⁴ The broader political environment, which was dominated by calls for more deregulation, fiscal belt-tightening, and a reduced role for government, bolstered the economic view of social policy.

The administration and the Kennedy-labor coalition were able to decide eventually in favor of the idea of an employer mandate in 1978, but they could agree on little else.³⁵ In July, the coalition officially

broke with the administration over health-care reform, and the following spring Kennedy formally submitted to Congress his new Health Care for All Americans Act, which was based on an employer mandate.³⁶ In promoting his new legislation, Kennedy stressed the need for any health policy proposal to be off-budget and said this was the primary reason he reversed himself and endorsed an employer mandate.³⁷ Kennedy and labor stressed that they had not abandoned the goal of universal health care. Rather, they had selected a new means to achieve that goal, one that was more compatible in their view with the new political and economic environment.

Labor and the Democrats did not singlehandedly propel the employer-mandate idea. This idea had been central to the thinking of a number of other leading health policy analysts for some time, notably Stanford economist Alain Enthoven, a consultant for the Carter administration and the grandfather of the managed-care approach to health care. Faced with a new political and economic environment in the 1970s, non-labor groups also began to abandon national health insurance and to endorse an employer mandate. At the same time, Kennedy's and organized labor's embrace of the employer mandate and their newfound willingness to retain a large role for the commercial insurers in the medical system antagonized other long-time supporters of national health insurance.³⁸ Kennedy and labor purportedly made the switch to an employer mandate to pick up additional political support, but that support never materialized.³⁹ In private, many labor leaders were con-

29. Steven Schlossberg, memo to Douglas A. Fraser, Apr. 5, 1978, UAW's President's Office: Douglas A. Fraser Collection (hereafter, UAW Fraser Collection), Wayne State University, Walter P. Reuther Library, Detroit, MI, Box 2, Folder 24, "CNHI, 1977-78." See also "Executive Committee Meeting Minutes," Mar. 20, 1978, CNHI Collection, Box 20, Folder 30, "Executive Committee Meeting Minutes"; and Max W. Fine, memo to Douglas A. Fraser and Lane Kirkland, Jan. 3, 1977, CNHI Collection, Box 5, Folder 23, "Lane Kirkland, Correspondence, 1971-80."

30. The account of this White House meeting is based on, "Notes on White House Meeting on National Health," Apr. 10, 1978, UAW Fraser Collection, Box 2, Folder 24, "CNHI, 1977-78." Emphasis in the original.

31. Carter's reluctance to give nonstate actors an institutional perch within his administration to develop an acceptable national health insurance plan stood in marked contrast to how Medicare had been developed a decade earlier. Derthick, *Policy-making for Social Security*.

32. Max Fine, memo to Douglas A. Fraser and Lane Kirkland, July 5, 1978, re: National Health Insurance - It's Time to Change Some Players, CNHI Collection, Box 5, Folder 23, "Lane Kirkland, Correspondence, 1971-80."

33. Max Fine, memo to Douglas A. Fraser and Lane Kirkland, July 5, 1978, re: National Health Insurance - It's Time to Change Some Players.

34. On the rising importance of the economics profession in the formulation of economic policy with the shattering of the Keynesian consensus, see Margaret Weir, *Politics and Jobs: The Boundaries of Employment Policy in the United States* (Princeton: Princeton University Press, 1992).

35. Max W. Fine, memo to Douglas A. Fraser and Lane Kirkland, June 2, 1978, re: Meeting of June 1, 1978 with Eizenstat on national health insurance, UAW Fraser Collection, Box 2, Folder

22, "CNHI, 1978"; Melvin Glasser, memo to Douglas A. Fraser, Mar. 3, 1978, re: National Health Insurance and the White House Staff, UAW Fraser Collection, Box 2, Folder 24, "CNHI, 1977-78"; Joseph Califano, memo to Jimmy Carter, May 22, 1978, CNHI Collection, Box 52, Folder 20, "Califano re: National Health Plan." Emphasis in the original.

36. Statement by the Committee for National Health Insurance, July 28, 1978, CNHI Collection, Box 50, Folder 16, "CNHI Statements on Carter NHI Principles"; and *Congress and the Nation, 1977-1980*, 10 vols. (Washington, DC: Congressional Quarterly Press, 1981), 5:638-39.

37. U.S. Senate, Finance Committee, "Presentation of the Major Health Insurance Proposals," 96th Cong., 1st Sess., June 19 and 21, 1979, 508-9.

38. In attacking the employer-mandate concept, Rep. James C. Corman (D-Calif.), champion of the Health Security Act, made at the time what turned out to be some prescient observations. He warned that "a myriad of unneeded problems and complexities result from gimmicks used to avoid a visible Federal commitment." James C. Corman, letter to Douglas A. Fraser, May 17, 1978, CNHI Collection, Box 70, Folder 33, "Corman, James C., Correspondence, 1978." See also James C. Corman, letter to Douglas A. Fraser, Dec. 20, 1978, UAW Fraser Collection, Box 2, Folder 23, "CNHI, 1978."

39. See the testy exchange between Rep. James C. Corman and Douglas A. Fraser during congressional hearings in 1979. Fraser noted that a couple of years earlier, thirteen senators and seventy-eight members of the House supported the Health Security Act, while presently only seven senators and fifty-nine representatives backed Kennedy's new proposal. "So you do not seem to have had a great leap forward during this compromise period," Corman

ceding that Kennedy's bill did not have a chance and thus questioned why CNHI had abandoned national health insurance for a less ambitious bill that was not going anywhere.⁴⁰

This brief account of the origins of the concept of an employer mandate and of organized labor's embrace of a policy prescription it had once spurned underscores several important points. In the late 1970s, organized labor endorsed an employer mandate without any serious, independent analysis of the broader economic context beyond consideration of what was becoming a national obsession with inflation and the size of the federal budget. Labor leaders had been primed to make the shift in part by the debate in 1975 over the issue of health benefits for unemployed workers. These incremental adjustments to a more hostile environment, which culminated in the embrace of the employer mandate, made labor an active participant in the more general recasting of health care from a social issue into an economic one.

In large part, labor officials left it to other political actors to decipher changes in the U.S. political economy and thus to define the nation's preeminent problems. Few challenged the contention that escalating government spending and accelerating inflation should override all other concerns. In the context of the health-care debate, labor generally accepted this view of the U.S. political economy as if it were an uncontested fact rather than a political claim.

II. THE "FIT" BETWEEN IDEAS AND INSTITUTIONS

Given how well ensconced antigovernment feeling was in the public discourse during the Carter years, it is not surprising that the employer-mandate idea arose and that labor and other longtime advocates of universal health care eventually endorsed it after years of fierce opposition. Unlike proposals for national health insurance, it was premised on a much smaller expansion of the government's role in health care. Furthermore, it preserved the nation's health insurance industry. The puzzle is why this idea had such staying power and why labor remained such a faithful carrier despite drastic changes in the U.S. political economy between the 1970s and 1990s. Labor's historic deference to the Democrats, its strident pragmatism, and the deepening backlash against the government during the Reagan-Bush years only partially explain labor's long embrace of the employer mandate and its reluctance to renew its earli-

dryly noted. U.S. House, Joint Hearing of the Subcommittee on Health and the Environment of the Committee on Interstate and Foreign Commerce and the Subcommittee on Health of the Committee on Ways and Means, "National Health Insurance," 96th Cong., 1st Sess., Nov. 29, 1979, 565 and 568.

40. "New Kennedy Bill Signals Retreat on National Health Insurance," *Labor Notes*, Apr. 24, 1979, 10. See also Keith W. Johnson, letter to Douglas A. Fraser, January 17, 1979, UAW Fraser Collection, Box 2, Folder 21, "CNHI, 1982-83."

er commitment to some vision of national health insurance.

Labor adopted the employer-mandate idea in a moment of political expediency in 1978. Over the next fifteen years, organized labor did not single-handedly keep the employer mandate afloat. However, unions did serve as generally faithful carriers of this idea, sticking by the employer-mandate solution despite vast changes in the U.S. political economy such that the very definition of what constitutes an "employee" would become a highly contested issue by the early 1990s. The employer-mandate idea took on a life of its own and remained afloat despite an extensive restructuring of the U.S. labor market that appeared to cut the other way.

When organized labor first endorsed the idea of an employer mandate, it was still skeptical that business could possibly play any positive role in health-care reform.⁴¹ By the end of the 1980s, leading labor officials made the case that business, at least big business, was prepared to be a reliable ally. Labor's newfound optimism about business had both political and institutional roots. On the political side, labor leaders made a series of misjudgments. There was a tendency among labor officials to take the seemingly sympathetic views of executives in the auto, steel, and other heavily unionized sectors of the economy as representing business sentiment overall. Furthermore, the encouraging views of the Chrysler Corporation, in particular, may have blinded organized labor to how tepid the support for comprehensive reform was even within the automobile sector.

