Abstract During the battle over comprehensive health care reform in the early 1990s, organized labor was not only unable to put together a winning coalition but also found itself divided and on the defensive as it struggled to prevent any further erosion of the private-sector safety net of the U.S. welfare state. Labor's relative ineffectiveness has deep institutional and political roots and was not merely a consequence of its dwindling membership base. Several key institutions of the private welfare state, notably the Taft-Hartley health and welfare funds and the Employment Retirement Income Security Act (ERISA) preemption, brought the interests of organized labor more closely in line with those of large employers and commercial insurers and aggravated divisions within organized labor and between unions and public interest groups. In addition, several political factors conspired to reinforce labor's tendency to stick to a policy path on health care issues that was predicated on an employer-mandate solution and that had been charted primarily by business and leading Democrats. As a result, organized labor did not emerge from the 1993–1994 struggle with its political base fortified nor with a viable long-term political strategy to achieve universal health care and to shift the political debate over health policy in a more desirable direction.

In the 1993–1994 struggle over health care reform, organized labor proved to be politically ineffective. Unions, which have played a critical part in the passage of a number of major pieces of social welfare legislation, notably Medicare (Marmor 1973; Derthick 1979), were not only unable to put together a winning coalition in the early 1990s, but also
found themselves divided and on the defensive as they struggled to prevent any further erosion of the private-sector safety net of the U.S. welfare state. Labor's political enfeeblement in the 1993–1994 battle over Clinton's Health Security Act and related health reform proposals cannot be attributed solely to its shrinking membership base.

Organized labor's capacity for political action depends on many factors, not just on the size of its rank and file. While labor's ranks certainly have thinned out since the 1950s, on other fronts unions have acquired new political resources in recent years that complicate any simple picture of inexorable political decline. These include the swelling number of activist union retirees, important favorable shifts in public opinion regarding unions, labor's formidable financial resources, and closer institutional and financial ties between organized labor and the Democratic Party. Yet analysts of contemporary health care politics tend to attribute labor's political weakness primarily to its dwindling membership and thus have had little more to say about the role of organized labor in the most recent quest for universal health care (Skocpol 1996: 84–88; Judis 1995: 71–72; Martin 1995: 433). In a similar vein, many labor officials and union staff members have been wont to blame labor's membership woes for its political setbacks in the 1993–1994 struggle over health reform.

Labor's relative ineffectiveness was not merely a consequence of its contracting membership base, however, nor of some of the other factors historically invoked to explain why unions are politically enfeebled in the United States, notably the absence of a labor party or a disciplined left-of-center party that has strong ties to labor and is able to navigate the racial shoals of U.S. politics. While these are certainly important factors, they focus more attention on labor's weakness and inactions and less on what labor actually did and why. Organized labor's political activities in the health care debate were self-defeating and demand a more direct explanation.

This article examines how the institutional context within which labor operated and the ideas to which it was committed help explain its political behavior with respect to contemporary health policy. More specifically, it focuses on two related variables. First, it considers how several institutions of the private welfare state, that patchwork of job-based

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1. For a development of this point, see Gottschalk 1997: chap. 2.
2. As a consequence, "organize the unorganized" became the mantra of delegates to the AFL-CIO's biennial convention held in October 1995, a year after the death of Clinton's Health Security Act (Moberg 1996).
social benefits sometimes called the "shadow welfare state" (Martin 1998: 233), constrained organized labor. Second, it examines how the specific stances labor took on health care reform and the specific political strategies it pursued contributed to its political defeats in this policy realm. These include labor's long embrace of a private-sector solution based on a government mandate that employers pay some portion of their employees' health insurance costs and its elusive quest for a cross-class coalition with business on health care.

As we will see, several institutions of the private welfare state became a kind of institutional straightjacket for organized labor. We will focus here on two in particular: the Taft-Hartley health and welfare funds, which are a major source of health benefits for tens of millions of Americans, and a minor provision in the Employee Retirement Income Security Act (ERISA) of 1974 that has since allowed employers and unions that self-insure to operate group health plans free of most state-level insurance regulations. Over the years, these two institutions brought the interests of the national leadership of organized labor more closely in line with those of large employers and the commercial insurers, who eschewed government-led solutions for comprehensive health reform. They also aggravated divisions within organized labor and between unions and public interest groups over health policy. These divisions and disagreements impeded efforts to knit together an effective political coalition on behalf of universal and affordable health care that would sever the connection between employment status and health benefits once and for all. As a consequence, organized labor found itself implicitly or explicitly siding with large employers or sitting mute on the sidelines during some of the major skirmishes over health policy leading up to the war over the Clinton health plan. The institutional context not only helped to define the coalitions, but also the worldview and the political strategies with which the fight for health reform would be waged.³

The specific institutional context is only part of the story, however. Several political factors conspired to reinforce organized labor's tendency to stick to a policy path on health care issues that was predicated on an employer-mandate solution and that had been charted primarily by elements of business and leading Democrats. This essay focuses in particular on why organized labor adopted and then held fast to the idea of an employer mandate despite a drastically changing economic and polit-

³ For more on how the institutional context affects coalition formation and the ways in which groups evaluate their interests and develop their worldviews, see Weir 1992, Hattam 1993, and Dobbin 1992.
The institutions of the private welfare state

While organized labor did make a number of political missteps on health reform, its difficulties were not entirely of its own making. Many of these missteps are rooted in the past. The inherited institutional context that molded labor’s political choices and the health care debate more broadly pushed labor toward private-sector solutions. It also compounded the divisions and disputes within and between organized labor and public interest groups. It needs to be noted at the outset that an interest in institutions per se is nothing new in discussions of why the United States has been unable to develop, enact, and implement comprehensive social policies except under very special circumstances (see, e.g., Weir, Orloff, and Skocpol 1988). A number of scholars concerned specifically with the politics of health policy in the United States, or the politics of organized labor more generally, have been keenly interested in institutions (Immer-
Sven Steinmo and Jon Watts (1995), in particular, contend that the fragmented and federated set of U.S. political institutions is biased against comprehensive national health insurance. Yet their analysis begs the question of why health care is defeated time and time again, as evidenced most recently by the 1993–1994 debacle, while other pieces of major legislation are able to persevere in the face of a virulent opposition and the same fragmented and federated set of political institutions. In short, what is so exceptional about health care? The health care issue is exceptional because the fragmentation of public institutions is compounded by the particular institutions of the private welfare state. These institutions of the private welfare state impede efforts to forge a winning coalition anchored by organized labor.

Several analysts have ably demonstrated how the fragmented institutional environment stymied efforts by segments of business to mobilize in the 1980s and early 1990s on behalf of some version of comprehensive health reform (Martin 1993; Berghold 1994; Brown 1994; Judis 1995). Yet few have considered how the institutional context affected organized labor's political capacity to mobilize on behalf of universal health care. Those scholars who lately have taken an interest in institutions and the politics of organized labor have tended to focus on the distinctive political structures and public institutions of the U.S.—such as the weak and undisciplined party system—and not on how the particular institutions of the private welfare state might affect labor's political fortunes in public policy (Piven 1991; Dubofsky 1994; Rogers 1993). Those few analysts who have concerned themselves with labor, health policy, and the private welfare state have tended to concentrate on much earlier periods and then to extrapolate briefly to the present (Derickson 1994; Stevens 1990; C. Gordon 1997). For example, Alan Derickson and Beth 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 1950s. This shift, in their view, subsequently posed formidable obstacles to achieving universal health care over the long run. Yet, the line 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

4. One notable exception is Weil 1997.
postwar years to the present not only fail to explain the twists and turns over time, but more important, fail to identify the mechanisms that perpetuate certain policy preferences.

