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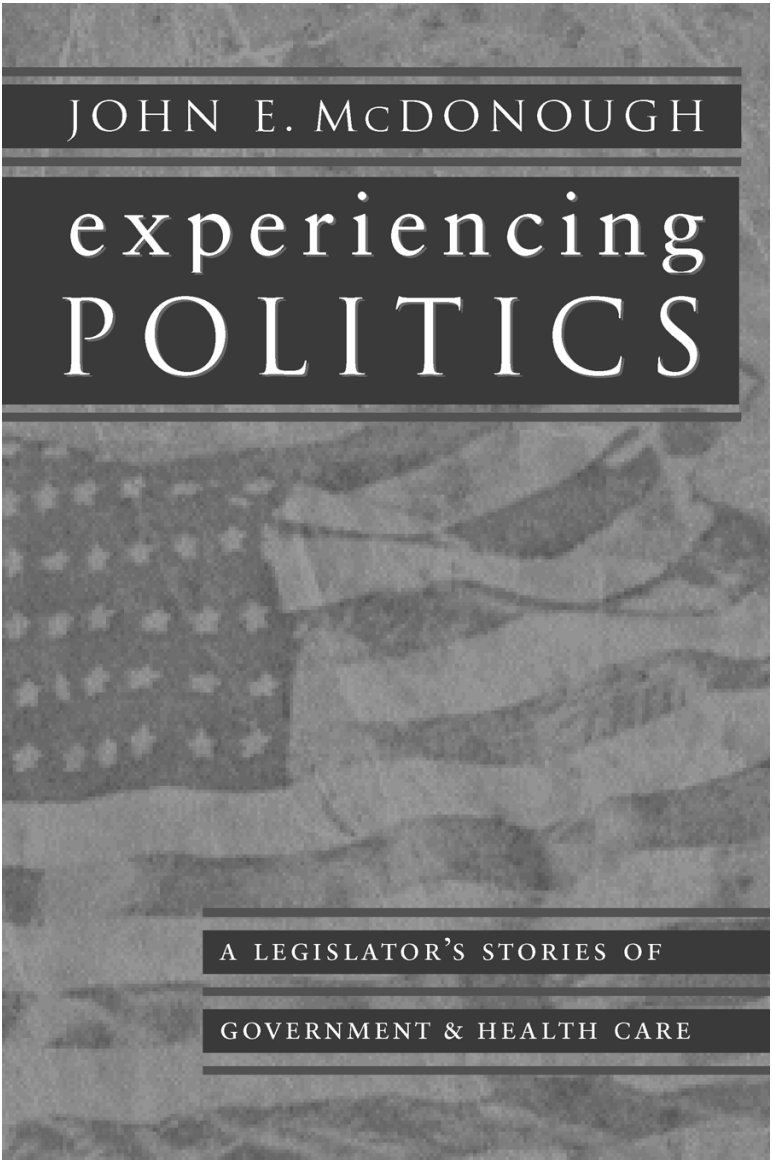


Introduction

Seeing Politics through Different Lenses

The real act of discovery consists not in finding new lands but in seeing with new eyes.

Marcel Proust

A long-serving member of the Massachusetts House of Representatives gingerly seated himself in the vacant black leather chair next to me in the cavernous and historic House chamber. A district border in southwest Boston was all we really shared in common. Prior to this moment, my most vivid memory of him had occurred during a meeting of the Boston legislative delegation in my first year as a rep, as I awkwardly made conversation by remarking that he always seemed to face difficult reelection fights that attracted multiple serious opponents. "Don't worry about me," he smiled. "My perception of vulnerability is my greatest strength." He most often could be observed seated at the far back of the chamber reading books connected with his two compelling passions: the right-to-life movement and the Catholic cause in Northern Ireland. Today, however, he wanted to be my friend. "John," he said in a voice cracking from years of tobacco smoke, "do you have any precincts near me that you would be willing to let me take?" He was referring to the upcoming redrawing of legislative districts, always an intense game of who gets what. "Gee, I don't know," I demurred. "I've worked them really hard. The people there know and like me. And why would you want them anyway when no one there knows you?" "Well," he said, "I find that I always do better in places where people don't know who I am."

It's a fact that most Americans don't know their elected officials, personally or from a distance.[1] Whether we know them or not, little seems to counteract the dispiriting cynicism that infects large portions of our

public life at the turn of the century. It is not difficult to understand why politics and public affairs are held in such low esteem. The constant, vituperative combat between Republicans and Democrats in Washington, D.C., and in state capitals, the imbroglios involving campaign cash, ugly and pervasive negative political advertising, and numerous and seemingly unending political scandals all combine to confirm the public's worst fear: that something is pathetically awry in our nation's civic and political culture. Briefly, in early 1997, signals were sent from both sides of the political aisle in Washington that a cooling of passions was in order. Some members of Congress from both parties even went on a retreat to Hershey, Pennsylvania, to try to establish a more collegial atmosphere (the trip was repeated in 1999). Not surprisingly, the cease-fire didn't last.

The cease-fire didn't last because it can't. The stakes are too high in public politics for both sides to sit complacently at the same time: the side that's out of power always wants to get in. Moreover, the issues under discussion are of such public consequence that no side can afford to appear passive. The media and the public contribute to this dynamic; they are always drawn to conflict, the more intense the better, and most often regard with boredom or skepticism occasional shows of unity and agreement. Even more basic, the structure of American government was consciously designed to ensure continuous conflict, rivalry, and egotism. "Ambition must be made to counteract ambition," Madison wrote in *The Federalist Papers,* No. 51, defending the structure of the proposed U.S. Constitution as one that would best protect the liberty of citizens. Nonetheless, Americans most commonly accept the view that our public institutions somehow have lost their way and strayed from the founders' vision.

At the same time, we invest enormous authority and trust in our government, and especially in our legislative institutions—federal, state, county, and local. We give our legislatures remarkable powers to pass laws that govern our own behaviors, from the trivial to the profound. In these bodies, we always find a striking range of talents, personalities, experiences, values, ideas, strategies, and energies. Those who have not worked in direct contact with legislatures—the vast majority of Americans—have little or no understanding of what really goes on, and how decisions really get made. And yet the decisions made in these bodies become laws that affect every aspect of our lives. We need to find ways to bring the realities of these institutions—good and bad—closer to the public's consciousness.

This book's premise is that a large portion of the public's cynicism is

rooted in misunderstanding of essential features of our public institutions, the policymaking process, and the much-maligned dynamic of politics in all its varied forms. Watching or participating in public affairs in a poorly understood way can be as vexing and confusing as trying to play or watch a sports contest or a card game with no knowledge of the basic principles and rules. The result usually is frustration, throwing one's hands up, and walking away. Yet, because of the system's openness and media coverage, many seem to assume that in politics they should automatically "get" what's going on without making the effort to learn the system or the rules.

Participating in politics and public affairs with a genuine understanding of the process, the dynamics, the pacing, and the "game" can be an enriching, liberating, and joyful experience that few appreciate who have not done it. The neophyte activist savoring his or her first political win (electoral or issue-based) can experience a high equal to any athletic achievement. The more who participate, the more exciting and satisfying the results can be. My purpose in writing this book is to give readers an understanding and appreciation of the real workings of politics and policymaking—a view from the ground where the battles are fought and the passions are most deeply felt. While most of my examples and case stories are drawn from the public policymaking sphere—primarily state, but also federal and local—the lessons and ideas presented here can help to make sense of politics in the private sphere as well, at work, in the community, with the family. Because being political is a core human attribute, many of the essential dynamics of politics are the same in both the public and the private spheres.

MODELS FOR POLITICAL LIFE

To explain and illustrate important dynamics in the political arena, this volume presents a series of ways to understand politics and the policy process that I have found useful in the course of my public political career. For thirteen years, between 1985 and 1997, I served as a state legislator in the Massachusetts House of Representatives representing several diverse neighborhoods in the city of Boston: Jamaica Plain, Roslindale, Roxbury, and Dorchester. As a legislator, I became involved in such issues as health care policy, public safety, housing and urban development, and criminal justice, and in tax and spending debates. As a community leader, I was caught up in issues of community and economic development, affordable housing, crime, and much more. Though I had spent

most of my life involved in politics in many ways, I had never been exposed to any organized, systematic ways of understanding political phenomena. Like most political activists, elected or not, I spent most of my time focused on the *what* of politics—the guts of issues—and little of my time focused on the *how*.

Between 1992 and 1996, while still in the legislature, I pursued a doctorate in public health at the School of Public Health of the University of Michigan and studied health care politics and policy with Dr. John Tierney of Boston College. He exposed me and my fellow students to many of the political models which form the core of this book. Because of my years as an elected official, I had a rare opportunity to engage in what is sometimes called "learning backward"—first engaging fully in a particular activity and later studying it, a process which greatly enhances and intensifies the learning experience. I brought to this learning process a sharp frame of reference to evaluate the relevance of these models and ideas—whether or not they made sense in the context of my own political involvement. (Aristotle complained: "The young man is not a proper audience for political science. He has no experience of life, and because he still follows his emotions, he will only listen to no purpose, uselessly."[2] This observation may not be true for others, but it certainly was for me.)

I began to employ some of the more intriguing policy tools in my work in the Massachusetts State House and in the community. I found them to be extraordinarily valuable, not just to understand something that had already happened, but to plan future activities and campaigns. I began to incorporate features of these models and ideas in my speaking engagements before a wide variety of audiences—from poor, minority women in a subsidized housing development in Roxbury looking to get better services, to national groups of physicians seeking to exert greater influence on health policy. In a course I taught on health policy and politics at the Boston University School of Public Health, I began to teach these models, asking students to apply them to their own experiences. I found intense interest and enthusiasm in learning these ways of viewing political phenomena. A common reaction I received was: "Why haven't I ever heard any of this before?" I remember having the same feeling. The truth is that while the models and concepts included in this volume are well known to political and policy science academics, they are completely unfamiliar to the vast majority of Americans, even those most actively involved in policymaking every day. I came to believe that if more people understood these concepts, some significant portion of the public's distaste for politics would diminish and be more productively chan-

neled. The writer Robert Kuttner has observed that Americans love democracy and hate politics, failing to make the connection that politics is the practice of democracy. Those of us from across the ideological spectrum who *love* politics—as I surely do—have a common stake in working together to create better public understanding of its essential features and nuances.