Around 1989 or so, John J. Sweeney, who became the first chairman of the health-care committee of the American Federation of Labor-Congress of Industrial Organizations (AFL-CIO), and a number of other labor leaders began to talk more and more about the potential for big business, small business, organized labor, and even parts of the medical establishment to be "singing seductively similar songs on health care solutions" before too long.⁴² The immediate catalyst for this optimistic view of business and labor working side-by-side to resolve the health-care issue was a series of remarks that Lee Iacocca, chairman of the board and chief executive officer of the Chrysler Corporation, made in 1989 about health care. On several occasions that year, Iacocca said he would support some kind of federal government solution to the nation's pressing health-care problems because rising medical costs were making U.S. products uncompetitive in the global marketplace. At the

41. Shortly before the unveiling of the Health Security for All Americans Act in 1978, Max Fine, CNHI's executive director, told Douglas A. Fraser of the UAW: "The Corporations don't give a damn, even though the high cost of health care weakens their competitive position internationally." Max W. Fine, memo to Douglas A. Fraser, Aug. 7, 1978, CNHI Collection, Box 2, Folder 22, "CNHI, 1978."

42. John J. Sweeney, "Healthcare Reform," SEIU, *Service Employees Union*, Oct.-Nov. 1989, 30.

time, United Auto Workers (UAW) president Douglas A. Fraser quipped that Iacocca was spending so much time talking about the need for universal health care that he was beginning to sound like an Italian socialist.⁴³ When asked why they thought business was finally willing to work with labor to find an acceptable solution for health-care reform, labor officials invariably brought up Iacocca and the positive signals that they believed were emanating from the automobile industry and the business sector more broadly.

Organized labor's optimism that business was prepared to be a constructive partner on health-care issues, and the related belief that active business support was necessary for any satisfactory solution, were founded on more than just positive cues coming from Chrysler and a handful of other business executives. The misplaced faith that big business would ultimately join with labor and do the right thing on health care had deeper roots. These reached to the heart of how labor officials understood the institutional setting within which organized labor functions, specifically to their understanding of postwar labor-management relations.

Ideas are more likely to gain currency if they are compatible with – or are perceived to be compatible with – existing institutions. When I use the term "institution" here, I have two types of institutions in mind. First, I am concerned with those formal organizations and procedures that determine "who gets what, when, and how" for a society and thus circumscribe political choice and political behavior.⁴⁴ But I also am referring to a second type of institution, one that is not characterized by formal organizations and procedures but rather by "stable, recurring and valued patterns of behavior."⁴⁵

The employer-mandate idea was consistent with preexisting and longstanding modes of discourse about labor-management relations in the United States that, entrenched as they were, constituted a kind of institution in their own right. Many of the leaders of organized labor cleaved to a view of labor-management relations that had become institutionalized in the 1950s. This view was premised on the belief that

if business and labor leaders could develop suitable organizational forums that would allow them to meet behind closed doors with one another, they could work out many of their differences through elite-level discussions with little government involvement and public scrutiny. This view, which is closely identified with John T. Dunlop of Harvard University, had ossified into an institution that constrained labor's autonomy from business and the Democrats.⁴⁶

The debate over health-care reform reveals the extent to which faith in corporatist possibilities for labor-management relations continued to mold the political behavior of organized labor into the 1980s, a decade characterized by a management offensive against labor that was unparalleled since the interwar years. In the 1980s, the Dunlop view of labor-management relations held enormous sway with AFL-CIO president Lane Kirkland and Sweeney, who was president of the Service Employees International Union (SEIU) from 1980 to 1995. At the highest reaches of organized labor, Kirkland and Sweeney pushed hard for working with business to solve the country's major health-care problems. They were convinced that significant – perhaps decisive – support would be forthcoming from the business community if organized labor took what they perceived to be the moderate position on health-care reform. The litmus test of moderation was whether labor would make an all-out push for a single-payer system inspired by the Canadian experience with national health insurance or would settle for some kind of employer-mandate solution that would leave the job-based system of benefits and the commercial insurers largely intact.⁴⁷ Thus, the employer-mandate idea, while a significant departure from labor's longstanding commitment to national health insurance, was in other important ways consistent with labor's preexisting modes of discourse vis-à-vis business.⁴⁸

46. See, for example, John T. Dunlop, "Business and Public Policy," in *Business and Public Policy*, ed. John T. Dunlop (Cambridge, MA: Harvard University Press, 1980), 103.

Although Dunlop's view did not go unchallenged, it was never really dethroned. Several scholars contend that the consensus of the 1950s was more apparent than real. See Elizabeth A. Fones-Wolf, *Selling Free Enterprise: The Business Assault on Labor and Liberalism, 1945–60* (Urbana: University of Illinois Press, 1994), 5. See also Howell John Harris, *The Right to Manage: Industrial Relations Policies of American Business in the 1940s* (Madison, WI: The University of Wisconsin Press, 1982); Ellen W. Schrecker, "McCarthyism and the Labor Movement: The Role of the State," in *The C.I.O.'s Left-Led Unions*, ed. Steve Rosswurm (New Brunswick, NJ: Rutgers University Press, 1992); Robert Griffith, "Forging America's Postwar Order: Domestic Politics and Political Economy in the Age of Truman," in *The Truman Presidency*, ed. Michael J. Lacey (Cambridge: Cambridge University Press, 1989); and Thomas A. Kochan, Harry C. Katz, and Robert B. McKersie, *The Transformation of American Industrial Relations* (New York: Basic Books, 1986).

47. See n.1 above for an explanation of single-player plans.

48. Other notable early advocates of this corporatist view of labor-management relations included Arthur J. Goldberg of the Steelworkers and Walter Reuther of the UAW, who began to take a more accommodational stance toward business in the postwar years. Nelson Lichtenstein, *The Most Dangerous Man in Detroit: Wal-*

43. Quoted in Sweeney, "Healthcare Reform." In an address on health care before the National Association of Manufacturers that year, Iacocca asked, "How would you like to compete without this albatross around your neck called runaway health costs?" He went on to say, "For me, it's \$700 a car and still going up at twice the rate of inflation. Other countries put their costs in their taxes. We put them in the price of our products" (Wilson da Silva, "American Companies Eye Canada's Health System," *The Reuter Business Report*, Aug. 7, 1989). See also Pat Wechsler, "Crying Uncle," *Newsday*, June 11, 1989, business section, 70.

44. Samuel P. Huntington and Jorge I. Dominguez, "Political Development," in *Handbook of Political Science*, 8 vols. ed. Fred I. Greenstein and Nelson W. Polsby (Reading, MA: Addison-Wesley, 1975), 3:47.

45. Huntington and Dominguez, "Political Development," 47; and Rogers M. Smith, "Political Jurisprudence, the 'New Institutionalism,' and the Future of Public Law," *American Political Science Review* 82 (1988): 91.

The idea of an employer mandate also appeared compatible with two key institutions of the private welfare state. The first institution is the system of Taft-Hartley health, welfare, and pension plans. The second is the Employee Retirement Income Security Act of 1974, which set up federal standards for pensions. The act included a little noted and seemingly minor provision – the so-called ERISA preemption – that has since allowed many large employers and unions that self-insure to operate group health insurance plans free of most state-level insurance regulations. Organized labor, together with large employers and insurers, helped to create and perpetuate these two institutions, which, in turn, molded the incentives and political behavior of certain groups in key ways that helped keep the employer-mandate idea afloat.

Most discussions of the Taft-Hartley Act tend to focus on the ways in which the measure politically muzzled and demobilized organized labor. However, the act also included several less noted stipulations that subsequently had a profound effect on the privatization of employee benefits and that hastened labor's eventual acceptance of and strong attachment to the provision of social welfare through the private sector and thus predisposed labor to the employer-mandate idea. Notably, the Taft-Hartley Act established the institutional framework for collectively bargained health and welfare trust funds. Commonly known as Taft-Hartley plans today, these funds became an important source of private-sector benefits for tens of millions of Americans and their dependents.⁴⁹ In fact, more than half of all union members covered by health plans receive their medical benefits through Taft-Hartley funds.⁵⁰

The institutionalization of union health, welfare, and pension funds through the Taft-Hartley Act furnished unions with an important mechanism to provide their members with health and other benefits via the private sector. Despite initial uneasiness on the part of legislators and labor officials, these funds began to proliferate in the 1950s as the movement for national health insurance sputtered. Over the next two decades, the system took root. Curiously, when organized labor made its last major push for national health insurance in the early 1970s, the fate of the Taft-Hartley funds does not appear to have been a

major concern. At the time, labor officials were not unduly alarmed by legislative proposals for national health insurance that, if enacted, would have put the Taft-Hartley funds largely out of the health insurance business.⁵¹ However, by the late 1980s, when these funds were under acute financial stress due to the escalating costs of health care, rolling recessions in the building and construction industry, and the expansion of the non-unionized sector of the work force, the national leadership of organized labor was reluctant to abandon them in favor of a national health insurance plan that would sever the connection between health benefits and employment status. The system was proving increasingly rigid, incapable of adjusting to changing conditions, but labor's support for it intensified.