Two institutions of the private welfare state—the Taft-Hartley health and welfare funds and what became known as the ERISA preemption or semipreemption—were key in molding labor's interests and, indeed, its political strategies and worldview. It is important to clarify briefly the historical development of these two institutions before discussing in greater detail the dramatic and pervasive effect they had on the politics of health policy in the early 1990s.

Among other things, the Taft-Hartley Act of 1947 established the institutional framework for collectively bargained health, welfare, and pension trust funds. These funds provide employers with a mechanism to contribute to benefit packages without assuming the administrative burden and expenses entailed in single-handedly running their own benefit programs.5 Today about 10 million American workers and 20 million of their dependents receive pension, health, and/or other benefits from joint labor-management plans established in accordance with the Taft-Hartley Act (International Foundation 1988; National Coordinating Committee for Multiemployer Plans [NCCMP] Taft-Hartley n.d.; NCCMP Multi-employer n.d.). More than half of all union members covered by health plans receive their medical benefits through Taft-Hartley funds (Dunlop 1983: 10).

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.6 Over the next two decades, the Taft-Hartley plans gradually took root, as did labor's attachment to them. The fact that this attachment was slow in coming is underlined by noting that when organized labor made its last major push for national health insurance in the early 1970s, labor officials were not unduly alarmed by legislative proposals that would have put the Taft-Hartley funds largely out of the health insurance business (Seidman 1996).7 By the late 1980s, however, many national labor leaders, especially those of the building trades, were

5. The typical Taft-Hartley plan requires employers to contribute some negotiated amount to a pension, health, and/or welfare fund. Employers usually are not actively involved in either the administration of the plan or the design of benefits.
6. See, for example, George Meany, letter to National and International Unions, State Federations, City Central Bodies, and Regional Organizers, 7 January 1953 (AFL-CIO Department of Legislation Collection, Box 24, Folder 39); and Millis and Brown 1950: chap. 15.
7. See also Bert Seidman, letter to Al Barkan, et al., 21 May 1970 (AFL-CIO Department of Legislation Collection, Box 25, Folder 24).
fighting tooth and nail to preserve the Taft-Hartley arrangements, even though many of these funds were under acute financial stress due to escalating health care costs and other factors. They were cool by now to single-payer proposals for national health insurance, preferring instead private-sector solutions based on an employer mandate.

Some labor leaders were reluctant to eliminate the funds because they viewed them 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 (Ray 1996; Nixon 1996; St. John 1996). Moreover, the Taft-Hartley funds had created a potential conflict of interest for organized labor because in effect they catapulted some union officials into the lucrative insurance business and thus served to realign the interests of some labor leaders more closely with those of large employers and insurers (Goozner 1991). Notably, in 1991, Robert Georgine, head of the building and construction trades department of the American Federation of Labor-Congress of Industrial Organizations (AFL-CIO), became chairman and chief executive officer of Union Labor Life Insurance Company (ULLICO), a private company that provides insurance for and manages the Taft-Hartley plans of hundreds of union locals (Crenshaw 1994, 1995).

Finally, and most important, thanks to the enactment of ERISA, the funds helped spawn an important coincidence of interests between unions that operate health and welfare funds and large employers, both union and nonunion. Enacted in 1974, the year of labor's last big push for national health insurance, ERISA included a clause that the courts subsequently interpreted to mean that states are permitted to regulate employer-provided group health insurance if the employer purchases it from an insurance company but not if the employer is self-insured. Representatives of labor at the national level worked side by side with large employers to slip the preemption language into ERISA (Fox and

9. See also J. Peter Nixon, memo to Hal Alpert, president of Local 531 of the SEIU, dated 2 March 1994 (Nixon Papers).
10. Richard Trumka, president of the United Mine Workers, reportedly tried but failed to have Georgine disqualified from voting on the critical issue of whether or not the AFL-CIO should endorse a single-payer plan when it came before the federation's health care committee in the 1990-91 period, charging that the head of ULLICO had a conflict of interest (McGarrah 1996; Ray 1996).
11. Firms that self-insure use their own assets to fund their health benefit programs and typically hire outside companies to administer the plans.
Schaffer 1989). Over the years, large employers and unions with large Taft-Hartley funds became increasingly committed to retaining the ERISA preemption as more of them switched to self-insurance so as to circumvent state laws mandating that group health insurance policies cover certain specified medical services (Jensen, Morrisey, and Marcus 1987; Treaster 1996). By the early 1990s, nearly 60 percent of Americans who were insured through their employers were covered by self-insured plans and more than half of all Taft-Hartley funds had switched to self-insurance (Gladwell 1992; U.S. Congress 1993c).

The ERISA preemption and the Taft-Hartley funds pose sizable obstacles to state-level initiatives to reduce health care costs while expanding access (Chirba-Martin and Brennan 1994; Parmet 1993). Together they have helped to short-circuit the state-level political experimentation and initiatives that in the past paved the way for the nationalization or quasi-nationalization of social welfare schemes like old-age security and workers' compensation in the United States and universal health care in Canada. For states desiring to experiment with some kind of single-payer plan of their own, the Taft-Hartley funds and other self-insured plans, inoculated as they are from state-level mandates by the ERISA preemption, lie tantalizingly beyond their legislative and regulatory reach.

Unions continued to stick by the ERISA preemption even though employers used it to perpetuate some highly discriminatory practices involving medical care. Thus, organized labor found itself on the opposite side of the barricades in the early 1990s from public interest groups that were battling the ERISA preemption in the courts. For example, organized labor did not join a number of public interest groups that mobilized on behalf of John McGann, whose health benefits for the treatment of AIDS were reduced from $1 million to $5,000 after his employer switched to a self-insured plan (Pear 1991, 1992; Stoddard 1992). And in 1993 organized labor found itself on a collision course with advocates for the handicapped and AIDS activists when the Equal Employment Opportunity Commission (EEOC) enlisted the Americans with Disabilities Act of 1990 to challenge employers and unions that attempt to use the ERISA preemption to deny health insurance coverage to people with AIDS and other costly illnesses (Oppel 1993; Michelini 1995).

In short, the establishment of the Taft-Hartley funds had several unintended consequences. It put some union officials in the insurance business and gave them a vested interest in maintaining the status quo—that is, a system of social welfare provision rooted in the private sector and
specifically based on job-related benefits. ERISA subsequently helped to fortify the coalition of unions and employers in favor of the status quo. These two institutions did not chain labor to the private welfare state overnight. Rather, they gradually pulled it in that direction. A vested interest in preserving the Taft-Hartley funds and ERISA preemption molded labor's political preferences and behavior, predisposing it to private-sector alternatives. The impact of these institutions was uneven, however, more so on some unions than on others, and more so in some time periods than in others. Nevertheless, labor's concerns about preserving these two institutions directly affected the course of the struggle over health reform in the 1990s, in particular the fate of Clinton's Health Security Act.

**The Employer-Mandate Idea**

The Taft-Hartley funds and the ERISA preemption did not create the job-based system of health benefits. Rather, they helped to lock it into place and to solidify the commitment of organized labor to the private welfare state. As such, they served as protective walls around the private welfare state.\(^\text{12}\) It is important to keep in mind, however, that institutions are not destiny. As such, institutional factors alone do not explain labor's political strategies and political setbacks in its quest for universal care. We need to understand the role of ideas and, specifically, how labor helped to bolster a particular understanding of the U.S. political economy that took hold beginning in the late 1970s and that changed the debate over health care in subtle but important ways. Just as institutions can cause groups to rethink their interests and form new alliances, as we saw above, so can ideas. We will focus here on the political trajectory of one policy idea in particular—the employer mandate—that both complemented labor's institutional attachments discussed above and helped perpetuate its commitment to private-sector solutions to health problems.