The models and concepts presented in this book can be thought of as lenses helping us to perceive key features of a politicized situation that could not have been seen without looking through them. Not every lens is effective in every situation. No one lens does it all. Each has limitations. But all can be useful in a wide array of circumstances. Graham Allison presented the best-known use of this approach in his book *The Essence of Decision*.[3] He used three different conceptual lenses or "maps," as he called them—the rational actor theory, the administrative operating systems theory, and the bureaucratic politics theory—to tell three entirely different stories about what happened in the 1962 Cuban missile crisis, each true yet each highlighting a different aspect of this crucial Cold War event. As Barbara Nelson describes the approach, "Each version has a different character as the protagonist, and a different interpretation and causation of events."[4] Allison powerfully demonstrates that even when we can agree on the basic facts of a situation, the search for meaning in politics—of events, data, statements, and decisions—is contested terrain. This volume seeks to help readers with the search.

Frequently I am asked to rank the various models in terms of their relative importance. While I have my personal favorites (Deborah Stone's ideas in chapter 2 and John Kingdon's model in chapter 7), I usually refuse the request. Instead, I liken the various models to tools in a carpenter's toolbox. Which of these—the hammer, the saw, the screwdriver, among others—is most important for the carpenter? It depends on the nature of the job. Similarly, the usefulness and applicability of these various structures depend on the nature of the political conflict and the challenges facing the various actors. Different models will be more or less useful depending on what one is seeking to accomplish or to understand. To aid readers, I have grouped the models and chapters into three sections: basic ideas, key themes, and integrative models. Certainly, other writers would choose other models to include, leave some of my choices out, and create different groupings. I don't claim my choices are the best; I only hope readers find them useful.

Readers should also understand that while I portray the various mod-

els in ways that emphasize their usefulness, they are *just* models, with limitations as well as advantages. Usually, political or policy scientists focus all or most of their attention on a single model in their books. By presenting about a dozen—one or two per chapter—I hope to convey a sense of their limitations, and also of their complementary features. While they are presented in separate chapters, some of the best insights can be obtained by applying them in an infinite variety of combinations and concentrations. The integrative models in part 3 perform best on this score.

STORIES FROM A POLITICAL LIFE

I structured and wrote this book to be unlike any other about politics and policy I have read. A series of models or ways of understanding politics are presented in separate chapters that describe and discuss each particular construct. Paired with each model are one or more case stories from my own political life, taken mostly from my thirteen years as a member of the Massachusetts House of Representatives. The stories are written to provide readers with an in-depth, inside look at real-life politics and policymaking in one state legislature and, equally important, to illustrate the particular model under discussion.

I use the term *case story* instead of the more familiar expression *case study* to emphasize the personal aspect of these examples. From over one hundred possible cases, I chose ten that I found compelling and helpful illustrations of each conceptual model. The stories are told from my own perspective, which was central to each. I am acutely aware that other participants could—as in Allison—tell vastly different and equally valid stories about the same episodes from their distinctive vantage points. All chapters have been read for accuracy and authenticity by at least one person directly involved in the episode. Nonetheless, each is told to a significant degree from my personal perspective.

Half memoir and half guide to useful political and policy models, this book seeks to do something different from the vast majority of books that can be found in bookstores under the category of "current affairs" or "politics." Most of these books are either memoirs that relate "war stories" from an individual's career or ideological discussions that seek to define and shape current thinking, left, right, or center. There is not a lot in them that seeks to explain what politics is, how it really works, and how it feels to be in the middle of high-stakes political conflict. That's my aim. In the process, I hope to provide tools readers can learn to use themselves to become more effective political players. This book is also

different from two other kinds of political books and sources. Journalistic accounts of political controversies and academic political science studies, because of their necessary and appropriate requirements for distance and objectivity, most often miss the *passion* that political activists experience and bring to their practice of politics. I'm not dismissing these efforts, just recognizing inherent limitations that leave many hungry for more.

As noted, the stories in this book are all taken from my own political life. Throughout my life, I have been unabashedly and without apology on the left of the political spectrum. The stories and my roles in them thus lean in that direction: health care access reform, tenants' rights, campaign finance reform, anti-death penalty. It is not my intention to proselytize readers or to convince them of the correctness of my positions or actions. My views on many of these issues have shifted over time. I hope readers with different beliefs and ideologies will not be repelled and will find value in exploring the models and learning about some of the realities of political and legislative life. The stories are presented to bring to life the conceptual models and to provide a real-life, inside look into the political and legislative arenas, no more and no less.

Readers will notice in the case stories and in the descriptions of various models a disproportionate reference to health care policy. That is because health policy was my area of specialization—and love—throughout my years in the House. Not all legislators choose to specialize, though many do, in areas such as criminal justice, environment, social services, transportation, insurance, housing, economic development, and education. I was widely recognized as a health policy specialist, and so I hope others interested and involved in health policy derive inordinate usefulness from this volume.

ORGANIZATION OF THE BOOK

Part 1, including chapters 1 and 2, presents the "Basics," several core ideas that permeate every successive chapter: first, a definition of politics, and second, a discussion of the ways language shapes political meaning.

Chapter 1 provides an answer to a question I ask frequently that stumps most people: what is politics? I find most people from all walks of life—including professional politicians—have great difficulty defining a term so commonly used that is such a universal dynamic affecting all our lives. Offering a definition seems a useful starting point. In describing a distinct and emblematic form of politics—electoral—I relate two

stories of personal campaigns for elective office, one my race for class president in the sixth grade and the other my first race for state representative in 1984. We are never too young or too old to learn.

Chapter 2 presents less a specific model and more a method of understanding politics by examining how we talk with—or at—each other in the political world. In this chapter, I draw on the work of Deborah Stone, who presents a compelling analysis of how we use and misuse words, metaphors, numbers, and other rhetorical devices to create shared meanings to achieve political goals. Sometimes, creative use of these devices enhances understanding and smoothes the path to progress; at other times, they confuse and impede, deliberately or inadvertently. The case story in this chapter relates my involvement in 1990 with a street gang whose members called themselves the "X-Men" and who sought to control a part of my district called Egleston Square. Their story illustrates the striking ways language and perspective shape vastly differing political meanings.

Part 2, "Themes," includes three chapters, each presenting a set of concepts that infuse a substantial proportion of political life. The first discusses the central role of conflict in political life; the second explores the ever-present tension between public interest and self-interest; and the third examines the critical dynamics of representation and/versus relationships in politics.

Chapter 3 presents ways to think about the role of conflict in politics and policymaking. Many of us are taught that conflict is bad and something "nice people" avoid. Often, we wonder why our elected officials fight with each other so much instead of just working things out. Drawing on writings of Niccolò Machiavelli, E. E. Schattschneider, and others, I outline a structured way to think about conflict in the political realm. Two related case stories involve two groups who fight with each other nearly all the time—tenants and landlords—and two legislative battles over rent control and condominium conversion protections.

Chapter 4 discusses interests, large and small, organized and unorganized, and seeks to answer a controversial question: are we all just looking out for our own individual self-interest, or are we instead motivated by ideas and the "public good"? Is there such a thing as the "public interest," or is it, instead, just a cover for collective greed? The chapter explores the growth of "rational choice" models and the competition between them and other approaches emphasizing the power of public ideas. The case story describes intense and excruciating battles during a severe

state fiscal crisis in 1989 and 1990, as well as a fierce dispute over the rights of elderly citizens who shelter their assets to avoid paying the state for their nursing home costs.

Chapter 5 explores two related concepts, representation and relationships. Representation presents a challenge nearly all elected officials face at some point: do I represent my own beliefs and conscience, or do I follow the will of my district? Writings of Hannah Pitkin and others provide useful guidance. I also use the representation dilemma to explore an equally important dynamic, the role of relationships. While it is easy just to say, "Relationships matter," I also explore a construct known as "agency theory" to understand them more concretely. The case story examines two related and vexing issues facing federal and state legislative bodies today, campaign finance and ethics reform. In the process, I explore the roles of representation and relationships, asking which, in the final analysis, matters more.

Part 3, "Models," presents two ways to understand key dynamics in politics and policy that combine many of the insights embedded in the previous chapters. The punctuated equilibrium model in chapter 6—as obscure as the name sounds—makes it easier to see when broad-based reform versus incremental change is possible. Chapter 7's agenda-setting model is an invaluable tool activists can use to chart and win political reforms.

Chapter 6 tackles the big picture, describing the nature of those brief, electric moments when broad-scale change—positive or negative—not only becomes possible but actually happens. The punctuated equilibrium model of policy change, developed by Frank Baumgartner and Bryan Jones, explains how this happens. Sometimes the only viable path is incremental, step-by-step change, whereas seeking reform too extensive can lead to nothing happening at all. Sometimes, though, major change is possible, and seeking modest reform wastes a historic opportunity. Deciding between these two scenarios is crucially important in politics. The punctuated equilibrium theory is a significant help. The case story involves big-picture change in Massachusetts hospital regulation in 1991. Three choices were presented: incremental tinkering with the existing structure, a huge governmental health expansion by establishing a "single-payer–Canadian" financing scheme, or deregulation and a sharp turn toward the market as the controller of the state's health future. Was this an opportunity for major, systemic change, and, if so, of what kind? When, why, and how a big change sometimes happens is the theme.