Why? Because, in at least three important ways, the Taft-Hartley plans had realigned the interests of some labor leaders, pushing them closer to large employers and insurers and bolstering their commitment to the employer-mandate idea. First, the Taft-Hartley plans created a potential conflict of interest for organized labor because they in effect catapulted some union officials into the insurance business. Second, some labor leaders came to view the funds as an indispensable device to maintain important institutional ties and to preserve a sense of cohesiveness and identity for union locals whose members are scattered across numerous work sites and locales. The third and most important factor was that the funds helped to spawn an important coincidence of interests between unions that operate multistate pension and welfare funds, and large employers, both union and non-union, whose business operations extend over more than one state. ERISA's passage helped to cement this unlikely coincidence of interests.

ERISA was enacted in 1974, the year of organized labor's last real push for national health insurance. This landmark pension legislation included a clause that has since been interpreted by the courts to permit Taft-Hartley funds and employers who provide health benefits to their members and employees through self-insurance to operate group health insurance plans that are not subject to state-level insurance regulations regarding coverage, benefits, cost, and the like. National labor representatives worked side-by-side with large employers to slip the preemption language into ERISA.⁵² Over the years, a powerful coalition of large employers, unions, and insurance companies worked hard to ensure that the ERISA preemption was not watered down or eliminated.

51. Bert Seidman, former director of the department of social security, AFL-CIO, interview, Washington, DC, June 13, 1996; and Bert Seidman, memo to Al Barkan et al., May 21, 1970, re: Health and Welfare Trusts and National Health Insurance, attachment, 2, AFL-CIO Department of Legislation Collection, Box 25, Folder 24, "Health Insurance."

52. Daniel M. Fox and Daniel C. Schaffer, "Health Policy and ERISA: Interest Groups and Semipreemption," *Journal of Health Politics, Policy and Law* 14 (1989): 236–60.

ter Reuther and the Fate of American Labor (New York: Basic Books, 1995), esp. chap. 13 and p. 361; and David L. Stebenne, *Arthur J. Goldberg: New Deal Liberal* (New York: Oxford University Press, 1996), esp. chap. 3.

49. "Multiemployer Trust Funds," *Employee Benefits Basics* (International Foundation of Employee Benefit Plans), July 1988, 1; National Coordinating Committee for Multiemployer Plans (NCCMP), "Taft-Hartley, Multiemployer Health & Welfare Plans and National Health Care Reform," report (Washington, DC: NCCMP, n.d.); and NCCMP, "Multiemployer Plans: A Basic Guide," pamphlet (Washington, DC: NCCMP, n.d.).

50. John T. Dunlop, "Health Care Coalitions," in *Private Sector Coalitions: A Fourth Party in Health Care*, ed. Jon B. Jaeger (Durham, NC: Department of Health Administration, 1983), 10.

The preemption worked to realign the interests of labor and business. Organized labor stuck by the preemption even though employers used it to perpetuate some highly discriminatory practices, such as eliminating promised health benefits for employees who contract HIV. This meant opposing the various public-interest groups that have battled the ERISA preemption and many of the discriminatory practices associated with it in the courts. In short, ERISA reconfigured the constellation of interest groups and their preferences in unanticipated ways. As such, this institution, together with the Taft-Hartley funds and the Dunlop way, bolstered organized labor's attachment to private-sector solutions for health-care reform, notably the employer mandate, and weakened its attachment to some kind of single-payer solution inspired by Canada's experience with national health insurance.

It is important to point out that labor was not of a single mind about health-care reform. By the early 1990s, the Taft-Hartley plans had become a major bone of contention within organized labor. Embittered advocates of Canadian-style reform charged that some labor leaders were opposed to any kind of single-payer plan because of a conflict of interest rooted in the Taft-Hartley system. They singled out Robert Georgine, the president of the building trades department of the AFL-CIO. In 1991, Georgine donned a second hat as chief executive officer of Union Labor Life Insurance Company (ULLICO). Established more than fifty years ago, ULLICO is a private company that provides insurance, investments, and benefits management for the Taft-Hartley plans of hundreds of union locals, many of which belong to the building trades.⁵³ Some union officials grumble that Georgine's position with ULLICO explained why he refused to throw the weight of the building trades behind any health-care reform proposal that would eliminate or greatly reduce the role of insurance companies in the provision of health care.⁵⁴

Even though many Taft-Hartley plans were in a perilous financial state and some of the rank and file were politically restive, the national leaders of the building trades and other unions remained committed to the old system. Prisoners of ideas and institutions they helped to create, they opposed any proposal for comprehensive health-care reform predicated on the establishment of a single-payer system or a greatly reduced role for the Taft-Hartley funds in the delivery of health benefits.⁵⁵

53. Albert B. Crenshaw, "The Aim to Be Letter Perfect; ULLICO Reproductions for Growth and 'A' Insurance Rating," *The Washington Post*, July 11, 1994, F-1; and "Ullico Inc.," *The Washington Post*, Apr. 18, 1995, F-47.

54. Merrill Gozner, "Health Care Debate Splits Union Ranks," *Chicago Tribune*, Feb. 18, 1991, 1; and Robert McGarrah, director of public policy, AFSCME, interview, Washington, DC, June 5, 1996.

55. Indeed, Georgine staunchly opposed the single-payer option at the highest reaches of the labor federation. In early 1991,

This is not just a simple case of material interests dictating political behavior, however. Notably, the International Ladies Garment Workers Union (ILGWU) remained an ardent supporter of national health insurance even though its membership was heavily dependent on Taft-Hartley arrangements for medical coverage.⁵⁶ Unlike the craft unions, the ILGWU has a long history of political activism on social welfare issues stretching back to the turn of the century. The ILGWU also has been a pioneer in the development of several key features of the private welfare state. It established some of the first union-sponsored benefit programs, union-run medical centers, and multiemployer welfare funds. Yet in experimenting with these private-sector schemes over the years, the charismatic leaders of the ILGWU did not abandon their commitment to broader social objectives. They would laud the union's individual accomplishments in the area of social welfare, yet were always careful to remind their members that "more important fundamental legislative and political solutions," such as national health insurance, were necessary to meet workers' security needs. They would stress that private solutions arrived at by unions and employers "necessarily are quite limited in their scope."⁵⁷ By contrast, many other labor leaders, once they had embraced the employer-mandate idea, increasingly hailed the private sector as the promised land for health-care reform and characterized rising health-care costs as the prime threat to both the livelihood of the American worker and the livelihood of corporate America.

In short, the Taft-Hartley funds and ERISA had far-reaching and unintended consequences. These two institutions evolved so as to divide unions from one another and from coalitional allies on the left. They cemented the commitment of some powerful unions and large employers to a system of health-care delivery rooted in one's employment status. They also reinforced labor's longstanding inclination to pursue the Dunlop way and to make securing an alliance with business a central feature of its health-care strategy.

he cast one of the deciding votes against endorsing a Canadian-style system at a contentious meeting of the federation's health-care committee that deadlocked 8-8. Robert McGarrah, AFSCME director of public policy, "Notes Re: 1/31/91 Meeting of the Health Care Committee," Personal Files of Robert McGarrah, AFSCME headquarters, Washington, DC (hereafter, McGarrah Papers); Joyce Frieden, "Unions Rev Up Health Reform Engines," *Business and Health*, Aug. 1991, 42-44; and Suzanne Gordon, "A.F.L.-C.I.O. Steps Backwards on National Health Insurance," *Labor Notes*, Apr. 1991, 1.

56. After Bill Clinton was elected president in 1992, the ILGWU did begin to qualify its support of national health insurance and to indicate its willingness to support health-care proposals based on the employer mandate and the preservation of the Taft-Hartley arrangements.

57. Raymond Munts and Mary Louise Munts, "Welfare History of the ILGWU," *Labor History*, 9, special supplement (1968), 96.

III. THE POLITICAL CONSEQUENCES OF AN IDEA

The institutional contours of the private welfare state and labor's longstanding commitment to the Dunlop way do not alone explain why the employer-mandate idea remained afloat and gathered steam after 1978. It is important to consider a second factor, namely the "fumbling efforts" that political actors make in "deciphering their environment," and the key role that ideas – even a single policy idea – can play in this process.⁵⁸ Ideas can serve as an important prism through which political actors decipher their environment. Like institutions, they can cause individuals or groups to rethink their interests, shift their political strategies, and establish new alliances.

As discussed earlier, when it was initially adopted, labor viewed the employer-mandate idea as a kind of "focal point" that could reconcile the interests of some state, labor, and business leaders such that they could forge a loose coalition on behalf of comprehensive health-care reform. Subsequently, this idea took flight, billowed by the institutional context discussed above and by the ways in which its carriers embedded this idea in a compelling causal story that *appeared* to explain some of the major shortcomings of the U.S. political economy. "Appearances" are the bread and butter of politics. Political actors – be they labor leaders, business executives, public interest groups, or government officials – all compete to come up with convincing narratives that define the cause of a particular problem in such a way that certain policy proposals appear to be natural and obvious solutions. Thus, some of the most skillful political actors are the ones most adept at framing the issues "while making it seem as though they are simply describing facts."⁵⁹ Policy and political outcomes depend in part on how one particular definition and explanation of a problem wins out. At issue is how interpretations come to be accepted as fact.