Paradoxically, as the bond between employer and employee weakened beginning in the late 1970s with the growth of the contingent workforce, such that the very definition of what constitutes an employee would become a highly contested issue by the early 1990s, organized labor's commitment to an employment-based system of benefits rooted in the private welfare state became more intense. The previous section ana-

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12. I am indebted to Professor Alan Draper of St. Lawrence University for this metaphor.
lyzed the institutional underpinnings of this commitment; this section examines its ideational roots. As a result of these institutional and ideational commitments, unions became less willing to battle for national health insurance modeled on some single-payer formula.

Despite significant misgivings among long-time supporters of national health insurance about the feasibility of an employer mandate, organized labor finally embraced this idea in 1978 after having spurned it since 1971, when President Richard Nixon first proposed an employer-mandate solution. As key Democrats, notably President Jimmy Carter and Sen. Edward M. Kennedy (D-MA), cooled to the idea of national health insurance, labor leaders hoped at the time that such a rightward compromise on labor's part would make unions part of a broader winning coalition and yet would not foreclose the possibility of achieving the ultimate goal of universal coverage (Wicker 1977; New Kennedy Bill 1979).

When it was initially adopted, the employer-mandate idea was thus a kind of focal point that served to reconcile temporarily the interests of state, labor, and business leaders such that they could forge a loose coalition on behalf of comprehensive health reform. Over time, this policy idea took on a life of its own, however, as it became embedded in a compelling causal story that appeared to explain some of the major shortcomings of the U.S. political economy. This causal story would have important consequences for the course of the debate over health policy, especially labor's political efficacy on health reform and other matters.

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 (Stone 1989: 282). Policy and political outcomes depend in part on how one particular definition and explanation of a problem wins out. As such, new ideas often take flight on the wings of compelling causal stories that come to be accepted as fact, not as interpretations.

Labor's fierce attachment to the employer-mandate idea over the years impeded its ability to come up with its own independent causal story.

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13. James C. Corman, letter to Douglas A. Fraser, 20 December 1978 (UAW Fraser Collection, Box 2, Folder 23); and Keith W. Johnson, letter to Douglas A. Fraser, 17 January 1979 (UAW Fraser Collection, Box 2, Folder 21).

14. See also Max W. Fine, letter to George Hardy, 30 May 1978 (UAW Schlossberg Collection, Box 56, Folder 43); and Committee for National Health Insurance, report sent to technical committee, 13 April 1978 (CNHI Collection, Box 15, Folder 20).

15. For more on "focal points," see Garrett and Weingast 1993.
about the relationship between the shortcomings of the U.S. political economy and the roots of the nation's health care dilemmas. As a consequence, organized labor was increasingly unable to develop a political strategy for universal health care that was independent of the perceived wishes and preferences of the business sector. Thus, labor was poorly situated to mobilize a wider constituency on behalf of universal health care, one that could outlast the political logic of the moment such that it could reshape health policy over the long run.

The Clinton administration's Health Security Act was developed and sold on the basis of several assumptions about the U.S. political economy and welfare state that had emerged during earlier debates over health care initiatives based on an employer mandate. In its eagerness to forge some kind of an alliance with business based on the idea of an employer mandate, labor not only embraced but even promoted these broader assumptions during the 1980s and 1990s. 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; 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. As such, these costs represented perhaps the prime threat to the U.S. economy and were the root cause for most of the economic woes of the American worker. Taken together, these assumptions helped give shape to an alternative worldview, one that was quite sympathetic to business. These assumptions were just that—assumptions. Yet organized labor treated them as a set of inevitable facts that were not subject to debate in the context of discussions of health care reform. However, a sustained and independent questioning of these assumptions might have revealed their contingency and highlighted that they were propositions rather than uncontestable truths.

For example, the heartfelt belief among labor leaders and other would-be reformers (including eventually Hillary Rodham Clinton) that business in the end would 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 (U.S. Congress 1987: 75; Bieber 1987; D. Jacobs 1989; U.S. Congress 1993b: 5) was a leap of faith in a few important respects. First, business support for comprehensive health reform based on some kind of employer mandate may have been broad, but it certainly was not deep,
as labor officials would belatedly discover. Moreover, 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 in the midst of a radical transformation as firms began to experiment widely with cutbacks in health and other benefits and with new ways of organizing the workforce, notably a greater reliance on part-time and other contingent workers (Polivka and Nardone 1989: 13–14; D. Gordon 1996: 226–227). From the 1970s onward, employment-based health coverage began to shrink (Swartz 1989) as the initiative in industrial relations shifted radically from union to nonunion firms and from labor to management in ways that would have important consequences for the private-sector safety net, including health benefits (Kochan, Katz, and McKersie 1986: 9, chap. 3; Jacoby 1991: 283; Strauss 1984: 3). Yet despite the rapid increase in the number of temporary, part-time, and self-employed workers, the plight of contingent workers remained marginal to most discussions of health reform during the 1970s and 1980s, even though such workers are more likely to be uninsured or underinsured (Levitan and Conway 1988; Pemberton and Holmes 1995: 263).

To sum up briefly to this point, the employer mandate incorporated in the Clinton proposal and its legislative forerunners was pitched as a fundamentally conservative solution to the nation's health care woes. By making the case for an employer mandate based on the argument that most employers were already providing their employees with health benefits, and that, as such, this solution was a moderate one, 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. It also downplayed the huge gaps and inequities on which the private welfare state was built. As a result, trapped by ideas it had adopted earlier, labor helped to minimize just how vulnerable the institution of job-based benefits was to shifting political and economic winds. In reality, employers in many sectors of the economy retained enormous capacity to engineer a retrenchment of the private welfare state in quick order.

Organized labor largely left it to state actors—and then to business—

16. For a development of this point, see Gottschalk 1997: chap. 5.
17. See, for example, the congressional deliberations surrounding the 1987–88 Minimal Health Benefits for All Workers Act, which was based on an employer mandate, and the final report of the bipartisan Pepper Commission, which endorsed a modified employer-mandate solution by a bare majority (U.S. Bipartisan Commission 1990).
to decipher the shifts in the U.S. political economy and thus to define the
nation's preeminent economic problems. Labor leaders eventually endorsed
the idea of an employer mandate, acting more as passive transmitters of
ideas rather than as active, independent initiators. Thus, organized labor
initially pursued what appeared to be the most politically expedient solu-
tion at that moment and subsequently continued along a policy path con-
sistent with its prior commitment to the idea of an employer mandate. In
contrast to what the Canadian labor movement and Canadian advocates
of national health insurance had done on behalf of universal health care
in the 1950s and 1960s, unions in the U.S. did not embed their health
care strategy in a longer-term political strategy derived from a compre-
hensive and independent analysis of the rapidly changing political and
economic context.18

Labor's attachment to the institutions of the private welfare state and
its embrace of a probusiness worldview, including a commitment to the
employer mandate, spurred unions to pursue what turned out to be
self-defeating political strategies. It is important to mention here, how-
ever, that organized labor was not of a single mind about health reform
in the late 1980s and early 1990s. As noted above, the impact of institu-
tions and ideas was uneven. Just at the moment when single-payer pro-
posals and the Canadian medical system were attracting wider attention
and gaining respectability among policy makers and the general public,
some labor unions were bitterly divided over this issue. However, several
AFL-CIO officials eventually succeeded in neutralizing the remaining
support within organized labor for a single-payer system. John J. Sweeney,
chairman of the federation's health care committee and president of the
Service Employees International Union (SEIU), played a pivotal role
here, as did Lane Kirkland, president of the AFL-CIO.