Chapter 7 explains why some issues get on the public agenda and receive speedy and favorable action, others get on the agenda but go nowhere, and still others never reach the public agenda at all. The answer can be found in Kingdon's agenda-setting model. I show how Kingdon's model explains the failure of President Bill Clinton's campaign for national health reform in 1993 and 1994 better than any explanation I have encountered. The case story illustrates my use of this model prospectively in 1995 and 1996 to seek passage of a major health care access law, a fight that required winning enough votes to override the veto of a popular incumbent governor.

Part 4, "Endings," wraps up the journey of this book with a simple and elegant dualism in chapter 8 that, to me, captures the essence of the political. Chapter 9 attempts the impossible: bringing it all together.

Chapter 8 presents one final way to understand politics by discussing two competing metaphors always in play, the conversation and the game. Which one better captures the essence of American politics at the opening of the twenty-first century? The case story relates my final legislative battle as a member of the Massachusetts House. This was a bitter dispute over whether to reinstitute capital punishment in the wake of a grisly and horrific murder—a dispute in which the dynamics of the conversation and of the game are both quite active.

Finally, in chapter 9, I pull these models and ideas together to provide some insights developed during my years in politics. I also present concluding perspectives on the role of legislatures and legislators, as well as my thoughts about the future of U.S. health care policy.

THE LEGISLATIVE CONTEXT

Because the case stories in this book focus primarily on the legislative portion of public policymaking, it will be helpful for some to understand the broader context of which legislating is only one part. Those who took social studies in high school are familiar with the tripartite division of labor in federal and state policymaking in the United States among the executive, legislative, and judicial functions.

A different and useful model provided by Beaufort Longest describes two distinct and consecutive policy phases, each with two separate parts. The first phase, "Policy Formulation," contains the first step, "agenda setting," by which issues/problems reach the public policy agenda for discussion and potential action, and the second step, "development of legislation," where issues that reach the public agenda are either addressed

by enactment of statutes or laid aside. Issues that successfully navigate the first phase move to the second, "Policy Implementation" (sometimes referred to as the "bureaucratization of policy"), which contains the third step, "rule or regulation making," and the fourth step, "operation," where policies are put into action.[5] Policy implementation always creates consequences, outcomes, and perceptions resulting in feedback that often triggers a third, "Policy Modification," phase. Once triggered, policies often need to be modified at any one of the four prior steps, resetting the process in motion. The Longest framework is presented in schematic form below:

Phase I: Policy Formulation
Step One: Agenda Setting
Step Two: Development of Legislation

bridged by enactment of legislation, leads to

Phase II: Policy Implementation
Step Three: Rule or Regulation Making
Step Four: Operation

creating consequences, outcomes, perceptions
creating feedback that can trigger

Phase III: Policy Modification

Legislators often will be key players in step one, the agenda-setting stage, though just as often they are not, and other officials or interests play that role. (Agenda setting is the central model in chapter 7.) Legislators normally, though not always, will be less involved in steps three and four, the rule-making and operation phases. Legislators will often be involved in triggering the policy modification phase. Legislators and legislatures always are indispensably and centrally involved in the second step, the development of legislation. A policy proposal moves forward or dies, most of the time, depending on the actions of legislative bodies. While their role in the overall policy process is not all-encompassing, it is crucial.

It must be noted that this volume is not intended as a guide to state legislatures as institutions or to the behavior of legislators as a group. That work has been performed admirably by others, most notably, Alan Rosenthal of Rutgers University, who tracks the historical evolution of state legislatures in the modern era and wonderfully captures their essence in the 1990s.[6] Tom Loftus, former Speaker of the Wisconsin State Assembly, provides an enlightening view of his institution in *The Art of Legislative Politics*.[7]

A NOTE ABOUT MASSACHUSETTS

Though the themes and ideas of this book are intended to be helpful to anyone, all of the case stories focus on Massachusetts state government, and its House of Representatives in particular. Accordingly, a little background information is in order.

Massachusetts, with more than six million residents, is the nation's thirteenth-largest state (one of four called a "commonwealth") and among its most reliably liberal-progressive (though its voters did choose Ronald Reagan in 1980 and 1984 as well as Republican governors in the three state elections in the 1990s). Governors play a major role in politics and policy, and four of them loom large in various chapters of this book. Liberal Democrat Michael Dukakis served between 1975 and 1978, and then again between 1983 and 1990. His nemesis, conservative Democrat (later turned Republican) Edward J. King, served between 1979 and 1982. Libertarian Republican William Weld served between 1991 and 1997, and moderate Republican Argeo Paul Cellucci filled out the remainder of Weld's second term beginning in August 1997 and was elected to the office in his own right in 1998.

The Massachusetts Senate and House of Representatives are known collectively as the General Court. The Senate includes 40 members with districts of about 150,000 persons, and the House includes 160 with districts including about 36,000 persons. Both have been overwhelmingly dominated by Democrats since the late 1950s, with Senate Republicans numbering between 7 and 16 during the course of this book, and House Republicans numbering between 27 and 36. The two key members in the Senate are the presiding officer—the President—and the chairman of the Senate Committee on Ways and Means, which initiates all spending bills. In the House, the presiding officer is the Speaker, and the chairman of the House Committee on Ways and Means also exercises huge influence. During the course of this volume, I interacted with four Speakers, each strikingly different from the others: Thomas McGee of Lynn (1975 to 1984), George Keverian of Everett (1985 to 1990), Charles Flaherty of Cambridge (1991 to 1996), and Thomas Finneran of Boston (1996 to the present). They will be introduced in greater detail during the course of the book.

Except for the committees on ways and means and a few others, the vast majority of legislative committees in the Massachusetts General Court are joint House-Senate bodies, each with six senators and eleven

representatives. All bills—with the exception of budget appropriations bills, which go directly to House Ways and Means—are first referred to a joint committee for a public hearing and consideration. Each committee is cochaired by a senator (named by the President) and a representative (named by the Speaker). After the two top leaders in each branch, the committee chairs wield the greatest amount of influence, particularly over the fate of legislation that emerges from each one's respective joint committee. While party caucuses in each branch ratify the President's/Speaker's nominees for chairmanships, it was always done pro forma during my years in the House. Because chairs have greater influence and prestige, and because they receive a salary hike of between $7,500 and $15,000, selection as a chair has great consequence for each individual legislator (at the time of this book's writing, the base salary for all senators and representatives was about $46,000). Because of the President's/Speaker's near-complete control over the selection process, they both hold enormous power over their respective chambers. Each individual who becomes President or Speaker makes a different choice as to how to exercise that power—as will be evident throughout the book.

Proposed legislation—called a bill—that emerges from a joint committee travels sequentially through the House and then the Senate, or vice versa. If one chamber refuses to act on a bill, the other can do nothing formally to pry that matter loose. Appropriations (budget) bills must always go through the House first. Once released from committee, nonbudget bills cannot be amended on the floor "beyond the scope" of the original bill; however, appropriations bills can be amended on the floor to include virtually anything, budget-related or not.

Prior to 1995, each session lasted for one year, from the first Wednesday in January to Tuesday midnight prior to the successive first Wednesday in January. Any bill not sent to the governor's desk prior to the midnight deadline died. Changes to the joint rules in 1995 created two-year sessions that permit bills to carry over from the odd-numbered to the even-numbered year, 1995–96 and 1997–98. Formal sessions are required now to conclude on July 31 of the even-numbered year, though both chambers may continue to meet until the end of the year in "informal" sessions where unanimous consent is required for all matters acted upon. While these procedural points may seem arcane, they are mentioned here because each has key relevance to several of the case stories. They are repeated at appropriate points.

FINAL POINTS

In writing this book, I was acutely aware that most of the men and women with whom I served in the Massachusetts legislature between 1985 and 1997 could have written a book full of stories at least as interesting and compelling as mine. Then again, the same could be said for the thousands of men and women serving in the other forty-nine state legislatures, not to mention the U.S. Congress. Any member who serves any length of time in any legislative body in the nation (federal, state, county, or local) has stories that reveal truths not just about legislating but also about human frailty and courage, humor and tragedy, honor and dishonor, growth and regression, challenges and change. Their stories are everywhere.

That begs a question: what is so special, then, about my stories? Not a whole lot. I simply had the idea, the time, and the energy to put them together in this volume in a way that, I hope, will inform and enlighten readers. I also hope pairing my stories with the models gives each story more relevance, power, and value. I have the modest ambition that telling these stories will help to create better understanding of government, policymaking, and politics in ways that will lead to the improvement of all three. I tell stories involving my own political work and my distinctive role because those are the ones I can truly tell from the point of view of an inside participant. I hope this volume will encourage other legislators and political actors to come forward with their stories. So many I have heard richly deserve telling to wide audiences.

Throughout this book, I reject the negative, cynical view of politics so pervasive in our society and culture. It is not my contention that politics is always good. Politics itself is neither good nor bad. It is a neutral force everyone of us uses in some way in all of our lives. Whether the practice of politics turns out for good or evil depends very much on the values we bring to our political engagements and on our personal perspectives about the appropriate uses of power. Politics is inherently neither bad nor good—it's what we choose to make of it. Many people—liberal, conservative, or whatever—get involved in political activity and leave dispirited and disgusted. They assume that the right of everyone to participate should somehow guarantee their right to win. But the best political actors know losses are as common as wins, and the only real losers are those who abandon the field to others.

Another cultural theme suggests politics is about "them": cigar-smoking pols who inhabit the lobbies and dark-paneled offices of Con-

gress, state capitols, and city and town halls. In this thinking, politics is about what "they" do to "us," how they take advantage of us to feather their nests and to satisfy their constant needs for ego gratification, cash, and reelection. This volume suggests, instead, politics is about "us," about the needs of ordinary people and how they get translated effectively or poorly into policies. How much politics is about "them" is heavily determined by the degree to which the political arena is abandoned or neglected by "us." My challenge and hope are to help readers become more familiar and comfortable with life in the arena so that you will want to join.