Organized labor carried not only the employer-mandate idea but also the idea of its congruence with the existing political and economic situation. In doing so, it promoted a highly selective view of the U.S. political economy based on assumptions that, taken together, were supportive of a worldview that was quite favorable to business. Thus, the employer-mandate idea functioned not just as one of the "switchmen" that launched organized labor onto a new policy path with respect to health care but also as a convenient hook on which hung the legitimacy of a

specific political-economic synthesis.⁶⁰ Elements of this worldview were clearly manifest in Clinton's Health Security Act.

The Clinton plan was promoted to the American public as a prescription not just for what was ailing the U.S. medical system, but also for what was ailing the U.S. economy and the American worker. In the course of pitching its proposal, the administration made some remarkable claims about the U.S. political economy, which organized labor had helped to legitimate over the years in its eagerness to forge some kind of alliance with business on the health-care issue. Among them was the assumption that the employer-mandate formula was not all that radical or even new a solution, but rather merely built upon the well-established institution of employment-based benefits in the United States. Furthermore, it was assumed that business bore most of the brunt of the private welfare state and thus the increasingly heavy burden of escalating medical costs, and that health-care costs were imperiling the competitiveness of U.S. firms in the international marketplace. The administration and labor leaders contended that escalating health-care costs were a major threat to the U.S. economy and were the root cause for most of the economic woes of American workers. Taken together, these assumptions, which are discussed below, helped to legitimize a worldview that was quite sympathetic to business and that ultimately undermined labor's broader political goals.

The Weak Foundations of the Private Safety Net

The first assumption was the idea that the employer-mandate formula was not all that radical or even new a solution but rather merely built upon the well-established institution of employment-based benefits in the United States. Labor officials and others consistently downplayed the wider political significance of the employer-mandate idea. Instead, they emphasized how the government would merely be requiring businesses to do what most of them – at least the socially responsible ones – were already doing voluntarily. The expressed belief among labor leaders and other would-be reformers (including eventually Hillary Rodham Clinton) that business would ultimately agree to support an employer-mandate solution because it would merely ratify what most employers were doing voluntarily, and because it appealed to the bottom-line interests of business, was a big leap of faith in a few critical respects.⁶¹ First, busi-

58. Douglass C. North, *Institutions, Institutional Change and Economic Performance* (Cambridge: Cambridge University Press, 1990), 23 and 22 respectively.

59. Deborah Stone, "Casual Stories and the Formulation of Agendas," *Political Science Quarterly* 104 (1989): 282. See also John W. Kingdon, *Agendas, Alternatives, and Public Policies* (Boston: Little, Brown, 1984); and Frank R. Baumgartner and Bryan D. Jones, *Agendas and Instability in American Politics* (Chicago: University of Chicago Press, 1993).

60. The well known "switchmen" metaphor comes, of course, from Max Weber, "The Social Psychology of the World Religions" (1913), in *From Max Weber: Essays in Sociology*, ed. H.H. Gerth and C. Wright Mills (New York: Oxford University Press, 1958), 280.

61. See, for example, the statement by UAW president Owen Bieber in UAW, *Washington Report*, May 29, 1987, 1; and Hillary Rodham Clinton, U.S. House, Committee on Education and Labor, "The President's Health Care Reform Proposal," vol. 1, 103rd Cong., 1st Sess., Oct. 7 and 14, 1993, 5.

ness support for comprehensive health-care reform based on some kind of employer mandate was not deep, as labor officials would belatedly discover. Moreover, the employment-based system of benefits in the United States that labor officials lauded had been erected on a weak foundation that business was already rapidly eroding.

All of organized labor's talk since the late 1970s about the need to pursue a health-care strategy that built upon the existing job-based system of benefits obscured how that system was itself in the midst of a radical transformation. From World War II until the 1970s, employer-based health plans covered an increasing proportion of Americans.⁶² From then onward, however, coverage began to shrink as the initiative in industrial relations shifted radically from union to nonunion firms and from labor to management.⁶³ Nonunion firms were the first to experiment widely with cutbacks in benefits and with new ways of organizing the work place and the work force, notably a greater reliance on contingent workers.⁶⁴

As the size of the contingent work force increased dramatically in the 1980s and early 1990s,⁶⁵ the plight of contingent workers remained marginal to most discussions of health policy, even though many such workers are uninsured or underinsured.⁶⁶ The specific ways in which the health-care question became disembodied from the chase for greater labor-market flexibility on the part of employers is starkly evident in the deliberations surrounding the Minimal Health Benefits for All Workers Act, which was introduced in the twilight years of the Reagan administration.⁶⁷ During congressional hearings on the legislation, there was little discussion about the proliferation of contingent employment in the United States and what ramifications this development might have for any

health-care legislation premised, as this one was, on an employer mandate.⁶⁸ Similarly, when the blue-ribbon, bipartisan Pepper Commission endorsed an employer mandate by a bare majority in 1990, supporters of the proposal stressed a familiar theme about how the Pepper plan built upon the existing system of job-based benefits and thus was evolutionary, not revolutionary. Rep. Pete Stark (D-CA) was the only member of the commission to underscore the jury-built nature of that system and its increasingly shaky status within the American welfare state due to vast changes in the labor market.⁶⁹

In subsequent discussions surrounding the various comprehensive health-care reform bills introduced in the early 1990s, the health-care issue was seldom tied to broader economic questions associated with the search by employers for greater labor market flexibility or to issues surrounding the future viability of the private welfare state. By attempting to sell various incarnations of the employer-mandate idea as merely extensions of the supposedly well-established institution of job-based benefits, proponents, including organized labor, minimized or diverted attention from the ways in which employers' search for greater labor market flexibility threatened the already fragile private welfare state in the United States.

The Downsizing of the Private Welfare State

In making their pitch for Clinton's Health Security Act and its legislative antecedents, proponents portrayed the job-based system of benefits, and the business sector more broadly, in a highly selective and sympathetic light. Foremost, they stressed how the existing health-care system greatly disadvantaged business.⁷⁰ Mrs. Clinton and other proponents of the Health Security Act bent over backwards to underscore how the weight of escalating health-care costs fell heaviest on the corporate sector.⁷¹ In doing so they distorted the reality of the health-care burden in the United States in several notable respects.

First, despite widespread claims to the contrary, the burden of health-care costs has weighed heaviest on the American public, not the business sector. In 1991, the United States was spending \$6,535 per family on health care; about two-thirds of that was paid for by families with the rest by business.⁷² In holding up the

62. Karen Swartz, *The Medically Uninsured: Special Focus on Workers* (Washington, DC: Urban Institute Press, 1989).

63. Kochan et al., *The Transformation of American Industrial Relations*, 9, and chap. 3; and Sanford M. Jacoby, ed. *Masters to Managers: Historical and Comparative Perspectives on American Employers* (New York: Columbia University Press, 1991), 283.

64. George Strauss, "Industrial Relations: Time of Change," *Industrial Relations* 23 (1984), 3; and Richard S. Belous, "How Human Resource Systems Adjust to the Shift Toward Contingent Workers," *Monthly Labor Review*, Mar. 1989, 7–12.

65. Anne E. Polivka and Thomas Nardone, "On the Definition of 'Contingent' Work," *Monthly Labor Review*, Dec. 1989, 10; Kathleen Christensen and Mary Murphree, "Introduction to," in *Flexible Workstyles: A Look at Contingent Labor* (Washington, DC: Women's Bureau, U.S. Department of Labor, 1988); U.S. House, Committee on Government Operations, *Rising Use of Part-Time and Temporary Workers: Who Benefits and Who Loses?* (Washington, DC: U.S. Government Printing Office, 1988); and David M. Gordon, *Fat and Mean: The Corporate Squeeze of Working Americans and the Myth of Managerial "Downsizing"* (New York: Martin Kessler Books, The Free Press, 1996), 226–27.

66. Carolyn Pemberton and Deborah Holmes, eds. *EBRI Databook on Employee Benefits*, 3d ed. (Washington, DC: Employee Benefit Research Institute, 1995), 263.

67. *Congress and the Nation, 1985–1988*, 10 vols. (Washington, D.C.: Congressional Quarterly, 1990), 7:599.

68. U.S. Senate, Committee on Labor and Human Resources, "Minimum Health Benefits for All Workers Act of 1987," Part 1, 100th Cong., 1st Sess., June 24, 1987.

69. U.S. Bipartisan Commission on Comprehensive Health Care (Pepper Commission), "A Call for Action" (Washington, DC: 1990), 2, 233.

70. Hillary Rodham Clinton, U.S. Senate, Committee on Labor and Human Resources "Health Security Act of 1993," Part 1, 103rd Cong., 1st Sess., Sept.–Oct. 1993, 48.

71. The media helped to perpetuate this view. See, for example, Edmund Faltermayer, "Why Health Costs Can Keep Slowing," *Fortune*, Jan. 24, 1994, 76.