At the time, Sweeney and Kirkland cautioned unions to avoid endors-
ing any specific legislation so as not to preclude the possibility of build-
ing a consensus with other groups, including business (Kearns 1989).
This was a major theme of a series of hearings on health care issues
that the AFL-CIO conducted around the country in fall 1990 (AFL-CIO
1990). 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

18. For more on labor and the Canadian case, see Taylor 1978, Maioni 1998, and Chandler
1977.
 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.  

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 described earlier, 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 (Colatosti 1990).

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 (S. Gordon 1991). At a critical and contentious meeting in early 1991, the health care committee of the AFL-CIO deadlocked 8 to 8 over whether to endorse the single-payer option. Faced with such an impasse, the AFL-CIO's executive council responded at the time by endorsing what appeared to be a "let a hundred flowers bloom" approach to national health reform and issued a statement supporting some vague "principles" for health care (O'Neill 1991).

Yet like the original Hundred Flowers campaign four decades ago in China, this one quickly lost its bloom as Kirkland and Sweeney clearly remained committed to the employer-mandate formula and to undercutting the single-payer position. That summer eight union presidents sent an angry letter to Kirkland complaining about indications he had given Rep. Dan Rostenkowski (D-IL) that all of the AFL-CIO unions, including the single-payer contingent, would support the employer-mandate

19. See, for example, Jobs with Justice newsletter, Report on Health Care Action Day—3 October 1990 (Amalgamated Clothing Workers of America [ACWA], Box 5); and McClure 1990.

20. See, for example, Robert McGarrah, letter to Gerald McEntee, 6 November 1990 (McGarrah Papers), and Robert McGarrah, letter to Gerald McEntee, 21 May 1990 (McGarrah Papers).

21. Sweeney reportedly was a widely acceptable choice to head the federation's health care committee precisely because his union, the SEIU, had extensive Taft-Hartley commitments (Nixon 1996).

22. 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). See also Frieden 1991: 42-44.
measure that the chairman of the House Ways and Means Committee was then pushing on Capitol Hill. In their view, the proposed bill did not even conform to the general principles adopted by the federation six months earlier. Three months later at the federation's biennial convention, speaker after speaker rose to denounce the Canadian model as politically unfeasible. The eleven international unions that favored a single-payer plan were mostly silent on the convention floor as the delegates passed a vague resolution that reaffirmed the federation's commitment to some unspecified restructuring of the health care system (AFL-CIO 1991). The real drama at the convention took place off the floor as Sweeney announced at a press conference the release of a report from the National Leadership Coalition for Health Care Reform (NLCHCR)—a coalition of unions, large employers, and advocacy groups—that called for an employer-mandate solution. Sweeney applauded employers' new willingness to make common cause with labor on health issues. Meanwhile, a representative of the American Federation of State, County and Municipal Employees (AFSCME) distributed a letter from the union's president, Gerald McEntee, that took issue with Sweeney and made a strong pitch for a single-payer plan (Colatosti 1992).

While Kirkland and Sweeney were able to keep the AFL-CIO from officially straying down the single-payer path, they were unable to quell completely the growing sentiment in several unions for a Canadian-style solution. 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.

Organized Labor, Clinton, and the Politics of Health Reform

Almost immediately after the election, labor appeared to close ranks quickly and effortlessly around Clinton on the health reform question. Yet, in fact, divisions simmered between unions and between the leadership and the rank and file. And the twin battles over NAFTA and health care reform in the summer and fall of 1993 helped to bring some of these divisions to the fore and to debilitate organized labor. These divisions

had institutional and political roots that reinforced one another. On the institutional side, as suggested earlier, was organized labor's commitment, especially the commitment of labor's leaders, to the Taft-Hartley funds and the ERISA preemption. On the political side, as also suggested earlier, was its commitment to the idea of an employer mandate, which meant seeking an alliance with business on health reform and distancing itself from the single-payer forces. After documenting some of the debilitating divisions within labor's ranks in this section, I will trace in the following section how the ideational and institutional underpinnings of the private welfare state exacerbated these tensions.

Days after Clinton was elected, AFSCME and the United Auto Workers (UAW), two critical anchors of the single-payer coalition, rejected a proposed postcard campaign on behalf of a single-payer plan, as well as the idea of making a bus caravan to Little Rock, Arkansas, to press their views. "We made a conscious decision not to do a grassroots campaign," explained Alan Reuther, legislative director of the UAW. "We saw it as setting our people all up to be pissed off at Clinton" (Reuther 1996). Officials from these two unions reportedly told other health care activists that they would only work from "inside" the Clinton team to influence the course of health reform. At the time, the defection of the UAW and AFSCME was perceived as "deeply wounding" to the single-payer coalition (Whoa 1992).

Several other unions, including the Communications Workers of America (CWA), the Teamsters, the International Ladies Garment Workers Union (ILGWU), and the Oil, Chemical, and Atomic Workers (OCAW), were less reluctant to put pressure on Clinton in the weeks immediately following the election (McClure 1993a). However, as the outlines of the Clinton plan began to take shape in the months afterward, most of these single-payer unions attempted to straddle the health care question. While they remained ostensibly committed to a single-payer solution, they increasingly found virtue in the plan the White House appeared to be putting together (McClure 1993b).

AFSCME's McEntee, who had been a pivotal voice for a single-payer plan over the years, was again a pivotal figure in swaying organized labor to go easy on the new president. At a meeting of the AFL-CIO's health care committee in early 1993, AFSCME reportedly voted in favor of managed competition, breaking with the single-payer contingent on the committee for the first time as the committee deadlocked 8 to 8 between supporters of managed competition on one side and single-payer advocates on the other (Boatman 1993). In a statement issued by the fed-
eration's executive council in February 1993 shortly after the deadlocked vote, the AFL-CIO did not mention the single-payer solution. Instead, the federation commended President Clinton for his leadership on health care and issued a two-page list of vague principles that it said should guide the drafting of any health reform legislation. It had little to say, however, about what labor was prepared to do politically to make universal health care a reality (AFL-CIO 1993a).

Despite the lack of any major legislative or political victories for labor in the months leading up to the official introduction of the Health Security Act in fall 1993, organized labor's commitment to the president did not waver much, at least in public (Moody 1993, 1993b; Brooks 1993; Del Valle 1993). In the summer of 1993, Ralph Nader's Public Citizen group attempted to enlist labor in its efforts to plan a major event to launch a campaign for Canadian-style reform that fall. But the consumer advocacy organization was unable to mobilize much support from organized labor because union officials said that they did not want to get involved in any activity that might be construed as opposition to the president (Ridgeway 1993). Clearly, the institutional and ideological influences discussed above were in full operation by now, especially among labor leaders. Even after Clinton decided to make the passage of NAFTA a top priority, relations between labor leaders and the White House remained cordial. When Clinton appeared as the keynote speaker at the AFL-CIO's twentieth convention in October 1993 at the height of the struggle over NAFTA, Kirkland vowed, "By and large, his agenda is our agenda, and we are and will be his most loyal troops" (AFL-CIO 1993b: 9).