CHAPTER SEVEN

Agendas and Children's Health Care

. . . chance favours only the prepared mind.
Louis Pasteur

It was a gorgeous spring day, with luxuriant blossoms dressing the trees that lined the Hooker entrance to the State House. Imperturbably guarding the entrance is the equestrian statue of Joseph Hooker, the Civil War general who briefly commanded the Army of the Potomac in 1863. It was my first year in the House, 1985, and I wasn't paying much attention to the surroundings, thinking instead of the hell-on-wheels week just past. It seemed I could do nothing right. Issues kept popping up that threw me off balance, and everyone in sight was angry or disappointed in me for one reason or another. As I stood on the steps, the legendary Senate President William Bulger happened to walk by, wearing his familiar grin suggesting nothing got him down. "Boy, this is tougher than I thought," I said in response to his polite, "How's it goin' kid?" "Listen," he said, lowering his voice, "you get so wrapped up in the day-to-day issues around here, and you think if you don't do things the way people want, they'll never speak to you again. And you're always wrong, because they always come back for more."

His words were comforting relief I remember to this day. Nonetheless, the odd, unpredictable, and chaotic way that issues popped up on the public's and the legislature's radar screens was puzzling and troubling to me. It seemed too random and out of control to be real, not just in Massachusetts but everywhere I looked. Some issues, such as welfare and immigration reform, suddenly reach the center stage of public attention, become incessant topics of controversy in governmental corri-

dors, newspaper columns, and policy discussions, and then result in the enactment of new laws. Other issues, such as universal health care and comprehensive national tobacco control, may reach the public agenda, generate substantial attention, and then collapse before enactment or implementation of any new policy or law. Still other issues that may reflect major public problems, such as homelessness, can languish offstage for many years with no significant public concern.

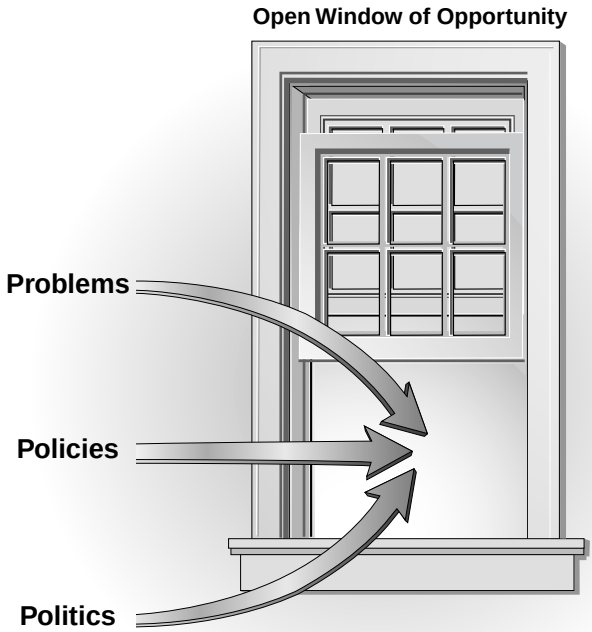
Is this just random luck of the draw? While it often seems that way from afar, the appearance of randomness is an illusion. Throughout many layers of society, all the time, individuals and groups inside and outside of government are hard at work setting up their next opportunities to create change. Those who understand the dynamics of a process called agenda setting and who operate according to its principles have a valuable advantage over those who do not. There is, indeed, an element of luck involved in this process. But, as Pasteur suggests, luck most often happens to those who prepare for it.

This chapter describes the dynamics of agenda setting, relying on a model developed by John Kingdon. In explaining his model, I use President Bill Clinton's ill-fated national health reform plan of 1993–94 to illustrate how the framework can be used retrospectively to analyze a successful or unsuccessful legislative campaign. I then describe how I used Kingdon's model prospectively to plan and promote major health care access legislation in Massachusetts in 1996.

AGENDA SETTING

Kingdon developed a simple and elegant model in the early 1980s to explain the emergence and recession of issues from the policy agenda.[1] I have found this framework genuinely useful in real life and one that people can easily understand. Because politics is both science and art, no model can explain everything. Rather, good models work like helpful tools—a hammer, a saw, a screwdriver—that can be used by most of us to perform a necessary job. Of course, there is always more to a successful job, such as the skill of the craftsperson, the quality of the materials. But the tools can also help a lot.

Kingdon's model was adapted from organizational theory that describes decision making in firms, whether for profit or not, governmental or nongovernmental. The model's basic premise is that leaders and managers in organizations and in politics are at the receiving end of a constant stream of disconnected, random, and chaotic information and



The Agenda Setting Model

feedback, flowing together in a form that makes little sense on its own. Creating some degree of order from all this varied input, finding a path through it, and then crafting an agenda for action are the essential challenges facing leaders both in organizations and in politics.

According to Kingdon's model, change can only happen when a "window of opportunity" for that change opens up—no open window, no change. For the window to open, three streams or dynamic processes must be moving at roughly the same time. The first stream is the *problem* stream, the sense among *those with the power to act* that a legitimate problem exists that deserves to be addressed. No genuine sense of a problem most often equals no action. Who are those with the power to act? That depends entirely on the forum in which the issue is being pursued. Changing a state insurance policy may require acceptance of legitimacy by the insurance commissioner and his or her appointing authority. Changing a university policy may require belief in the legitimacy of the issue by the president, the dean, and the board of trustees. If the issue

requires action in a legislative body, then key legislative leaders and committee chairs are the ones who must recognize the legitimacy of the problem. Change in the regulatory structure governing managed care was a major issue in the Massachusetts legislature in 1997 and 1998 (as in many other states), with many bills and lots of interested organizations involved in the fray. Ultimately, nothing happened, largely because the Speaker of the House, in his gut, did not believe that the dispute represented a genuine problem and thus used his power to delay any consideration until very late in the session. In this example, the political and policy streams were moving well, while the problem stream was halted by a critical person with the power to act.

The second stream is the *political* stream, the sense among those with the power to act that the timing for action is right in relation to public sentiment and consistency with other policy objectives. This stream combines the mood of the electorate, election results (who has been put into positions of power), the process by which groups are mobilized, and more. Promoting a major public spending proposal during a recession when budgets are being cut and pushing a major antiabortion bill in a state with high levels of pro-choice support are two examples where there may be an implementable policy and even officials who strongly support it. But progress will be held back by the political stream.

The third stream is the *policy* stream, the existence of an implementable policy that fits the scope of the problem, is understandable to those who need to understand it, and can attain sufficient support. At all times, so-called *policy networks* in every conceivable area and microarea of public policy are at work developing, refining, and promoting policy ideas and proposals. These networks are composed of government officials, academics, industry leaders, consultants, journalists, and more. They argue and test out ideas with each other, hungrily anticipating the moment when a problem will emerge to which their favored solution or policy can be applied. Indeed, policy solutions often precede the emergence of problems; effective *policy entrepreneurs* work hard to spot emerging problems to which their new policy ideas can be applied.

When all three streams are flowing at a sufficient pace, the window of opportunity opens, creating the possibility for substantive policy change. Implicit in the model are several important caveats. First, having only one or two of the three streams in motion is usually insufficient, particularly on matters that generate substantial controversy and attention. Retrospective analyses of failed attempts to change policy can usually reveal deficiencies in one or more of the streams. Second, just as surely

as windows of opportunity open, they close, making it important for advocates to move before an opening vanishes. Timing is not everything, but often it will be pretty close. Third, all window openings are not the same size. A policy proposal can easily be of a scale too large to fit through the size of the open window, either because the policy addresses far more than the perceived problem or because political limitations cannot permit a solution of the scale proposed.

President Bill Clinton's ill-fated national health reform proposal in 1993 and 1994 is a strong example of how Kingdon's model can be used retrospectively to analyze a failed policy initiative.[2] At the time of Clinton's presidential inauguration in January 1993, the problem stream was moving with terrific force. Throughout the 1980s, analysts in numerous health policy networks had demonstrated that out-of-control health spending and rapidly increasing numbers of uninsured Americans were symptoms of a growing systemic crisis. Throughout the decade, the cost of health insurance, public and private, rose at a rate far greater than general inflation or the growth of the overall economy. Health spending rose from less than 10 percent of the gross national product in 1980 to more than 14 percent in the early 1990s, with projections that spending would rise as high as 20 percent by the year 2000 if trends continued (the rate stabilized around 14 percent through the middle and later 1990s). Business and labor leaders, consumer groups, state and federal lawmakers, and media voices concurred that health spending was out of control with no end in sight. During this same period, the numbers of Americans with no health insurance coverage at all began to increase by about a million persons per year, from twenty-five million uninsured in 1980 to more than thirty-eight million by 1993 (and forty-four million by 1999). As both sets of numbers worsened, health policy researchers began paying closer attention to various dimensions of the problem, media began publishing stories describing the human aspects, and state and federal commissions, such as the Pepper Commission chaired by U.S. Senator Jay Rockefeller, further documented the problems and the needs.

Kingdon points out that there are many unfortunate conditions in life that are not recognized as public policy problems. "Conditions become defined as problems when we come to believe that we should do something about them," he observes.[3] By the end of 1992 no credible voice anywhere in the nation doubted the existence of a serious problem in our nation's health system.

Policymakers' sense that the political stream was moving adequately to justify action had evolved over several years. In 1988, Democratic pres-

idential candidate and Massachusetts Governor Michael Dukakis used health care concerns as a central policy plank in his national campaign. He had established his credentials on the issue with the signing of a so-called universal health care law in his own state in April of that year, a law that included a mandate for most employers to cover their workers and that was scheduled for implementation in 1992. While the Dukakis campaign floundered badly in the late summer and early fall in the face of an aggressive and negative campaign by then Vice President George Bush, it was widely agreed in campaign postmortems that the health issue had given Dukakis a late campaign lift, though not enough to overcome other weaknesses. The health care issue would increase in prominence in future presidential campaigns, several analysts wrote, though probably not until 1996.