72. Families USA, "Health Spending: The Growing Threat to the Family Budget" (Washington, DC: Families USA Foundation, 1991).

system of employment-based benefits as a model to be emulated and built upon, proponents of employer-mandate solutions ended up minimizing the enormous gaps and gross inequities on which the private welfare state was erected. Indeed, in certain important respects, it is a misnomer to refer to the health-care system in the United States as an employment-based system at all. It is really more like a net through which a significant percentage of the population passes untouched. Historically, labor market variables have been strong predictors of who receives benefits like health insurance coverage and pensions in the United States. Some of the critical labor-market variables include the racial, gender, and ethnic composition of occupations, how physically demanding a job is, and whether the work force is unionized or not.⁷³ For example, women are less likely to receive health insurance through their employers because they are more likely to work part time, to predominate in low-paying, non-union jobs, and to experience greater job mobility (and thus be more vulnerable to clauses in group health plans that exclude coverage for new employees and that do not cover preexisting medical conditions for a designated period of time).⁷⁴ In 1990, only 48 percent of Hispanics were covered by a private source of health insurance, compared with nearly 77 percent of whites, and 52 percent of African Americans.⁷⁵ For all the talk from the 1970s to the early 1990s about the need to build upon the “employer/employee partnership,” the fact is that only about 61 percent of the nonelderly population was receiving medical coverage through employment-based benefits when Clinton took office.⁷⁶ Indeed, most employers *did not* offer health insurance through the work place, and many of those who did required employees to assume a large portion of the cost.⁷⁷

73. Angela M. O’Rand, “The Hidden Payroll: Employee Benefits and the Structure of Workplace Inequality,” *Sociological Forum* 1 (1986): 657–83; Lawrence S. Root, “Employee Benefits and Social Welfare: Complement and Conflict,” *The Annals of the American Academy of Political and Social Science* 479 (1985): 101–18; Laurie Perman and Beth Stevens, “Industrial Segregation and the Gender Distribution of Fringe Benefits,” *Gender and Society* 3 (1988): 388–404; Nancy S. Jecker, “Can an Employer-Based Health Insurance System Be Just?,” in *The Politics of Health Care Reform*; and “Health Inequities Put Hispanic Workers at Risk,” *AFL-CIO News*, May 25, 1992.

74. Perman and Stevens, “Industrial Segregation and the Gender Distribution of Fringe Benefits;” and Jecker, “Can an Employer-Based Health Insurance System Be Just?” When wages are controlled for, the difference in pension, health, and disability coverage for men and women disappears. Janet Currie, “Gender Gaps in Benefit Coverage,” NBER working paper no. 4265 (Cambridge, MA: National Bureau of Economic Research, 1983).

75. “Health Inequities Put Hispanic Workers at Risk,” *AFL-CIO News*, May 25, 1992; and *The Wall Street Journal*, Jan. 9, 1991, B-4. See also, Peter T. Kilborn, “Denver’s Hispanic Residents Point to Ills of the Uninsured,” *The New York Times*, Apr. 9, 1999, A-1.

76. *EBRI Databook on Employee Benefits*, 3d ed., 237.

77. John J. Motley, vice-president for federal-governmental relations of the National Federation of Independent Business, estimated that only 42 to 45 percent of U.S. employers provide

The burden that health-care costs pose for individual Americans and their families has grown steadily since the 1970s in part because employers retain enormous capacity to engineer a retrenchment of the private welfare state in short order. As the social and political pressure to maintain the private-sector safety net eased up in the 1980s, employers were poised to shred significant pieces of it. They proved quite willing and capable of shifting more of the expense of medical care onto their employees through higher deductibles and copays, reduced coverage for employees and their dependents, the elimination of coverage for certain ailments, and drastic cuts in health benefits for retired workers.⁷⁸

As the employer assault on retiree health benefits and other pieces of the private welfare state intensified in the late 1980s, the number of workers striking primarily over health benefit issues increased sharply.⁷⁹ Nonetheless, the AFL-CIO remained committed to the belief that the crushing expense of the private welfare state would, largely on its own, prompt employers to cooperate with labor and legislators on behalf of an employer-mandate solution. Many in organized labor promoted the view that business, when forced to confront the stark reality of the escalating cost of health benefits for retirees and other workers, would be forced by a compelling bottom-line logic to endorse, if not national health insurance, some sort of comprehensive health insurance reform based on an employer mandate that would shore up the private welfare state.⁸⁰ Yet business responded instead by testing the political waters and further shredding the private-sector safety net.

employment-based health benefits. See U.S. House, Subcommittee on Small Business, “The Small Business Community’s Recommendations for National Health Care Reform,” 103rd Cong., 1st Sess., Aug. 4, 1993, 17.

78. Congressional Research Service, “Health Insurance and the Uninsured: Background Data and Analysis” (Washington, DC: Government Printing Office, 1988), 3; Ida Hellander et al., “The Growing Epidemic of Uninsurance: New Data on the Health Insurance Coverage of Americans,” *International Journal of Health Services* 25 (1995): 377–92; Richard Kronick, “Health Insurance, 1979–1989: The Frayed Connection Between Employment and Insurance,” *Inquiry* 28 (1991); Laura A. Scofea, “The Development and Growth of Employer-Provided Health Insurance,” *Monthly Labor Review*, March 1994, 3–10; SEIU, Department of Public Policy, “Employer-Paid Health Insurance is Disappearing” (Washington, DC: SEIU, 1989); Clifford Staples, “The Politics of Employment-Based Insurance in the United States,” *International Journal of Health Services* 19 (1989): 415–31; Gail A. Jensen, Michael A. Morrissey, John W. Marcus, “Cost Sharing and the Changing Pattern of Employer-Sponsored Health Benefits,” *The Milbank Quarterly* 65 (1987); and Mark J. Warshawsky, *The Uncertain Promise of Retiree Health Benefits: An Evaluation of Corporate Obligations* (Washington, DC: The AEI Press, 1992).

79. J. Peter Nixon, “Health Care Reform: A Labor Perspective,” in *Health Care Reform in the Nineties*, ed. Pauline Vaillancourt Rosenau (Thousand Oaks, CA: Sage, 1994).

80. Labor’s wishful thinking and contradictory position on the issue of retiree benefits, and health benefits more broadly, are epitomized in Karen Ignagni, “Retiree Health: Bargaining for the 1990s,” *AFL-CIO News*, August 5, 1989.

Health-Care Costs and Economic "Competitiveness"

In tapping big business as a key ally in the health-care debate, organized labor largely accepted the Fortune 500's definition of what was ailing the American economy and hence the American worker. Much of organized labor jumped on the "competitiveness" bandwagon. In their public statements, labor and business leaders regularly sang off the same song sheet. Their refrain was a simple one – higher medical costs were making American products less competitive in the international marketplace, which was severely hurting the U.S. economy and the American worker.

The tight linkage that labor leaders made between the health-care issue and the competitiveness question ended up boxing organized labor into a remarkable spot, as demonstrated by a report released by the SEIU in 1992, just as the debate over health-care reform was heating up. The report laments how most workers were earning less per hour in 1992 than they did in 1980 – about 4.4 percent on average after adjusting for inflation. While the report mentions in passing how "[s]low productivity growth and structural changes in the U.S. economy" have contributed to falling wages, it identifies health-care costs as the main villain for the woes of the American worker. It blames the country's "out-of-control" medical expenses for a host of sins, including falling wages, the plummeting savings rate, the large federal budget deficit, the precarious financial situation of the states, slowing economic growth, and, notably, the "non-competitiveness of American businesses." The report identifies the growing health-care cost burden as the primary cause of the restructuring of the U.S. economy that has wrought so many hardships for so many American workers and portrays U.S. corporations as largely passive onlookers in that restructuring.⁸¹

Labor leaders worked side-by-side with corporate leaders and government officials to portray the stemming of health-care costs as the magic bullet that would wound, if not slay, the dragon of intensified economic competition that was reportedly pricing American workers out of the global marketplace and eating away at their standard of living. They portrayed U.S. employers as largely willing – but increasingly unable – to offer health benefits because of this intensified competition. In taking this stance, organized labor conceded some important political and intellectual ground to business in several key areas related to the competitiveness question and broader economic issues. Organized labor accepted an image of the U.S. economy and U.S. firms drowning in imports produced by either low-wage, low-benefit developing countries that were irresistible havens for U.S. direct foreign investment, or by other advanced industrialized countries that enjoyed significant cost advantages over U.S. firms because of their lower

medical expenses. These premises were open to challenge, but labor joined in the chorus.

In its eagerness to make common cause with business on the health-care issue, labor contributed to the widespread misperception about the extent to which medical costs were indeed hurting corporate profits. In fact, spending on health care as measured as a percentage of corporate profits remained surprisingly stable from 1985 to 1991. More significantly, employer spending on wages and salaries, and on total compensation as a percentage of after-tax profits, dropped significantly after 1985 in the United States.⁸² Thus, while health-care costs may have been rising, employers were having great success at squeezing wages and other forms of compensation.