This close identification with Bill Clinton's agenda ended up vexing labor with a serious case of political cognitive dissonance that undermined its stated quest for universal health care. This is most apparent in the drastically different approaches that the AFL-CIO and major unions took simultaneously in their campaign against NAFTA and on behalf of health care reform. By the time Clinton unveiled the broad outlines of the Health Security Act on 22 September 1993, organized labor and many Democrats were already distracted by the growing demands of the anti-NAFTA campaign they were waging (Salwen 1993; Clark 1994). At the same time that unions were engaged in this pitched battle with business and the White House over the free-trade agreement, they were trying to make the case that both of them could be counted on to be constructive partners on the health reform issue. As such, the political message was decidedly mixed and inconsistent. In the struggle over NAFTA, labor leaders faulted U.S. multinationals for what they characterized as a ruth-
less and unwarranted effort to shift production to low-wage countries with laxer environmental and labor standards, at great cost to the American worker (Moberg 1993; Richman 1993). Unions sought to make the treaty a referendum on how corporate America was failing the average American worker and his or her family. Yet in discussions of health care, labor officials conceded, 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 (see, e.g., UAW 1992: 123, 142).

As an analytical aside, it should be noted that labor's contrasting approaches to NAFTA and to the health care debate dramatically underline 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 reform matters, even though this strategy was fraught with contradictions. The latter strategy only makes sense when one keeps in mind labor's imperfect but longstanding attachment to the private welfare state's institutions for health care provision and to the idea of an employer mandate.

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. While the report mentions in passing how "slow productivity growth and structural changes in the U.S. economy" (SEIU 1992: 3) have contributed to falling wages, it identifies health care costs as the main villain responsible 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 "noncompetitiveness of American businesses" (1). The report identifies the growing health care cost burden as an important 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 (SEIU 1992: 1-10).

In the case of the free-trade agreement, unions sought to energize their grassroots supporters for what they hoped would turn out to be a highly
partisan fight that, simply put, would pit labor against capital. In doing so, organized labor forged some unprecedented alliances with consumer, environmental, farm, labor, and civil rights groups at home and abroad. In the case of health care reform, however, organized labor threw its lot in with an avowedly nonpartisan group composed of a loose-knit coalition of consumer, provider, business, and public interest groups called the Health Care Reform Project, which was slow to get off the ground (Priest and Weisskopf 1994). The members of this coalition were united by their shared commitment to the general idea of comprehensive reform of the U.S. medical system and by their expressed willingness to work with Congress, the administration, and the two main political parties to find an acceptable solution.

As the smoke cleared from the NAFTA battle following congressional approval of the treaty in November 1993, it appeared for a moment as if organized labor might finally stake out a political path that was more independent of the Clinton White House. At the time, labor leaders were embittered over the way the administration had conducted its campaign for ratification of the trade agreement in the eleventh hour and used uncharacteristically harsh language to denounce the White House (Clinton-Republican 1993; Kirkland 1993). Several union leaders vowed to punish at the polls those senators and representatives who had supported the treaty, a promise that went largely unfulfilled (Nomani 1994; Apple 1994; Gordon 1994). The AFL-CIO did, however, cut off funding to the Democratic National Committee for a period of almost six months. This left the DNC's campaign for health care reform, which was already strapped for money, in a real pinch (Johnson and Broder 1996: 292). Labor leaders acknowledged that their rank and file had been alienated by the great lengths the administration had gone in order to pass a measure that they perceived as deeply detrimental to their interests. They also warned that the business-Republican alliance Clinton had forged for NAFTA would not hold in the health care debate. Kirkland and other labor leaders conceded that the NAFTA setback had deflated the rank and file's enthusiasm for Clinton, thus jeopardizing the prospects for his Health Security Act (Byrne 1993; St. John 1996; Baker 1996; Reuther 1996). In early December 1993, the AFL-CIO introduced a plan designed to train union activists in how to educate the rank and file about the Clinton plan (O'Neill 1993b). However, federation officials postponed sending their staff members into the field for several weeks because of the rank and file's continued hostility to Clinton over NAFTA. Over the next few weeks, the Clinton administration intensified its efforts to smooth the
ruffled feathers of organized labor as senior labor officials appeared to distance themselves from the glowing endorsement they had given to Clinton’s Health Security Act in early October (Kilborn 1994a; Friedman 1993).  

Despite Kirkland’s personal reaffirmation of labor’s commitment to the Clinton framework for health care reform in early 1994 (O’Neill 1994), debilitating divisions simmered within organized labor. The complex nature of the Clinton proposal compounded these divisions over reform. Training sessions for union activists tended to concentrate on providing detailed explanations of how the Clinton plan would work in practice and reassuring union members that they would not be made worse off by the Health Security Act. As such, little time was devoted to explaining the political rationale behind labor’s support of the Health Security Act and to discussing how to rev up the rank and file for the fight for comprehensive health reform (Henry 1996). It appears that rank-and-file union members were not the only ones who felt uneasy about the complexities of the Clinton plan and who needed to be convinced that the Health Security Act would not leave them worse off. Asked what he thought of the Clinton plan, Robert M. McGlotten, who was legislative director of the AFL-CIO at that time, bluntly said after the fact, “It scared me to death” (McGlotten 1996).

The single-payer activists among organized labor’s rank and file remained reluctant to heed the leadership’s call for a united front with the Clinton administration on health care reform. For many years, the rank and file of those unions that had been the most active on health care issues, including the UAW, AFSCME, and the ILGWU, had been hearing from their leadership about how a single-payer plan was the only way to go in terms of access, affordability, simplicity, savings on administrative costs, and preservation of freedom of choice for patients. Yet, now they were being told to mobilize in support of a complicated, untried plan that was rooted in the existing job-based system of benefits and that retained a sizable role for the major commercial health insurers. Moreover, the plan had been hatched by a president who had just kicked sand in labor’s face during the NAFTA struggle.

These rank-and-file activists were emboldened by two related developments to stay the single-payer course in defiance of their national leadership. First, public interest groups with whom organized labor had established closer ties during the NAFTA fight began making direct appeals

to labor's rank and file on behalf of Canadian-style solutions. Second, a new movement to establish a labor party as an alternative to the Democrats and Republicans had emerged in the early 1990s and had singled out national health insurance as one of its top priorities. This movement presented neither an immediate threat to the Democratic Party nor a serious challenge to the pro-Democratic Party line of the leadership of the AFL-CIO. However, it did provide a new venue for disgruntled labor activists to pursue an alternative political agenda and to link the single-payer issue to other broader social and economic concerns. As such, it provided an opportunity for political activists to focus not just on the legislative battle of the moment but on the development of long-range strategies to engineer a major and enduring political shift.

In the 1993–1994 period, single-payer activists from Ralph Nader's Public Citizen made a conscious effort to court labor's rank and file through visits to union locals in which they explained why, in their view, the single-payer approach was superior to the Clinton plan. Single-payer activists revved up labor's rank and file with facetious slogans that poked fun at the alleged lack of political imagination that went into developing and selling the Health Security Act. These attempts to appeal directly to the locals over the heads of their national leadership jeopardized the new climate of détente that had emerged in the struggle over NAFTA as liberal public interest groups and the mainstream of organized labor were able to overcome some of their historic antagonisms and work together with a degree of cooperation that was perhaps unprecedented.

These efforts by liberal-leaning public interest groups to appeal directly to the rank and file on behalf of Canadian-style health reform were not the only new source of tension. In the late 1980s a handful of public interest and labor activists had begun working together to lay the foundation for a third political party; in early 1991 they formally launched the Labor Party Advocates (Moody 1991; Slaughter 1993). Their actions heightened tensions both within organized labor and between the national leadership of organized labor and certain public interest groups (Slaughter 1995).