The event that changed policymakers' perceptions about the political stream occurred in Pennsylvania in November 1991. Republican U.S. Senator John Heinz had been killed in an air crash in April of that year. Richard Thornburgh, the sitting U.S. attorney general at the time, resigned his cabinet position to run for Heinz's seat and began the campaign more than forty points ahead of his little-known rival, Democrat Harris Wofford, who had been appointed to the seat until a special election could be held. While Thornburgh publicly dismissed the notion that the health system was in crisis, Wofford made health reform his major issue, running television ads proclaiming, "If criminals have the right to a lawyer, I think working Americans should have the right to a doctor." When Wofford won the nationally watched contest, political observers widely agreed that health care was the issue that turned the election in his favor, even though his reform prescription was thoroughly undefined.

Democratic presidential candidate Bill Clinton made health cost control and access expansion central parts of his campaign, though once again in an undefined form embracing an untested, ambiguous concept called *managed competition*. After his victory, health reform was viewed as an electoral mandate issue, a point he emphasized repeatedly during his transition, most prominently at an economic summit he hosted in Little Rock, in December 1992. By inauguration day, 1993, with Democrats in control of the presidency and both houses of Congress, few doubted that the political stream was moving strongly in the direction of comprehensive, national health system reform.

But two streams are not enough to make change, especially big change, happen. It was the third stream, the existence of an implementable and understandable policy, that created the nascent adminis-

tration's greatest challenge. Deborah Stone discusses how broad labels such as "liberty," "security," "efficiency," and "equity" can be used to mask gaping differences in real policy preferences. By January 1993, the time for discussion of broad and abstract concepts—managed competition, health care reform, universal coverage—had passed. Instead, it was time to talk turkey.

Kingdon's model suggests that early 1993 was the time to take a policy off the shelf and move it through Congress while the problem and political streams were optimal. Instead, President Clinton appointed the much-maligned Health Care Task Force, headed by First Lady Hillary Rodham Clinton, that quickly ballooned to about 500 participants whose job was to figure out what his policy should be. It was not until late September 1993 that the president announced his Health Security Plan to Congress (not delivering an actual bill until late October), after deciding that the plan would follow consideration of his budget package, narrowly approved in August, and ratification of the North American Free Trade Agreement, approved later in the fall.

By the time Congress readied itself for serious deliberation, the size of the open window of opportunity was already narrowing. An improving economy reduced the public's sense of a health care crisis as many Americans regained health benefits when they found new jobs. Enemies of the president's plan in the insurance industry, small business, and the Republican Party took advantage of the delay to find a better footing for their opposition. In January 1994 the public heard a curious and remarkable open conversation over whether the U.S. health system was experiencing a "crisis" (a position espoused by Clinton plan backers) or a "problem" (a position promoted with increasing confidence by Clinton plan opponents). While the crisis advocates won the short-term rhetorical battle, reciting citizen horror stories to the media in droves, opponents succeeded in driving home the point that more than 80 percent of Americans were satisfied with their own coverage, however they might feel about larger systemic issues. The problem stream's flow was beginning to diminish.

The force of the political stream faced a similar depletion. While in January 1993, the U.S. Chamber of Commerce and other national business groups had publicly supported a national employer mandate, by early 1994 other small business voices had organized to force the chamber to reverse its position and to oppose any mandates. The combined weight of the small business community and the commercial health insurance industry, represented by the Health Insurance Association of America

(HIAA), had alternately emboldened and frightened members of Congress to oppose or remain neutral to the president's plan. The sheer complexity and breadth of the plan left many confused and open to negative impressions about its potential impact. Even Clinton's secretary of labor, Robert Reich, who traveled across the nation to speak for the plan, confessed in his memoir, *Locked in the Cabinet,* that he didn't really understand it:

> The health plan plays into its opponents' hands. It's unwieldy. I still don't understand it. I've been to dozens of meetings, defended it on countless radio and TV programs, debated its merits publicly and privately, but I still don't comprehend the whole. In the public arena, nothing is more vulnerable to organized opposition than a huge and complex idea.[4]

The Kingdon model helps to explain the nature of the Health Plan fiasco. An extraordinary opportunity in terms of public recognition of a problem, and political momentum for significant change, was lost because of the failure to develop a coherent, understandable policy and to move it in a timely way. Success with only two of the three streams is not enough to create major public policy change. Missing the moment by not moving forward when the time was most auspicious in January 1993 was a grave mistake. Overestimating the size of the open window of opportunity by proposing a policy change that went far beyond the public's sense of the problem was the other.

Hindsight, of course, is much easier than looking ahead. Like many state health policy leaders in 1993, I supported and worked for passage of the Clinton plan and would have been happy to see a plan that went even further. Understanding the nature of that failure by using the Kingdon model helps us to imagine how the result could have been different. Kingdon's model suggests a successful outcome would have required a less comprehensive plan that would not have nurtured the opposition coalition that formed. For example, had the president moved forward in January 1993 either with a straightforward plan to establish a national employer mandate to require most employers to cover their workers or with a national program to cover all uninsured children, he might have achieved a substantial victory that would have placed the nation's health system in a very different position in the late 1990s. In early 1993, many major business groups were on record in support of an employer mandate. Others groups such as the insurance industry's HIAA that were so highly effective in their opposition to the president's plan also sup-

ported an employer mandate and would not have moved forward with their highly publicized and effective "Harry and Louise" television ads against such a requirement absent the other controversial elements of his proposal.

Perhaps this alternative scenario also would have been unsuccessful. I don't think so, but that's actually beside my point, which is to illustrate the usefulness of this model in analyzing highly charged public policy battles. The Clinton Health Security Plan fiasco was, above all, a failure to devise a policy that fit the public perception of the problem and the existing political opportunity. The use of the Kingdon model does just what one would hope: it enables users to see critical facets of a situation that would not be as apparent without applying the framework.

One final aspect of the Kingdon model is helpful to understand. There is a tendency in politics to play the "blame game" when something goes wrong, to point fingers in any direction except at ourselves. Thus, the common reaction of Clinton plan supporters is that the 1993–94 failure was the result of insurance industry–small business–Republican Party opposition. But nothing done by this trio should have been at all surprising. When a legislative proposal seeks to put a substantial professional group out of business (as the Clinton plan would have done to many commercial insurers and insurance agents), it should not be surprising that these forces will fight like hell against the plan. Engaging in critical self-examination in the face of policy failure is a painful experience but also an empowering one. It suggests that the power to make change happen lies significantly within and begins with understanding the true nature of an open window of opportunity.

All this discussion, however, is used retrospectively to analyze a past event. In 1995 and 1996, I had an opportunity to use the Kingdon model in a prospective fashion: to plan and execute a campaign for major health care access reform in Massachusetts. The following case story shows how it happened.

HEALTH CARE ACCESS REFORM, 1995–96

It was the morning of Wednesday, April 3, 1996, as I walked up the marble State House staircase to the Senate Reading Room (where little if any reading ever occurs). I recalled the words of Nick Littlefield, longtime trusted aide to Senator Edward Kennedy, who had told me a few months before, "Nothing big ever happens without someone who gets just pas-

sionately crazy about it, and who keeps at it no matter what happens until it gets done." In this situation, that seemed to describe me, the crazy. The main question, though, was whether this exercise would result in tangible accomplishment or simply be one more round of frustration and deadlock.

I was anxious as I walked into the Senate Reading Room, located across an elegantly carpeted corridor from the chamber of the State Senate on the third floor of the State House. Senators use the Reading Room for off-the-record chats and meetings with important guests who are invariably impressed with its ornate ceiling, thick rugs, and high plush curtains. Surrounding the room are imposing portraits of former leaders of the body, including U.S. President Calvin Coolidge who presided over the State Senate during the First World War, Horace Mann, known as the father of American public education, and Kevin Harrington, a dominating six-foot-six leader from the 1970s whose long and imposing cigar is only one of his portrait's distinguishing features.

Large meetings in the Reading Room are rare, and only for those with solid connections. No one doubted that this meeting of fifty or so members of the Success By 6 Coalition met the test. Organized in 1994 by Marian Heard, the dynamic and engaging president of the United Way of Massachusetts Bay, Success By 6 was a coalition of Greater Boston's most powerful and influential business and civic leaders to promote public policy change on behalf of kids up to age six, especially in health care and early education. Members included Chad Gifford, head of the Bank of Boston, Paul O'Brien, former chief of the telephone giant NYNEX, Leo Breitman, the boss of Fleet Bank, Paul LaCamera, the president of Channel Five, and Carol Goldberg of the Stop & Shop grocery store chain. Thrown in for good measure were people like Hubie Jones, former dean of the Boston University School of Social Work, and Dr. Barry Zuckerman, head of pediatrics at Boston Medical Center. Marian displayed extraordinary savvy in leading the group, especially in hiring a skilled political organizer, Margaret Blood, as the group's director. Margaret knew the State House cold and as head of the legislature's Children's Caucus had worked with Representative Carmen Buell in 1991 to establish a small health program for uninsured children.

My study of thirty years of health policymaking in Massachusetts had convinced me of one critical fact: no major health care financing initiative had ever won State House approval without some significant and visible business support. On that April 3 morning, I had none and there were fewer than four months remaining in the legislative session that

would end on July 31 to get a bill through both branches and to the governor's desk. My strenuous efforts in 1995 and 1996 to find a meaningful alternative to the health care employer mandate signed into law by Governor Michael Dukakis in 1988 but never implemented had been woefully unsuccessful. The 1988 universal health care mandate was scheduled to take effect on August 1, 1996, but unless I could broker an alternative plan, the legislature had promised to simply repeal the statute and put nothing else in its place. The week before, I had succeeded in getting a controversial access bill voted favorably by the Joint Health Care Committee, which I cochaired, but only by the narrowest of margins, with several members reserving their rights as a favor to me. The broad array of Massachusetts business groups that focused on health issues made clear their opposition to my plan. The prospects of that bill making it through the process and then surviving a certain veto from Governor William Weld were nil. At the same time, the only bill that the governor would sign was unacceptable to me and to other key groups. Success By 6 seemed the most likely business group to win over, but they hated any kind of employer mandate, opposed new taxes, badly wanted to avoid any kind of public confrontation with the governor, whom they personally regarded as their pal and a good guy, and were principally interested in covering kids through age six, not up to eighteen as my plan proposed.