Moreover, by comparing what U.S. firms pay *directly* for health care relative to their foreign competitors, organized labor and business leaders conveniently ignored the higher indirect costs that many European firms shoulder due to the relatively higher corporate and personal income taxes they must shell out to support more extensive public welfare states. They overlooked the fact that European and Japanese firms at the time were able to remain highly competitive even though the benefits packages they provided for their workers were far more generous, and thus far more costly, than those offered by American firms.⁸³

In rising so ardently to the defense of U.S. firms allegedly battered by lower-cost competitors from abroad at this time, organized labor absented itself from some of the wider and more penetrating debates about the U.S. political economy. For example, labor leaders ended up on the sidelines in discussions about whether American multinationals were increasingly shedding their national identity for a global identity, and whether, as a result, their interests were fundamentally at odds with those of the average American worker.⁸⁴ Labor's obsession with the competitiveness angle of the health-care question helped to buttress the dominant view that structural forces in the international political economy that were largely out of the control of U.S. firms and state actors (notably the speed and ease with which capital could seek out lower-cost havens) were to blame for most of the economic woes of the American worker. While this view did not go unchallenged, it fell upon others, namely iconoclastic economists and not organized labor, to take it on.⁸⁵

82. *EBRI Databook on Employee Benefits*, 3d ed., Table 10.14, 368.

83. Congressional Research Service, "An International Comparison of Fringe Benefits," cited in Andrew Remes, "The Attack on Benefits," *Economic Notes* 53 (1985), 1–2; and Patricia Capdevielle, "International Comparisons of Hourly Compensation Costs," *Monthly Labor Review*, June 1989, 10–12; and Martin Rein, "The Social Policy of the Firm," *Policy Sciences* 14 (1982): 126.

84. Robert Reich, "Who is Us?," *Harvard Business Review*, Jan.–Feb. 1990, 53–64. See also William J. Holstein et al., "The Stateless Corporation," *Business Week*, May 14, 1990, 98–105; and Gerald Epstein, "Mortgaging America: Debts, Lies, and Multinationals," *World Policy Journal* 8 (1990–1991): 27–59.

85. For instance, economists Paul Krugman and David M. Gor-

81. SEIU, "Out of Control, into Decline" (Washington, DC: SEIU, 1992), pp. 1–10.

In the context of the health-care debate, organized labor did not challenge the dominant view of the changing U.S. political economy, which equated falling competition with rising health-care costs. This analysis was one that was essentially proposed by business. As a consequence, labor's ability to develop a coherent, compelling, and independent political program to address the economic dislocations of the 1980s and 1990s was impaired, as was its specific strategy on health-care reform. In defending the employer-mandate idea, organized labor ended up legitimizing a number of assumptions about the restructuring of the U.S. political economy that cast business in a highly favorable light. These assumptions also drew attention away from the sobering fact that employers had been quite successful at shredding more of the private welfare state by shifting more of the costs of health care onto employees. In short, labor's commitment to the employer-mandate idea and to the worldview that flowed from that commitment had significant political consequences.

It is important to mention here that organized labor was not of a single mind about health policy in the late 1980s and early 1990s. The impact of institutions and ideas, as noted above, was uneven. At the time when single-payer proposals and the Canadian medical system were attracting wider attention and gaining respectability among policy makers and the general public, labor unions were still divided over this issue. However, several AFL-CIO officials, including Sweeney and Kirkland, were pivotal in neutralizing the remaining support within organized labor for a single-payer system.

In the early 1990s, Sweeney and Kirkland cautioned unions to avoid endorsing any specific legislation so as not to preclude the possibility of building a consensus with other groups, including business.⁸⁶ This was a major theme of a series of hearings on health-care issues that the federation conducted around the

country in the fall of 1990.⁸⁷ Yet the federation's efforts to mobilize its membership on the health-care issue were falling flat around this time because of its refusal to support any specific proposal and because of deep divisions between unions and within unions over the single-payer option. Many local labor organizers reported that members wanted to rally around a specific proposal, but beyond the call for health care for all, there was no specific program.⁸⁸

The showdown for organized labor over national health insurance came in late 1990 and early 1991 as several unions pushed the AFL-CIO to endorse a single-payer solution. Although Kirkland and Sweeney took an open-ended approach in public, in private they were strongly opposed to any Canadian-style solution. Behind the scenes, and consistent with the analysis above, Sweeney advocated some variant of the employer-mandate model, believing it was the one most acceptable to business because it built upon the existing system of private-sector health benefits. This approach was also attractive to him because it would not force unions that provided health benefits through the Taft-Hartley funds to give them up.⁸⁹

Sweeney and Kirkland brought the full weight of the AFL-CIO's bureaucracy and the Democratic party to bear behind the scenes on the supporters of the single-payer path.⁹⁰ At a critical, contentious meeting in early 1991, the health-care committee of the AFL-CIO deadlocked over whether to endorse the single-payer option.⁹¹ Faced with such an impasse, the federation's executive council responded by endorsing what appeared to be a "let a hundred flowers bloom" approach to national health-care reform and issued a statement supporting some vague "principles" for health care.⁹²

Like the original Hundred Flowers campaign four decades ago in China, this one quickly lost its bloom

don challenged the conventional wisdom that rising imports from lower-cost producers from abroad were the primary cause of the economic difficulties of U.S. workers. In a similar vein, health-care economists Uwe Reinhardt and Mark Pauly respectively questioned the popular view among business and labor leaders that the overall percentage of GNP devoted to health care in the U.S. economy "is too high for the nation's long-run competitiveness" and that higher health-care costs are to blame for stagnating wages for workers. See Paul Krugman, *Peddling Prosperity: Economic Sense and Nonsense in the Age of Diminished Expectations* (New York: W.W. Norton, 1994); David M. Gordon, "The Global Economy: New Edifice or Crumbling Foundations?," *New Left Review* 168 (1988): 37, 61, and 58–59; Uwe E. Reinhardt, "Health Care Spending and American Competitiveness," *Health Affairs* 8 (1989): 5–21; and Mark Pauly as quoted in Louis Uchitelle, "Insurance as a Job Benefit Shows Signs of Overwork," *The New York Times*, May 1, 1991, A-1. See also Linda Weiss, "Globalization and the Myth of the Powerless State," *New Left Review* 225 (1997): 3–27.

86. Robert Kearns, "Unions Set Drive to Overhaul Health Care," *Reuter Business Report*, Nov. 15, 1989.

87. AFL-CIO, "The Case for Health Care Reform: The People Speak, Transcripts from Regional Hearings, September–October 1990" (Washington, DC: AFL-CIO, 1990).

88. Jobs With Justice newsletter, "Report on Health Care Action Day-October 3, 1990," Sheinkman Papers, Amalgamated Clothing Workers of America Records, Labor-Management Documentation Center, Cornell University, Box 5, "Jobs With Justice"; and Laura McClure, "Does a 'Reformed' System Mean a Better System?," *Labor Notes*, July 1990, 9.

89. Robert McGarrah to Gerald McEntee, Nov. 6, 1990, "AFL-CIO Health Care Committee Meeting," McGarrah Papers; Robert McGarrah to Gerald McEntee, May 21, 1990, "AFL-CIO Health Care Meetings," McGarrah Papers; and Camille Colatosti, "What Are Unions Doing About Fixing the Health Care System?," *Labor Notes*, July 1990, 8–9.

90. Suzanne Gordon, "AFL-CIO Steps Backwards on National Health Insurance," *Labor Notes*, Apr. 1991, 1.

91. This account of the meeting is based on the handwritten notes of Robert McGarrah, AFSCME director of public policy, who was present. "Notes Re: 1/31/91 Meeting of the Health Care Committee," McGarrah Papers; and Joyce Frieden, "Unions Rev Up Health Reform Engines," *Business and Health*, Aug. 1991, 42–44.

92. Colleen M. O'Neill, "Health Care Campaign Reaches Hill," *AFL-CIO News*, Feb. 4, 1991, 1.

as Kirkland and Sweeney clearly remained committed to the employer-mandate formula and to undercutting the single-payer position.⁹³ While these two labor leaders were able to keep the AFL-CIO from officially straying down the single-payer path, they were unable to quell completely the growing sentiment for a Canadian-style solution in several unions. As a result, the AFL-CIO was forced to adopt a "wait-and-see" approach to health-care reform that, not surprisingly, failed to inspire the rank and file, and that left labor fragmented and tentative just as the health-care issue lurched once again into the national spotlight with the election of Bill Clinton in November 1992.