The 100,000-member OCAW union was the main catalyst behind this movement to organize a third party. Third-party activists in the OCAW and other unions placed national health insurance at the center

25. Two of the slogans that sparked chuckles from union members were: "Hey, hey, ho, ho, arguably better than the status quo," and "What do we want? Universal health coverage. When do we want it? As soon as the savings are available" (Nichols 1996).
of a new social agenda around which they hoped to organize a viable labor party. In contrast to many other labor leaders, OCAW officials regularly expressed doubts in public about the degree to which business could be counted on to cooperate with labor to find an acceptable health care solution and viewed the issue of universal health care as a pillar on which to build a wider critique of U.S. corporations (Labor-Management 1988; OCAW 1991a: 6). OCAW officials did not shy away from drawing a connection between the health care issue and broader questions about the role of corporations in the U.S. (Hoyle 1993; Wages 1993; We Were Never Meant 1992). In its coverage of health care matters, the OCAW's leading publication did not just document the problems of the U.S. health system and explain why Canadian-style reform could ameliorate many of these difficulties. Unlike most other unions, the OCAW published detailed articles about the political context out of which national health insurance in Canada was born. Over the years the OCAW also pointedly challenged what it viewed as the AFL-CIO's wait-and-see approach to health care reform and its favorable stance toward employer-mandate proposals.

The OCAW was one of the few single-payer unions that did not attempt to straddle the health care issue in the 1993–1994 period. Instead, it unequivocally rejected the Clinton plan. A number of other unions tried to have it both ways. They would say nice things about the Clinton plan, yet attempt to keep one foot, or at least one toe, in the single-payer waters. In justifying their retreat on the single-payer question, many representatives of organized labor dismissed Canadian-style reform proposals as not politically feasible or politically viable. They stuck to this position even though single-payer proposals had attracted the greatest number of cosponsors and even though the Congressional Budget Office (CBO), which was required to cost out all health reform proposals, had deemed single-payer plans very cost effective (Skocpol 1996: 292, n. 47; McNamee 1993).

To sum up, in the 1993–1994 period labor was divided over whether or not to assume a more confrontational stance vis-à-vis the Democrats. Differences over the single-payer approach further divided labor and opened up schisms within the public interest community. Lingering hostility to President Clinton because of his zealous support of NAFTA made it difficult to mobilize the rank and file on behalf of health reform, as did the

26. See, for example, the OCAW Reporter cover story on health care (1990) and Hoyle 1993.
mixed, inconsistent, and at times contradictory messages that organized labor employed simultaneously in the NAFTA and health care reform debates. Furthermore, organized labor's mainstream, which had begun to erect some important bridges with liberal-leaning public interest groups during the struggle over NAFTA, was unable for various reasons to utilize these connections to forge a winning coalition for health care reform. "Labor was fractured. It couldn't really decide what it wanted," explained long-time congressional staffer David Abernethy (1996). Another key Capitol Hill staffer on health matters described labor unions as "being at war with each other" over health care reform at this time.28

Organized Labor, Clinton, and the Institutions of the Private Welfare State

The inherited institutional context compounded these divisions over health care reform within organized labor. Unions that depend heavily on Taft-Hartley funds for their health benefits remained reluctant to give them up, and this had far-reaching consequences for the fate of the Health Security Act and other comprehensive reform proposals. These unions fought long and hard to get a provision included in the Health Security Act that would permit Taft-Hartley funds with 5,000 or more members to opt out of the proposed health alliances if they so wished. The main lobbying group for the Taft-Hartley plans, the NCCMP, hailed the Clinton plan with its 5,000-member cutoff as a welcome prod to force smaller, less efficient Taft-Hartley funds, which had resisted efforts over the years to get them to merge, to finally do so in order to remain independent of the alliances (Ray 1996; SEIU 1993:9). In giving his endorsement to the Health Security Act, NCCMP chairman Robert Georgine stressed that under the Clinton plan, many Taft-Hartley funds could continue doing business as usual (U.S. Congress 1993c:103).

This opt-out provision for the Taft-Hartley funds ended up strengthening the hand of large employers, many of whom, as members of the Corporate Health Care Coalition, had been lobbying hard for such a provision for themselves. Once organized labor had successfully made the case that large Taft-Hartley funds should be free to choose whether or not to join a health care alliance, it became that much more difficult for unions to argue that all large employers should be required to participate in the alliances. Kirkland of the AFL-CIO testified on Capitol Hill that

28. His remarks were not for attribution.
while organized labor did not like the provision in the Health Security Act that would permit large employers to remain outside the alliances, "if it's necessary to broaden support for the plan, we're prepared to live with it" (Parks 1993).

Some union officials went ballistic over Kirkland's efforts to preserve the independence of large Taft-Hartley funds and to keep them out of the alliances, however. They contended that by doing so labor was sanctioning the deleterious practice of carving up the health care market in a way that would essentially perpetuate the practice of experience rating. As such, the health care alliances would end up as the dumping grounds for less healthy people in need of greater—and more costly—medical care. Furthermore, by securing an opt-out provision for organized labor, they charged, unions helped open the door to a lengthy debate over just how low to set the cutoff point for requiring private-sector employers to join the alliances. In discussions of the Health Security Act, a cutoff point as low as 100 employees was seriously considered (which in effect would have allowed more than half the workforce to remain outside the alliances).

The institutional context antagonized the divisions within organized labor over health reform in a second respect. Not wanting to appear as if they had totally sold out on the issue of Canadian-style reform, unions with strong single-payer contingents pushed the Clinton administration to incorporate some single-payer language into the Health Security Act, reportedly against the wishes of AFL-CIO president Lane Kirkland. They were joined in their efforts by a number of public interest groups, notably Consumers Union, which called upon the White House to provide federal financing to help individual states establish single-payer programs if they so wished (Consumers Union 1994: 26; Shearer 1996). In the end, the White House did include a measure in the Health Security Act that would allow states to create single-payer systems of their own if they so chose. This neither-fish-nor-fowl legislative compromise proved to be highly

29. Under experience rating, health insurance is priced on the basis of the health experience of a particular group. The alternative is community rating, whereby the entire community assumes the risk for those who might become ill; under that system insurance rates do not vary much from one individual to the next in a given community.

30. AFSCME, whose membership is made up primarily of government employees, was particularly upset because the Health Security Act, as originally proposed, permitted large employers in the private sector and private-sector unions with big Taft-Hartley funds to keep their employees and members out of the alliances. Yet it required all public employees to participate in the new system (McGarrah 1996; Robert McGarrah, memo to Gerald McEntee, 22 April 1994 [McGarrah Papers]).


Not surprisingly, corporations were here joined in their efforts by unions that rely heavily on Taft-Hartley funds to provide benefits to their members. These unions feared that the single-payer provision in the Health Security Act would permit states either to force unions to give up their Taft-Hartley funds or to begin dictating to labor how to run these funds (Ray 1996; U.S. Congress 1993c: 103–105). In short, the single-payer provision appeared to put the ERISA preemption so cherished by employers that self-insure and unions with Taft-Hartley funds on a collision course with the Health Security Act (Wise 1993). Labor's extreme sensitivity to the ERISA issue reportedly prompted the AFL-CIO to pull its support from the eleventh-hour compromise legislation proposed by Sen. George Mitchell (D-ME) in the summer of 1994. The proposal appeared to threaten the sanctity of the preemption by permitting government surcharges on Taft-Hartley funds for the first time.32

Even some unions without sizable Taft-Hartley commitments, notably the UAW, did not favor the idea of allowing individual states to create their own single-payer plans. The UAW and other unions with multistate contracts feared that the emergence of a hodgepodge of single-payer plans at the state level would impede their efforts to negotiate and implement uniform contracts spanning several states (Reuther 1996). This fear of jeopardizing multistate contracts and of weakening the ERISA preemption through state-level initiatives tended to reinforce a longstanding tendency within organized labor to look askance at social reform efforts at the state level.