It was time to make a deal. . . .

THE MANDATE

Path dependent is a term that describes the real nature of policymaking. It means that potential actions have to be related in some logical way to whatever has gone before. There may be many potential paths to address any given policy problem, but the list of viable alternatives is sharply narrowed by what has come before. If I am driving down Route 2, I can't just wish myself onto the Massachusetts Turnpike. I have to take myself there, exit by exit, road by road. The health policy debate that came to a head in 1996 in Massachusetts represented the convergence of two paths. The first path involved the 1988 universal health care employer mandate. The other involved the Weld administration's 1994 request for a so-called Medicaid 1115 waiver from the federal government.

In 1988, by extremely narrow margins, the Massachusetts House and Senate approved what was called a "universal health care law" by the

public and "Chapter 23" by the health care cognoscenti, referring to its designation as the twenty-third statute signed into law that year. Governor Michael Dukakis, then running for U.S. president, trumpeted the new law as a model for the nation in an elaborate signing ceremony in front of the State House replete with colored balloons, a music band, and banners. While the Dukakis presidential campaign helped to convince a reluctant House of Representatives (I and only a few other reps were enthusiastic backers) to enact the mandate, support in the State Senate was more solid because of determined advocacy on the part of the powerful chair of the Senate Committee on Ways and Means, Patricia McGovern. While Chapter 23 had many complex provisions, the most controversial required all employers with more than six employees either to provide family health coverage for their workers, with employers paying at least 80 percent of the cost, or to pay a $1,680 per worker annual tax to the Commonwealth that the state would then use to finance coverage for the worker and family. In an unsuccessful attempt to mollify small business groups that opposed the mandate, implementation was held off until January 1, 1992.

Two important developments occurred in the four years between 1988 and 1992. First, the Commonwealth plunged into its worst economic recession since the 1930s, with major layoffs, business closings, and financial distress for most public and private employers. This recession greatly exacerbated concerns about the mandate's potential impact on small business. Second, in January 1991 Democratic Governor Dukakis, who was firmly committed to implementation of the employer mandate, was replaced by Republican William Weld, who was as adamantly committed to repealing the requirement and quickly filed legislation to achieve that objective. Weld's key health adviser, Charles Baker, publicly talked of how much he "hated" the mandate and said he would resign his job rather than implement the requirement.

In 1991, the political situation within the Senate and House had also changed. The 1990 election that elevated Weld to the corner office also increased the number of Republicans in the forty-member Senate from eight to sixteen, more than enough to sustain gubernatorial vetoes and—combined with conservative, antimandate Democrats—more than sufficient to repeal most of Chapter 23. McGovern personally warned me in a late-1990 telephone call that "it's up to the House now to keep the employer mandate alive. I can't protect it over here any more."

On the House side, the sentiment of members was clear. If the choice was between implementing or repealing the mandate, repeal would pass

overwhelmingly; but if the choice was to repeal or delay implementation, delay had a shot. The new Speaker, Charles Flaherty, was criticized by many progressives and the *Boston Globe* during 1991 for being overly solicitous of the new governor, but he was determined not to lose the opportunity for health reform presented by the mandate. He concurred with the recommendation by his new Health Care Committee chair, Carmen Buell, and me to move legislation to delay the effective date of the mandate from January 1992 to January 1995. Recognizing that the House would not send him legislation repealing the mandate, Weld signed the delay into law. Not coincidentally, 1995 was beyond Weld's current term of office, signaling our hope that a new governor after Weld would view the mandate differently.

But Weld coasted to a massive reelection margin in November 1994, trouncing his Democratic opponent, Mark Roosevelt, who made no campaign issue of health care or the employer mandate. Prospects for ever implementing the 1988 mandate in the wake of President Clinton's own health reform fiasco—which included a national employer mandate—were nil. Carmen Buell and I, however, were determined not to see the mandate repealed without winning some significant health care access expansion as the price for repeal. Again we prevailed upon Flaherty to postpone the mandate's implementation date for one additional year until January 1996 to give us time to work on an alternative health care access plan with the Weld administration. For a second time, in late 1994, the legislature agreed to postpone the mandate's implementation and Weld signed the delay.

By late 1995, Carmen Buell had resigned her seat in the legislature to move to North Carolina where her husband had been named head of the state university, and I had succeeded her as the House chairman of the Joint Committee on Health Care. We had made some progress with the Weld administration in agreeing to a health care reform package but still had a long way to go. Reluctantly, I successfully pleaded with my colleagues for one, final ("I promise!") delay of the mandate, from January 1, 1996, to August 1, 1996, and committed on the floor of the House that if we could not find an acceptable, alternative plan by then, I would personally bring to the floor and support a simple repeal bill. Though I did not know in late 1995 what that final alternative package would include, the selection of August 1 as the drop-dead date was to ensure that sometime before the end of our session on July 31, 1996, the House and Senate would be compelled to address health reform, one way or another. We purposefully put a gun to our own heads.

THE WAIVER

For a laid-back person, Bill Weld is one ambitious guy. Harvard undergrad, Harvard law, Rhodes scholar, with family roots tracing back to the *Mayflower,* the tall, red-haired, red-faced governor had become immensely popular with the Commonwealth's voters. He mixed a hard-edged libertarian message of no-new-taxes, pro–death penalty, and tough on welfare recipients with progressive stances in favor of abortion and gay rights, all the while maintaining a goofy, self-effacing personal style that included proposing that all the state's flags be lowered to half-mast in recognition of the death of Grateful Dead guitarist Jerry Garcia. Since the 1950s, Republican voter strength in Massachusetts had been in steady and heavy decline, requiring Weld to stitch together a base that included heavy doses of independent and Democratic voters. Part of his strategy to win the governor's office in 1990 included convincing moderate-to-liberal Republican State Senator Paul Cellucci to abandon his own gubernatorial ambitions and to run for lieutenant governor on a ticket with Weld. In gratitude for this gracious move, Weld wanted to do everything possible to get out of the way to give Cellucci a clear path to the corner office by 1998.

In 1993, Weld and his key lieutenants had two related ideas. The first was that Weld might be a viable contender for the Republican presidential nomination in 1996 to challenge incumbent Bill Clinton. Failing that, there would be a potential challenge to U.S. Senator John Kerry, the state's second-term junior senator. The second idea was that in order to appear viable, Weld needed his own plan to address the key national issue of the year, health care access. This was the period when the Clinton health plan was still considered viable and many thought some form of national health reform was inevitable. Weld knew he possessed the talent to create his own plan.

Within his administration, Weld had two key players eager to meet his need. Charles Baker was a hard-driving supply-sider, the son of a high-ranking health official in the Reagan administration, and the former chief of a right-tilting Massachusetts think tank, the Pioneer Institute. As Weld's assistant secretary of health and human services, Baker was a blunt-speaking, conservative thinker who loved health policy and who led the charge in 1991 to close state hospitals and to dismantle a hospital regulatory system in favor of market-driven health care. In his office was a photo of Bill Weld, personally autographed to Baker as "the soul of the Weld Administration." In 1993, he became Weld's second secre-

tary of health and human services, and would move in 1995 to become Weld's third secretary of administration and finance, a position often called "the deputy governor."

Close to Baker was Bruce Bullen, the low-key but intense commissioner of medical assistance, who ran the state's behemoth Medicaid program, labeled the leading "budget buster" during the heated recession days when the program's costs were rising by more than 20 percent while the overall state budget was hemorrhaging red ink. Despite working for a Republican administration, Bullen came from a Democratic background, having served as budget director to Patricia McGovern at Senate Ways and Means and later moving to Medicaid during the final years of the Dukakis administration in 1989. Baker had admired Bullen's work and kept him on to lead the transformation of the Medicaid program from a passive payer of provider bills to an aggressive health purchaser. Bullen had watched as the state of Tennessee implemented in 1993 an ambitious "TennCare" program that used savings from the implementation of Medicaid managed care to expand coverage to large numbers of uninsured persons. He and Baker thought Massachusetts could do the same thing, and do it better.

In the spring of 1994, the Weld administration filed a request with the federal Health Care Financing Administration (HCFA) for a so-called Section 1115 waiver to permit the state to redesign its Medicaid program in experimental ways. The federal government, through HCFA, pays between 50 and 80 percent of Medicaid expenses in states (50 percent in Massachusetts) and requires conformance to numerous standards related to benefit design, service delivery, and more. States can deviate from these standards only by obtaining at least one of several waivers from the administering agency, HCFA, which runs Medicaid and Medicare within the U.S. Department of Health and Human Services. While the 1115 waiver option provides states with the greatest amount of flexibility to expand access to otherwise ineligible persons, it also includes a "revenue neutrality" requirement so that the federal government will not pay more than it would in the absence of the waiver. From the state's perspective, meeting all the requirements and answering all the questions to obtain the 1115 waiver are major challenges. Governors often complained about the lengthy and burdensome process but sought waivers as the only way to experiment with the program while retaining cherished federal dollars.

The Weld administration 1115 waiver proposal as crafted by Baker and Bullen included several complex and related parts.

First, eligibility for Medicaid coverage would be expanded to all families whose incomes were below 133 percent of the federal poverty line (about $20,000 for a family of four) instead of the traditional standard where coverage was only provided to some poor people, those who fit into specific categories such as Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI).