During the 1993–1994 battle over Clinton's Health Security Act, the administration stressed the familiar theme about how escalating health-care costs were the root cause of the woes of the American firm, and hence the American worker. For President Clinton, this was an important shift away from the picture of the U.S. economy that he had painted on the campaign trail. As the Democratic party's presidential candidate in 1992, Clinton certainly did not launch any stinging broadsides against corporate America. However, he did gingerly suggest in his stump speeches that a complex mixture of factors was to blame for the fact that more Americans were working harder than ever just to maintain the economic foothold they had. In short, "It's the economy, stupid."⁹⁴ Yet after the bruising battle over the budget that dominated his first seven months in office, Clinton emerged with a reduced vision of what was ailing the American worker. In short, "It's the health-care costs, stupid," a theme that labor had helped to popularize and legitimize over the previous decade and a half.⁹⁵

In this same period, labor once again strove to make the case that both business and the White House could be counted on to be constructive partners because they shared similar bottom-line concerns about rising health-care costs and their impact on the American worker. Yet, at that same moment, organized labor was simultaneously engaged in a pitched battle with business and the White House over the North American Free-Trade Agreement (NAFTA), in which unions faulted U.S. multination-

als for what they characterized as a ruthless and unwarranted effort to shift production to low-wage countries with laxer environmental and labor standards at great cost to the American worker. Opponents attempted to turn the free-trade treaty into a metaphor for the widespread and free-floating anxiety among Americans about their economic futures and their deep mistrust of "corporate decisions made by nominally American companies."⁹⁶ Yet in discussions of health care, labor officials continued to concede, as they had for years, that U.S. corporations were under mounting and dire competitive pressures from low-wage, lower-benefit producers at home and abroad, and that escalating health-care costs compounded those pressures. All of which presented labor with a serious case of political cognitive dissonance that impeded its efforts to rally the rank and file and to build an effective and enduring coalition on behalf of universal health care.

Labor's contrasting approaches to NAFTA and to Clinton's Health Security Act dramatically underscore the inadequacy of any explanation of labor politics that emphasizes labor's shrinking membership and related political weakness. In the case of NAFTA, labor chose to confront business and a Democratic president as it sought to defeat this free-trade agreement. By contrast, labor leaders eagerly sought the cooperation of business on health-care reform matters, even though this strategy was fraught with contradictions. The latter only makes sense when one keeps in mind labor's imperfect but longstanding attachment to the institutions of the private welfare state for health-care provision and to the idea of an employer mandate.

A group's strategic choice at one time can lead it or prime it to accept more encompassing arguments about the "definition of the problem" at a later point. Unions made a strategic choice in 1978 to abandon national health insurance and endorse the employer-mandate idea. This had enormous political consequences later. As E.E. Schattschneider once reminded us: "The definition of the alternatives is the supreme instrument of power."⁹⁷ Unions got locked into a certain definition of the health-care problem – which then locked them into particular coalition-building strategies that turned out to be untenable and ultimately self-defeating. The institutions of the private welfare state coupled with the ruling discourse about the basically cooperative nature of labor-management relations in the U.S. reinforced these strategies.

Organized labor, and later the Clinton administration, sought to marshal support for the cause of universal health care by shifting attention away from the

93. Morton Bahr et al., letter to Lane Kirkland, Aug. 9, 1991, McGarran Papers; and Camille Colatosti, "AFL-CIO Takes Health Care Reform 'One Step at a Time'," *Labor Notes*, Jan. 1992, 3.

94. These factors included an inequitable tax system, inadequate government and corporate investment in infrastructure, education, economic development, and environmental protection, and the "biggest imbalance in wealth in America since the 1920's." Gwen Ifill, "Clinton's Standard Campaign Speech: A Call for Responsibility," *The New York Times*, Apr. 26, 1992, sec. 1, pt. 1, 24.

95. See, for example, Bill Clinton, Sept. 1993 Health Security Speech, in Erik Eckholm, ed. *Solving America's Health-Care Crisis* (New York: Times Books, Random House, 1993); and Robert B. Reich, U.S. House, Committee on Education and Labor, "Hearings on the President's Health Care Reform Proposal," vol. 1, 103rd Cong., 1st Sess., Oct. 7 and 14, 1993, 183–84.

96. David Moberg, "The Morning NAFTA," *In These Times*, Dec. 13, 1993, 20–21. See also Louis S. Richman, "Why Labor Hates NAFTA," *Fortune*, Nov. 15, 1993, 28.

97. E.E. Schattschneider, *The Semi-Sovereign People* (New York: Holt, Rinehart and Winston, 1970), 68.

plight of the poor and uninsured. They tried to build public support by arguing that an employer-mandate solution would help everyone by restoring economic competitiveness. The economic competitiveness argument was a powerful rhetorical device, so there were compelling incentives for labor and other political actors to build on this causal story, whether they believed it or not. While the competitiveness argument had some strategic value, it was politically costly in other respects.

Over time, labor became wedded to a solution that was increasingly out of sync with the economic realities of the workplace in an era of large-scale economic restructuring. From the 1970s onward, health policy and employment policy moved in contradictory directions. Labor's attachment to an employer-mandate formula grew even as employers' attachment to their employees, as traditionally understood, attenuated. In making the case for an employer mandate, labor argued that most employers were already providing their employees with health benefits, and, as such, this solution was a moderate one. In doing so, labor unwittingly helped to draw public attention away from the enormous transformations that were taking place in the labor market and from employer culpability in these changes as employers rapidly shredded health benefits and other core pieces of the private-sector safety net. It also downplayed the huge gaps and inequities on which the private welfare state was built in the first place. As a result, labor, trapped by ideas it had adopted earlier, helped to minimize just how vulnerable the institution of employment-based benefits was to shifting political and economic winds. In other words, labor failed to create its own understanding of how to pursue its interests.

IV. CONCLUSION

This essay traced some of the important political consequences of labor's commitment to the idea of an employer mandate. The narrow focus on a single idea has broader analytical implications both for how we think about organized labor and the welfare state and for how we think about the role of ideas in explaining political outcomes. Much of the literature on ideas in political science tends to focus not on a single idea, but rather a cluster of related ideas and related policies – for example, Keynesianism, Stalinism, or monetarism – that became the lens that defined, if not a new political and economic era, at least a new and compelling political or economic model.⁹⁸

While it certainly is important to consider the role of clusters of ideas – be they “programmatically beliefs,” “worldviews,” “principled beliefs,” “causal beliefs,” or “policy paradigms” – in ushering out one era or model and ushering in another, we should not ignore or

98. See, for example, the contributions to Goldstein and Keohane, eds., *Ideas and Foreign Policy*; Hall, ed., *The Political Power of Economic Ideas: Keynesianism Across Nations*.

underestimate the consequences of a single idea.⁹⁹ Adopted initially out of political expediency and as yet not linked to any grander vision or framework, a single idea can have important unintended consequences. In periods fraught with uncertainty, when the sun is setting on one cluster of ideas and policies, such as Keynesianism, and a new day has yet to dawn on another cluster, such as Reaganism and monetarism, single ideas often provide the raw materials out of which a new paradigm, ideology, or worldview is molded or legitimated. In this instance, a single idea – the employer mandate – helped to legitimize a worldview that saw a strong coincidence of interests between labor and business in the face of a vast restructuring of the U.S. economy. This, in turn, had important consequences for the political efficacy of organized labor and for the ongoing quest for universal health care in the United States.

In their dissections of the politics of contemporary social policy, and health policy in particular, many scholars give short shrift to organized labor and the private welfare state, however.¹⁰⁰ For example, Paul Pierson contends that organized labor, which may have been critical to the early development of the welfare state, is less relevant to the politics of retrenchment today because of its shrinking membership base and the emergence of new interest groups dependent on the state for various social provisions, including the aged, the disabled, and health-care consumers. He views these new groups as the welfare state's most ardent defenders, and persuasively makes the case that the thicket of interest groups that has grown up around the *public* welfare state may be its best defense against any major retrenchment.¹⁰¹

Yet, as argued above, this tangle of interest groups may be poorly suited or poorly situated to forestall a retrenchment of the *private* welfare state on which so many people in the U.S. depend for health insurance and other types of social provision. Furthermore, many of the same groups that act as the major bul-

99. For these alternative definitions or understandings of ideas, see respectively Sheri Berman, *The Social Democratic Moment: Ideas and Politics in the Making of Interwar Europe* (Cambridge, MA: Harvard University Press, 1998), 21; Goldstein and Keohane, “Ideas and Foreign Policy,” 8–11; and Peter Hall, “Policy Paradigms, Social Learning, and the State,” *Comparative Politics* 25 (1993): 275–96.

100. Paul Pierson, “The New Politics of the Welfare State,” *World Politics* 48 (1996): 143–79; Goran Therborn and Joop Roebroek, “The Irreversible Welfare State: Its Recent Maturation, Its Encounter with the Economic Crisis, and Its Future Prospects,” *International Journal of Health Services* 16 (1986); and John Myles and Paul Pierson, “Friedman's Revenge: The Reform of ‘Liberal’ Welfare States in Canada and the United States,” *Politics and Society* 25 (1997): 443–72. On labor and health policy in particular, see Theda Skocpol, *Boomerang: Clinton's Health Security Effort and the Turn Against Government in U.S. Politics* (New York: W.W. Norton and Co., 1996), chap. 3, esp. 84–88; John B. Judis, “Abandoned Surgery: Business and the Failure of Health Reform,” *The American Prospect* 21 (1995): 71–72; and Cathie Jo Martin, “Stuck in Neutral: Big Business and the Politics of National Health Reform,” *Journal of Health Politics, Policy and Law* 20 (1995): 433.