Historically, the AFL-CIO and its antecedents have tended to be ambivalent or downright hostile toward attempts to extend the safety net on a state-by-state basis. Among other things, federation officials have feared losing control of the social welfare agenda to the states. Moreover, they have feared that the most socially backward and poorest states would end up setting the national standard for social welfare. They also

32. In the words of James Ray of the NCCMP, unions with Taft-Hartley funds "went berserk" over the Mitchell proposal and were proud to have brought it down (Ray 1996).
have questioned the capacity of individual states to develop and implement comprehensive social welfare reform programs on their own.\textsuperscript{33} Gerald M. Shea, who headed the federation’s 1993–1994 health care reform campaign, described state-level initiatives as a “drain on political energy for national action.” Furthermore, he said he doubted that labor and other activists could prevail by pursuing universal care on a state-by-state basis (Shea 1996). In 1993 and 1994, the national leadership of some unions that had once been ardent single-payer supporters began pressuring single-payer advocates at the state level to change their tune. AFSCME pushed hard to get the Coalition for Universal Health Insurance for Ohio (UHIO), which had first introduced a state-level single-payer bill in 1990, to support the managed-competition approach favored by the White House (Boatman 1993; Healthy States? 1992). Moreover, the national leadership of the AFL-CIO did not mount any high-profile efforts on behalf of California’s Proposition 186, which aimed to create a statewide single-payer system and was placed on the November 1994 ballot thanks to a state-level labor-community coalition that gathered over 1 million signatures in record time.

Despite all the time and energy that union officials and some public interest groups devoted to getting some single-payer language incorporated into the Health Security Act, organized labor won few kudos for their efforts from the diehard members of the single-payer coalition (Nichols 1996). “This was their badge of loyalty to the cause,” said Barbara Markham Smith, a former legislative aide to single-payer advocate Rep. Jim McDermott (D-WA). She dismissed labor’s efforts as a “meaningless trophy” (1996).

These divisions within and between organized labor and public interest groups, together with the distractions of the NAFTA fight, made it difficult for organized labor to take the offensive on health care reform. Preoccupied with NAFTA until November 1993, organized labor left the field clear for opponents of comprehensive health reform—most notably the Health Insurance Association of America (HIAA)—to define the terms of the public debate early on beginning with the devastating Harry and Louise commercials, which saturated the airwaves in select television markets that fall. At least as early as October 1993, key union staff members were indicating in private that Clinton’s Health Security Act

\textsuperscript{33} See, for example, Sweeney 1991. In 1991, Sweeney tried to get the Ohio AFL-CIO to rescind its support of legislation that would create a single-payer system in Ohio (Boatman 1991).
was in trouble.34 After the NAFTA vote in November 1993, labor was unable to recapture the initiative on health care. Valuable time was spent attempting to repair rifts between its grass roots and the tree tops, as well as between the White House and labor. As such, organized labor's campaign for health care reform did not get into full swing until about February 1994, just as the Clinton plan was in its death throes.

That month the two central assumptions on which organized labor had staked its health care strategy for more than a decade finally came crashing down in quick succession. The first was the belief that business could be counted on to be a constructive partner in health care reform if organized labor distanced itself from any Canadian-style solution. The second was the belief that an employer-mandate solution would ultimately triumph because it built on the existing system of job-based benefits and thus placed no additional burden on the federal tab.

Despite an intense lobbying effort by the White House, the Business Roundtable, an elite business organization comprised of two hundred or so leading CEOs, refused to endorse the Health Security Act. Instead it voted on 2 February to back the rival plan sponsored by Rep. Jim Cooper (D-TN), which would not require employers to pay any of the costs of their employees' health insurance (Schneider 1996; Stout and Wartzman 1994; Ifill 1994; Priest and Weisskopf 1994). The following day, the Chamber of Commerce, in an important retreat, unequivocally disavowed the Clinton plan (U.S. Congress 1994a: 16–17, 54; Sprague 1996). By that time, the National Association of Manufacturers (NAM) was likewise distancing itself from the Clinton plan in no uncertain terms (NAM 1994; Johnson and Broder 1996: 316–318). Labor officials tried to counter the U.S. Chamber of Commerce, NAM, and Business Roundtable setbacks in early 1994 by imploring business leaders, notably executives of the Big Three auto makers, to reaffirm publicly their commitment to comprehensive health care reform. Their attempts to encourage the leading CEOs of the automobile industry to author a high-profile op-ed on behalf of the Clinton administration's efforts were unsuccessful, however. "There was this deafening silence when we needed business to take a stand," said Mary Kay Henry of the SEIU (1996).

The second major blow to labor's strategy came at about the same time. The appeal of the employer-mandate solution had rested on what

34. See, for example, Nancy Donaldson and Ned McCulloch, memo to Bob Welsh and Gerry Shea, 2 October 1993 (Nixon Papers).
turned out to be a questionable assumption—that it would not be con-
sidered a tax increase and that it thus would not affect the federal budget
in any significant way. In early February, Robert Reischauer, head of
the CBO, swept away this "tortured fiction" that had sustained labor's
deep faith in an employer-mandate solution over the years. He told leg-
gislators that the federal government would have to treat the health insur-
ance premiums that firms would be required to pay for their employees
under the Health Security Act as a tax increase for business (Marmor and
Mashaw 1994; White 1995). AFL-CIO president Lane Kirkland subse-
quently conceded that this decision by the CBO was a major blow for
labor (Hardesty 1994).

In light of a string of political setbacks on health care reform and other
issues in late 1993 and early 1994, labor leaders began to debate whether
organized labor should recommit itself once again to the single-payer
path (AFSCME 1994). Teamsters president Ron Carey called on Presi-
dent Clinton to alter his strategy on health reform after the business
community resoundingly deserted his compromise proposal in February
1994 (Carey Calls 1994). Several unions, including AFSCME, UAW, and
ILGWU, were reportedly ready to put up substantial sums of money on
behalf of the single-payer solution and entered into discussions with one
another and legislators about conducting a major publicity campaign for
it. But this effort sputtered because of continued disarray and dis-
agreement within and between unions, liberal public interest groups,
and legislators (Corn 1994; Kilborn 1994b; Weil 1997; Johnson and

In short, organized labor's efforts to mold the health care debate in
early 1994 were sporadic at best. For the most part, the debate over
health care reform was conducted in a vacuum in which labor seldom
raised broader issues about economic restructuring, the responsibilities
of employers to their employees, and the role of insurance companies in
the U.S. medical system. The harshest criticism of the job-based system
of benefits, the commercial health insurers, and the competitiveness
argument wielded by business in its campaign against the administra-
tion's health reform proposal came not from leading figures in organized

35. In private, drafters of the Health Security Act had been uneasy about how the Congres-
sional Budget Office would ultimately choose to categorize the employer mandate for budget-
(McGarrah Papers).
37. See also Robert McGarrah, memo to Gerald McEntee, 21 March 1994 (McGarrah
Papers).