Second, a new program of tax credits to employers and subsidies to low-wage workers would be provided when the worker had a family income below 200 percent of the federal poverty level (about $32,000 for a family of four) and the employer provided health insurance paying at least half the cost. The employer would get a $400 per year tax credit for providing individual coverage, $800 for spousal coverage, and $1,000 for family coverage. The worker subsidy would be greater, scaled according to income. The administration labeled this proposal the Insurance Reimbursement Program (IRP).

Third, and most controversial, principal funding for the IRP would be obtained by diverting more than $200 million from the state's Uncompensated Care Pool, a $315 million program created in 1985 to assist hospitals in paying the cost of caring for persons in need of hospital services who had no health insurance. From the hospitals' perspective, this was *their* money and it was already insufficient to cover their growing charity care costs.

Fourth, the administration urged the legislature to reform the so-called nongroup insurance market that exists for individuals who cannot obtain group coverage through employers. This coverage is too expensive for most uninsured persons to afford, and many were excluded from useful coverage because of restrictions on persons with preexisting conditions, experience rating, and a variety of other requirements.

Fifth, the administration proposed to the legislature the creation of a state tax break for so-called medical savings accounts that permit individuals to set aside funds in tax-deferred accounts to use for their own medical costs. The concept was highly popular in Republican circles as a means to encourage health consumers to spend money on health needs more prudently and unpopular with Democrats because of the feared and expected negative effect on remaining insured populations.

Sixth, the administration proposed to repeal the 1988 employer mandate.

The first two items required specific approval from HCFA because of the intended use of federal dollars to finance the reforms. The latter four required no federal action but would be part of a legislative package sub-

mitted to the House and Senate to implement the waiver once needed federal approvals were obtained.

There are two ways for a governor to win the necessary approvals to implement a Medicaid waiver. One is to get agreement and approval from the legislature first and then seek federal approval. The risk is that HCFA may require modifications requiring another round of legislative approval, something most governors prefer to avoid. The second route is to obtain federal permission and then seek ratification of the arrangement from the state legislature. The risk here is that the legislature may not agree with the structure of the waiver as negotiated by the administration, requiring further approvals from the feds. Governor Weld and Lieutenant Governor Cellucci decided to follow the second route, filing their plan for an 1115 waiver with HCFA with fanfare in April 1994. "Universal coverage without an employer mandate" was their tagline, claiming that more than 400,000 of the Commonwealth's 500,000 uninsured residents would be covered if the plan were fully implemented.

Later detailed examination of the administration's claims would reveal that at most 150,000 of 700,000 uninsured would be covered, and only if *everything* went precisely according to plan. No one publicly challenged the administration's estimates at the time, thus allowing Weld to boast that he had found the route to universal health care without the harsh medicine of an employer mandate. Aside from exaggerated estimates, the Weld plan had several other looming problems, chief among them opposition from the hospital industry at the prospect of more than $200 million being diverted from the uncompensated care pool to finance the IRP tax credits and subsidies at a time when hospitals were feeling financially pressed by growing competition and growing numbers of uninsured patients.

By the end of 1994, Governor Weld had been reelected with a historic margin, the drive for national health reform had ended in ignominious defeat, the 1115 waiver was still pending before HCFA, and the Dukakis employer mandate was scheduled to become effective in January. The legislation approved at the end of 1994 to delay implementation of the mandate until January 1996 anticipated that the waiver would be approved in some form by federal officials and thus directed the governor to establish a special commission to review the waiver and to report to the legislature its recommendations for implementation. The expectation was that this work could be completed by the end of 1995, permitting a final resolution to the fate of the mandate.

On December 24, 1994, the Weld administration suspended any fur-

ther admissions into a small state program called the Children's Medical Security Plan that had been set up in 1991 through the advocacy of Representative Carmen Buell, Margaret Blood, and others to provide a basic package of primary and preventive care services to uninsured children. Budget limits kept most kids out of the program, but advocates had been informing more and more parents of the option and were outraged and mobilized by the freeze. Two days after the freeze, a Children's Health Coalition formed, made up of the advocacy group Health Care for All, the Massachusetts Medical Society, the Massachusetts Academy of Pediatrics, and the Massachusetts Teachers Association. It was an unusual coalition, and MTA President Bob Murphy declared at its start, "Our goal is that no child in Massachusetts will go without needed health care."

In late April 1995, the federal government approved the Weld administration's 1115 waiver request, with some modifications and pending review and approval by the state legislature. Only a handful of the 200 senators and representatives had any sense at all of what the administration's plans contained. To decide the next move, eyes turned toward the newly formed special commission.

THE COMMISSION

Legislatures like to create special commissions to examine complex and controversial problems. Legislators tend to be generalists: even the most expert lawmakers are usually not as up-to-date as outside experts and constituency leaders. When outsiders can be brought together in a way that leads to consensus, the route to legislative approval can be considerably smoothed. One key challenge is composition. Stacking a commission with people who agree with the appointing authority's point of view gets the report he or she may prefer, but it then enjoys less credibility; constructing a diverse and conflicting membership may lead to no recommendations at all, setting back the process considerably.

Despite their regular use, special commissions in Massachusetts on complex health matters had generally followed the second pattern and had been uniformly unsuccessful. Special commissions in 1981, 1987, and 1990 all failed to reach agreement on reforming critical elements of the Commonwealth's health care financing laws. Health care providers and insurers simply had too much at stake to make their deals at the commission stage, which preceded normal legislative considerations. Final deals usually were cut much later in quieter rooms where the brokers were Ways and Means chairs, House Speakers, or Senate Presidents.

Carmen Buell, the House chair of the Health Care Committee, was the point person for health care reform in 1994 and 1995. Smart, progressive, and politically savvy, she entered the House in the same class as I did in 1985 and beat me in a competition for Health Care chair in January 1991. Flaherty named me House chair of the Joint Committee on Insurance in January 1995, giving me a stronger role in health policy discussions. Buell and I shared a strong commitment to finding a way to expand access to growing numbers of uninsured. Buell was Speaker Charlie Flaherty's key leader on this issue, and I worked with and supported her.

Buell and the Senate Health chair, Marc Pacheco, agreed on a plan for the composition of the commission that was included in its enabling legislation: three senators and four representatives (one Republican from each branch); Weld's secretary of health and human services (this would be a new player, Gerald Whitburn, brought in from Wisconsin by the Weld administration because of his reputation for aggressive welfare restructuring—he readily admitted to knowing little about health care); Weld's commissioner of insurance; and "six members appointed by the governor, two [of whom] shall be consumers representing diverse cultural backgrounds and geographic regions, three [of whom] shall be members of the business community who represent different size employers and geographic regions, and one [of whom] shall be nominated by the Massachusetts AFL-CIO." To Buell's calculation, the five Democratic legislators and two consumer reps and one labor union rep would give our side eight votes, with Whitburn, Weld's insurance commissioner, two Republican legislators, and the three business seats giving their side seven votes—if it came down to a voting, instead of a consensus, situation.

Though establishment of the commission was authorized in January 1995, Governor Weld waited until May 1995—after HCFA gave its initial approval of the 1115 waiver—to make his appointments, giving the commission little more than four months to complete the review by its September 30 legislatively mandated deadline. Rather than appoint a mix of two consumer and three business representatives, Weld appointed five business group leaders, two men and three women, all white, to the panel. This move gave Weld's allies a nine-to-six voting majority for their positions. Buell and Pacheco, who became the commission cochairs, seeking to move the commission forward as rapidly as possible to meet a tight deadline, decided not to contest the governor's clear violation of legislative intent regarding the composition of the nongovernmental ap-

pointees. The governor's appointees liked to refer to the panel as the "Blue Ribbon Commission." I loathed the term and refused to use it. It made me feel like a judge of the prize pig contest at the State Fair. The official and statutory title of the panel was a "special commission established for the purpose of making an investigation and study of methods for achieving universal health coverage for residents of the commonwealth."

Shortly after the start of the commission's work, Buell announced that she would be resigning from her legislative seat in July to move to North Carolina with her husband, Michael Hooker, who had just been named head of the University of North Carolina at Chapel Hill. With her departure, House Speaker Flaherty moved me from chairmanship of the Insurance Committee to the Health Care Committee, and the Special Commission members chose me to assume Buell's cochairmanship of that group as well. Prior to Buell's departure, I had deferred to her lead, having my own load of issues (nongroup health insurance market reform, homeowner insurance redlining discrimination, long-term care insurance reform) to carry as chairman of the Insurance Committee. Now, finally, in July 1995, ten and a half years after entering the House, working with my Senate chair, Marc Pacheco, I was in charge.

In discussions with Weld's point person on the commission, Secretary Whitburn, it became clear that the governor was in no mood to make any significant concessions on health reform. The political climate in the summer and fall of 1995 was markedly different from the atmosphere prevailing in the heady health reform days of 1993 and 1994. With Newt Gingrich as the new Speaker of the U.S. House of Representatives and triumphant Republican majorities in both houses of Congress looking confidently to revolutionize the Medicaid program—seeking to create block grants to give near–carte blanche authority to states to run the programs as we saw fit—the relevance of the 1115 waiver seemed questionable. According to Whitburn, the governor would consider no compromise on repeal of the employer mandate, no new state revenues to finance additional health expansions, and no major changes to his plan. In fact, it was apparent that Weld didn't care very much whether we moved on the waiver at all. Since late 1994, he had aggressively pursued a tough-on-crime, no-new-taxes, and tough-on-welfare-recipients agenda. Health care was off the list. Take it or leave it was the message. It was also clear that Whitburn commanded a majority on the commission, nine for him and six for us.