101. Pierson, “The New Politics of the Welfare State,” 151.

wark against the retrenchment of the *public* welfare state, notably organized labor, may also represent a considerable obstacle to any major expansion of that welfare state to compensate for the retrenchment of the private welfare state, such as the establishment of national health insurance and the elimination of the employment-based system of medical benefits in the United States. Once developments in the private sector are factored in, it becomes harder to sustain Pierson's claim that "the welfare state remains the most resilient aspect of the postwar economy."¹⁰² Indeed, the last two decades have been a transformative period for the welfare state in the United States, nowhere more so than in the area of health care, where the proportion of people without adequate health insurance continues to surge.

Organized labor was a central player in this transformation. Labor's tepid and hesitant response to renewed calls for national health insurance in the 1980s and early 1990s was not merely the consequence of a shift in the ideological tenor of the times as the drumbeat of balanced federal budgets and market-led solutions drowned out the ideals of the New Deal and Great Society. While the recalibration of the American political spectrum to the right beginning in the late 1970s is important, it does not entirely explain why private-sector solutions trumped public-sector ones time and again in discussions of health policy. It is important to examine how the American welfare state developed in the years prior to the Reagan revolution so as to facilitate organized labor's continued embrace of private-sector solutions in the 1980s and its lukewarm stance toward proposals that called for eliminating the commercial health insurers and job-based medical benefits. As such, we need to understand, among other things, how a single policy idea, the employer mandate, adopted in a moment of political expediency in 1978 as state actors reordered their preferences, became embedded in a compelling worldview and causal story. This new worldview was quite favorable to business and yet vexed labor with a serious, but largely unrecognized, case of political cognitive dissonance.

The few analysts who have focussed on labor, health policy, and the private welfare state have tended to concentrate on the immediate postwar years and then to extrapolate to the present.¹⁰³ Yet, the line

102. *Ibid.*, 170.

103. For example, Derickson and Stevens convincingly show how organized labor played a central role in the turn toward private-sector, employment-based solutions for medical coverage with its embrace of collectively bargained health benefits as the campaign for national health insurance sputtered in the 1940s and 50s. This shift, in their view, subsequently posed formidable obstacles to achieving universal health care over the long run. Alan Derickson, "Health Security for All? Social Unionism and Universal Health Insurance, 1935–1958," *The Journal of American History* 80 (1994): 1333–56; and Beth Stevens, "Labor Unions, Employee Benefits, and the Privatization of the American Welfare State," *Journal of Policy History* 2 (1990): 233–60. See also Colin Gordon, "Why No National Health Insurance in the U.S.? The Limits of Social

between the institutional developments of the 1940s and 1950s and the contemporary failure to achieve universal health care in the United States is not such a straight and predictable one. Such extrapolations from the immediate postwar years to the present fail to explain the twists and turns over time, and, more importantly, fail to identify the mechanisms that perpetuate certain policy preferences and political coalitions.¹⁰⁴

The employer-mandate idea was an important twist. It not only committed organized labor to a new stance on health-care policy, but also ultimately affected how it interpreted and responded to the new political economy. In serving as an important carrier and legitimizer of the employer-mandate idea, organized labor helped to legitimize a highly selective understanding of the U.S. political economy, one that was generally uncritical of the role of corporations in the restructuring of the economy.

Health policy analysts generally portray the choice of an employer mandate as a natural, logical response to the political and economic environment. As such, its selection, for them, needs little or no explanation. Theda Skocpol, for example, contends that the twin legacies of Reaganism – a huge federal deficit and deepening distrust of the government – gave policy makers little choice but to ensure that any new social program be kept off budget.¹⁰⁵ Yet, as argued above, the idea of an employer mandate took on a life of its own long before it was embraced by the Clinton administration, even prior to the spread of the antigovernment ideas that were the leitmotif of the Reagan years. Moreover, this policy idea developed such that it played a critical role in defining the strategies and coalitions around which the health-care debate would be waged.

The battle over health-care reform in the first term of the Clinton administration would likely have been lost regardless of labor's stance. The fate of any proposal for comprehensive health-care reform depends

Provision in War and Peace, 1941–1948," *Journal of Policy History* 9 (1997): 277–310.

104. One notable exception to this tendency to extrapolate from the 1940s and 50s to the present is Sanford Jacoby's *Modern Manors*. Jacoby shows how key nonunion firms largely succeeded over time in their goal of creating a specific kind of private-sector safety net, one in which job-based health and other benefits were consciously structured so as to stem the spread of unionization of the work force and blunt the edge of public demands for national health insurance and other expansions of the public safety net. As such, the benefits packages of nonunion firms became a major piece of the institutional straightjacket that constricts the possibility of national health insurance and contributes to the persistence of great inequities in health care. Sanford M. Jacoby, *Modern Manors: Welfare Capitalism Since the New Deal* (Princeton: Princeton University Press, 1997). Another notable exception is Laurence A. Weil, "Organized Labor and Health Reform: Union Interests and the Clinton Plan," *Journal of Public Health Policy* 18 (1997): 30–48.

105. Skocpol, *Boomerang*. For a good detailed discussion of some of the origins of Clinton's Health Security Act, see Jacob S. Hacker, *The Road to Nowhere: The Genesis of President Clinton's Plan for Health Security* (Princeton: Princeton University Press, 1997).

on a range of other factors, including the political make-up of Congress, the electoral and other strengths of the president, the response of insurers, the medical profession and other stakeholders, the vagaries of public opinion, media coverage, and the strategic choices of many other interest groups.¹⁰⁶ In the short term, labor's rejection of the employer mandate and endorsement of a single-payer system would not have fundamentally altered these other factors. However, had labor positioned itself differently, it might have enhanced the chances that the losing side might congeal and increase its influence over health policy over the long term with labor's presence and help.

Organized labor was highly constrained by the institutional contours of the private welfare state and by broader shifts in the U.S. political economy. And certainly it also was constrained by other features of the political and institutional environment, notably its thinning ranks, its dependent relationship with the Democratic party, the formidable barriers to creating a third party in the United States, the rise of a more forceful right flank in American politics, and the disproportionate resources that its opponents – notably the business sector – could muster. While these obstacles are real and significant, they do not entirely explain labor's political inefficacy on the health-care question and why it remained committed to the employer-mandate option for so many years. A central argument here is that labor was constrained by its own lack of political imagination as well. On the health-care issue, organized labor chose to accept the given political environment and to concentrate most of its political activities and resources on what appeared to be achievable in the short term. Yet much of politics is about developing a vision that supersedes the given political environment and then using that vision as a tool or weapon to undermine, chip away at, delegitimize, and ultimately transform the existing political environment.

In contrast to what the Canadian labor movement and Canadian advocates of national health insurance did on behalf of universal health care in the 1950s and 1960s, U.S. unions neglected to develop a long-term strategy to secure universal health care embed-

106. See the special issue of *The Journal of Health Politics, Policy and Law* on the defeat of Clinton's Health Security Act, 20 (1995).

ded in some broader vision of how to restructure a decidedly unfavorable political environment.¹⁰⁷ For example, instead of accepting the conventional wisdom that it was time to just say no to any new spending on social programs, labor could have argued more forcefully for military conversion and for cuts in defense spending with the end of the Vietnam war and, later, with the waning of the cold war. Instead of giving up on Canadian-style health-care reform because of the burden it purportedly posed for the budget, organized labor could have redoubled its efforts to educate the public and state actors about the enormous cost savings associated with single-payer plans due to lower administrative expenses and other factors. Labor could have forcefully underscored how Western European countries, with their more extensive public welfare states, spend proportionally less on health care, yet still manage to achieve near-universal health care coverage.¹⁰⁸ Rather than heralding the resilience of the private welfare state, organized labor could have shown how the shadow welfare state of job-based benefits, never adequate or efficient to begin with, was under siege for a complex set of political factors and not simply because of economic pressures to be more competitive in a global market. In short, organized labor forfeited an opportunity to use the campaign for universal health care as a platform on which to develop a more encompassing and durable political movement that challenges the prevailing assumptions about the political economy and reasserts broader social aims.

107. For more on the Canadian case, see Malcolm G. Taylor, *Health Insurance and Canadian Public Policy: The Seven Decisions that Created the Canadian Health Insurance System* (Montreal: McGill-Queen's University Press, 1978); Antonia Maioni, *Parting at the Crossroads: The Emergence of Health Insurance in the United States and Canada* (Princeton: Princeton University Press, 1998); William M. Chandler, "Canadian Socialism and Policy Impact: Contagion From the Left?," *Canadian Journal of Political Science* 10 (1977): 755–80.

108. By comparison, an estimated one in every five people in the United States is without health insurance at some point in a given year. Healthline, "Health Insurance? Interruptions in Coverage Getting Shorter," June 24, 1996 (electronic database). The United States spends nearly 14 percent of its GNP on health care – or nearly \$1 trillion in 1994. By comparison, Canada, Sweden, and France spend just 9 percent of their GNP on health care; Germany spends 8 percent; and Great Britain and Japan spend just 7 percent. Paul A. Lamarche, "Our Health Paradigm in Peril," *Public Health Reports*, Sept. 1995; and Robert Pear, "Health Care Costs Are Growing More Slowly," *The New York Times*, May 28, 1996, A-13.