For the most part, the leaders of organized labor raised few of these deeper structural issues in their public discussions of health care reform in the 1993–1994 period. In their appearances before Congress, they tended to give a qualified "yes, but" endorsement to the Health Security Act and, in some cases, to follow it up with some pleasantries about the single-payer approach (U.S. Congress 1994c: 7–75). Few dared to raise some of the third-rail questions associated with health care and the role of corporations in the new work order in the United States. One notable exception was Tom Gilmartin, a vice president of the Teamsters, who in his congressional testimony directly tied the health care reform question to broader issues concerning economic restructuring. When he was asked why, given the concerns he had raised, organized labor was not speaking out more loudly and forcefully on behalf of a single-payer system, Gilmartin told legislators: "That is certainly a question our general executive board and president ask quite often" (U.S. Congress 1994d: 255, 294).

Conclusion

In the 1980s and 1990s, a social movement or reform coalition pushing more radical proposals for health care reform—such as national health insurance that did away with the commercial health insurers and the employment-based system—never congealed. The political conditions seemed promising enough for the emergence of such a movement, given the economic dislocations associated with employers' quest for greater labor-market flexibility. After all, as the bond between employer and employee frayed, workers faced a radically new economic environment with the downsizing of the labor force, the retrenchment of the private-sector safety net, growing income inequality, and a burgeoning contingent workforce.

There are numerous reasons why such a social movement or powerful reform coalition did not emerge around these issues and why the health care reform question failed to galvanize one. One central reason has to do with the role of organized labor. With its attempts over the years to woo the business community, culminating in what it thought to be a business-friendly legislative solution, organized labor helped lay the political groundwork for the Health Security Act and the worldview that
the Clinton administration employed to sell it. Business was able to dominate the health care debate over the years because the whole health care problem, so to speak, got defined with the help of organized labor in ways that favored the economic worldview of key business executives and prominent economists.38

While the recalibration of the U.S. political spectrum to the right beginning in the late 1970s is important, it does not entirely explain why private-sector solutions, most notably the employer mandate, trumped public-sector ones time and again in discussions of health policy. It is important to understand how the U.S. 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.

Several institutions of the private welfare state—notably the Taft-Hartley funds and the ERISA preemption—developed in the postwar years so as to facilitate labor’s turn toward private-sector solutions. The employer mandate helped to fix labor’s gaze on the private welfare state. This policy idea was adopted in a moment of political expediency at the prodding of state actors. Eventually it became embedded in a compelling worldview and causal story that were favorable to business, and that ended up vexing labor with a serious but largely unrecognized case of political cognitive dissonance. By endorsing the Clinton proposal and its legislative antecedents based on a job-based solution, organized labor ended up endorsing a highly selective understanding of the U.S. political economy. It generally accepted that in this age of widespread economic restructuring and a manic search on the part of employers for greater labor-market flexibility, the institution of job-based benefits was a well-established, stable one that had long shielded most U.S. residents and would continue to do so. Moreover, by holding up the existing system of employment-based benefits as a model of social responsibility, organized labor minimized or whitewashed the gross inequities embedded in that system which, during earlier campaigns for national health insurance, it had spotlighted and taken issue with. It thus helped to promote the misperception that business shouldered most of the burden of the private welfare state and, in particular, most of the burden of escalating health

38. For more on how policy outcomes vary with the ability of business to define the relevant issues in ways that favor or disfavor business, see Mucciaroni 1995. On the pivotal role of economists in recasting the health care debate, see Melhado 1998.
care costs. In doing so, organized labor became an accomplice in mini-
mizing the retrenchment of the private welfare state that was under way.

The institutions of the private welfare state and the employer-mandate
idea were mutually reinforcing, and both, in turn, molded labor's politi-
cal choices and behavior. It is not my contention here that the idea of an
employer mandate and the institutions of the private welfare state mor-
tally wounded the Health Security Act. Rather, I have attempted to show
how they represented a severe impediment to forging a winning politi-
cal strategy and coalition that could secure universal and affordable
health care over the long haul. In this sense, they contributed to the defeat
of comprehensive health reform in 1994. These institutions and ideas
helped to realign the interests of labor more closely with those of busi-
ness. They also contributed to tensions within and among unions and
liberal-leaning public interest groups that impeded efforts to form a
durable coalition. These divisions made it that much more difficult for
labor to lead rather than follow in the health care reform debate and rein-
forced organized labor's tendency to defer to the leadership of the Demo-
icrat Party on social policy questions.

This focus on organized labor's mistakes in the health care debate
should in no way minimize the fact that labor was up against not just for-
imidable institutional obstacles but also formidable political obstacles. It
faced powerful opponents who could muster enormous resources, finan-
cial and otherwise, to shape the fate of comprehensive health care reform.
Furthermore, in discussions of health care reform, the media and oppo-
nents of the Health Security Act generally distorted the public debate
(Peterson 1995; Marmor 1995).

During the battle over the Health Security Act, the Clinton administra-
tion echoed the view that escalating health care costs were the root cause
of the woes of the American firm and hence of 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." Yet after his bruising battle over the

39. 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 1920s" (Ifill 1992).
budget, which dominated his first seven months in office, Clinton emerged with a reduced vision of what was ailing the U.S. worker. In short, "It's the health care costs, stupid."[40]

In her explanation of the failure of health reform in the 1993–1994 period, Skocpol faults the administration for not doing more to shape the public debate by educating the public about the details of the Clinton proposal, in particular the rationale for the employer mandate, the health alliances, and the heavy regulatory hand underpinning the Health Security Act. Yet the right message will not, on its own, assure passage of major social policy legislation, especially in the face of decided ambivalence on the part of big business and the absence of a crisis on the order of, say, the Depression.[41] Ultimately, advocates of universal health care need to figure out how to create and nurture durable political alliances glued together by something more than just the right message for a specific policy. This is especially so today in an age when budgetary concerns drive social policy.[42] Major social policies ultimately raise fundamental questions not just about which is better—more government or less—but about what constitutes a fair and just society and who should bear what burden to that end. And that question is inherently controversial. And during periods when the winds of retrenchment blow hard, that question is inescapable.

To enter into a broader public debate about how the employer mandate would work and the reasons for it would have meant opening up a broader discussion about why the United States has such a jerry-built system of employer-sponsored benefits in the first place. It would have meant confronting not just the question of whether employers should provide benefits like health insurance, but what social obligations, if any, employers have in exchange for the right to do business in the U.S. In doing so, the Clinton administration would have had to confront many of the volatile issues raised by the wrenching restructuring of the U.S. economy that has been under way for almost two decades now.

In presenting the idea of an employer mandate to the public, Clinton and organized labor together might have raised some of these deeper questions about the U.S. economy and triumphed in the court of public opinion. But to do so would have required building more than just a fair-weather coalition that entered into a marriage of convenience over

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41. For more on crises and cross-class coalitions, see Swenson 1997.
42. On the obstacles to coalition building today, see Weir 1998.
health care reform with elements of business after engaging in a messy public spat over NAFTA. Given Clinton's conservative Democratic Leadership Council credentials, his deep ties to the financial sector, and his lack of any solid political or ideological grounding, it is unlikely that he would have begun this public debate on his own accord. However, organized labor together with some public interest groups might have been able to drag him in this direction. Yet, as we saw here, the institutional constraints of the private welfare state, internal divisions within and between organized labor and public interest groups over health care reform, labor's dogged commitment to working with business to solve the nation's health care dilemmas, and its general lack of political imagination precluded this option.

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