In the process of the commission's work during the summer, the gov-

ernor's appointees emphasized their enthusiastic support for their sponsor's plans, especially for the tax credits and subsidies to businesses that insured workers with family incomes below 200 percent of poverty (the so-called IRP), repeal of the employer mandate, individual market insurance reform, and creation of medical savings accounts. It became increasingly apparent to those of us not with the governor that many of the numbers behind his plan were cooked. Most important in this regard was the IRP portion of the plan that would provide tax credits to eligible employers and employees, including employers who were already covering their workers. It was obvious to us that most firms currently providing health benefits would claim the credit, but what percent of firms not offering coverage would start doing so because of the IRP? This was crucial in order to judge how effective the approach would be. The administration's confidently stated answer was "70 percent." I was suspicious, knowing that similar tax credits in other states attracted no more than 15 percent of eligible employers. I kept asking them, "Where did you get 70 percent?" When they realized that I wouldn't stop asking, one of the administration's operatives told me privately, "It was a guess."

In September, after a series of public hearings, meetings and working groups, Pacheco and I decided to euthanize the commission as quickly and quietly as possible. The next stage after the commission would be at the legislature's Joint Committee on Health Care, which we solidly controlled. We permitted Whitburn to write most of the language that he wanted in the final report, and we included our dissenting opinions wherever we chose. The final report, which all members signed, included useful information on the background of the reform issues facing the Commonwealth but confirmed that the commission members had been unable to reach agreement on the most controversial and important matters. As Pacheco and I had intended, the issuing of the commission's final report was a nonevent.

When it suited our purposes, we would speak about the broad areas of agreement that commission members had found—but those areas were minuscule in comparison with the disagreements. Pacheco and I used that language of consensus to convince the House and Senate in November to postpone implementation of the employer mandate to August 1, 1996. We both committed publicly on the floors of our respective chambers that we would not ask for any more extensions after this. One way or another, we would resolve the issues behind the employer mandate and

the waiver before the end of formal sessions on July 31, 1996. Now we just had to figure out what to do. . . .

THE STREAMS

It was September 1995, and everything seemed a mess. The employer mandate had minuscule support at best and nowhere to go. The administration's waiver plan was full of holes. The public clamor for health care reform was nowhere. Congress seemed on the verge of dismantling the basic structure of Medicaid as President Clinton began to move in the Republicans' direction. The Massachusetts House was experiencing growing tension as a federal criminal investigation of Speaker Charles Flaherty gathered steam with an incessant stream of newspaper leaks; meanwhile, Flaherty's majority leader, Richard Voke, and his Ways and Means chairman, Tom Finneran, had begun sub-rosa but intense and bitter campaigns to line up votes should the Speaker's chair become vacant. On the personal front, I had only eight months to write and complete my doctoral dissertation or else violate the terms of a federal grant I had received to help me write it.

In midsummer, shortly after becoming Health Care chair, I picked up my copy of John Kingdon's book *Agendas, Alternatives, and Public Policies*. I recalled the intuitive simplicity and elegance of the Kingdon model, the three streams and the window of opportunity that I recently learned in doctoral studies at the University of Michigan from John Tierney of Boston College. I thought, "What about trying to use this model to plan a campaign prospectively instead of just using it to analyze a political effort after the fact? Hey, do I have a better idea? What do I have to lose?" Without telling anyone, several times a month I would sit down and evaluate progress and plan next steps according to the three streams. . . .

Problems. Kingdon's framework suggests that *those with the power to decide* must be convinced that a genuine and significant problem exists in order for this first stream to move. In 1995, the challenge was to convince not only key lawmakers but also the media and the public. Support for expansion of access to health care services seemed to have disappeared during the first year of the Republican revolution in Washington and in the aftermath of the Clinton health plan fiasco. Discussions concerning health care "reform" focused overwhelmingly on Republican plans to reduce substantially the rate of Medicare spending growth and to transform the Medicaid program into flexible block grants to states

that also would lessen federal expenditures. In October of that year, I attended a joint National Governor's Association–National Conference of State Legislatures session in Washington, D.C., where speaker after speaker advised us to get ready for the brave, new, and inevitable world of Medicaid block grants.

At one session, my friend and then Michigan Medicaid director, Vern Smith, posed a vivid metaphor to describe our state of mind in anticipating block grants and the removal of federal regulatory authority. His son had taken up sky diving and recalled looking out the doorway of the flying plane, holding onto a bar above his head. He looked down at the earth below and froze. He looked up, closed his eyes, and then "just let go," enjoying a liberating and energizing experience. "And, friends, that's what we have to prepare ourselves to do," said Smith. "We have to have the confidence in ourselves to *just let go*."

The time for comments came, and I couldn't resist. My days when I would flame out at the drop of a hat had passed but rushed back to me. "As we anticipate the brave new world of block grants and just letting go, I'd like to speak on behalf of all the folks out there without parachutes. I can recall coming to meetings like this in the 1980s when we would discuss how to meet the challenge to provide health coverage for all Americans. Today, we have millions more uninsured Americans and all we're talking about is how to cut back. We have a moral imperative to meet their needs." Scattered applause. More than a few scowls. A senator from Wyoming got up to say that all his people wanted was to get Washington off their backs. I thought of myself as Donald Sutherland in the remake of the movie *Invasion of the Body Snatchers*. Who *were* all these people? Would we ever be able to change the topic of conversation back to the uninsured?

One way to refocus attention on the problem was to develop evidence of its scope and to create awareness—according to Deborah Stone's approach—of a number. Back in 1988, our best estimates indicated that about 600,000 of six million Massachusetts residents lacked any health insurance. By 1990, because of access expansions in the 1988 universal health care law, data indicated that the number of uninsured had dropped to about 450,000. By 1994, Carmen Buell and I believed that the number had risen substantially to perhaps as high as 700,000 because of anecdotal reports from health care providers and growing demands on the hospital uncompensated care pool. Weld administration officials openly suggested their belief that the number had actually declined to between 200,000 to 300,000. Buell had the foresight to push

for and win a budget appropriation directing the administration to contract for a professional research study to estimate the actual number of residents without coverage in 1995.

The Weld administration contracted with three respected health research professionals from the Harvard School of Public Health, Robert Blendon, Katherine Swartz, and Karen Donelan, who used the Lou Harris polling firm to conduct a telephone survey of Massachusetts households during late May 1995. The results indicated that the number of residents without coverage had risen from 455,000 in 1989 to 683,000 in 1995, while the number of uninsured children had risen from 90,000 to 160,000 during the same time frame. The researchers informally gave me the results in July. Because the researchers had a contract giving the administration control over release of the data, I held onto the results until Weld officials chose to release them.

Government and media relations specialists know there are good times and bad times to release information, depending on one's desire for extensive or limited media coverage. Weld administration officials waited until the second Friday in August, in the afternoon, to release the results of the Harvard study. The timing of the release ensured that coverage of the story would appear in the Saturday newspapers, the least-read edition of the week, during one of the least-noticed weekends of the year. Good news from the Weld administration gets announced in Room 157 in the State House, with its deep-blue carpet and sky-blue walls, prefabricated speaking platform and stage, and elevated back platform for the cameras. Good news, the kind of news the administration wanted to get out, would be announced by Bill Weld himself or at a minimum, his lieutenant governor, Paul Cellucci. On August 11, the news about the new number of uninsured in Massachusetts, a huge 50 percent increase, was announced by Weld's secretary of health and human services, Gerald Whitburn. The news was not announced in the State House but rather in Whitburn's office on the eleventh floor of the John McCormack State Office Building.

"At least our numbers are still below the national average," offered Whitburn in a vain attempt to find a silver lining in the report's clouds. The next day's story appeared on page 23 of the Saturday, August 12, *Boston Globe*. The Weld administration's efforts to keep the issue of the uninsured away from central public attention, to manage the public agenda by minimizing the public's sense of the problem, had seemed to succeed.

The Harvard team's contract with the Weld administration lasted until the end of September. Before then, they were contractually unable to speak out or testify on the results of their study without Whitburn's prior approval, and all comments and testimony had to be approved beforehand as well. Beginning on October 1, they would be free agents. On September 25, the Special Commission issued its final report and dissolved, unmourned except for the five business representatives who frequently asked Pacheco and me to file legislation to extend the panel's life. "That would be very difficult," I said. "We have a long way to go through the legislative process, and need to get moving." Privately, I thought, "in your dreams."

But the release of the commission's final report gave Pacheco and me a plausible rationale to call a public hearing of the Health Care Committee during October. Instead of placing the commission's report at the top of the hearing agenda, when the TV cameras and press paid the most attention, we asked Blendon, Schwartz, and Donelan to lay out the details of their findings on the growth in the Commonwealth's uninsured population. The rest of the hearing was uneventful. A decent amount of press coverage gave the numbers of uninsured the attention we had wanted. From that point onward, every speech, presentation, discussion, interview, article, comment from me included mention of two numbers: nearly 700,000 uninsured residents and 160,000 uninsured children. We distributed the commission report only to those who asked; we distributed the Blendon report everywhere.

Deborah Stone's work on discourse theory emphasizes that numbers are both tools and weapons in politics, never complete unto themselves, always used in a specific context with a political purpose in mind. I was clear about my purpose in using numbers: to nurture a sense that the problem of uninsurance was serious, unacceptable, growing, and in need of a significant public response by government. My tool of choice in the fall of 1995 was a number, 700,000. When Speaker Flaherty and I made our first public proposal in January 1996, Karen Van Kooy of my staff prepared a large poster board with the oversized figures "700,000 uninsured residents."

Later in 1996, when it became clear we would not be able to address the needs of the broader population of uninsured and instead chose to focus on uninsured children, we switched to talking exhaustively about "160,000 uninsured kids." In March, U.S. Senator John Kerry began a series of nine vitriolic and bitter debates with his formidable challenger,

Bill Weld. In every one of those debates, at some point, Kerry hurled "160,000 uninsured kids in Massachusetts" at Weld. Kerry's reference was not coincidental; a handful of influential Kerry backers and I worked aggressively beginning in December 1995 to convince Kerry to help us carry this issue into his U.S. Senate fight. By the time the debates actually occurred on the floor of the Massachusetts House of Representatives in June and on the floor of the Senate in early July, awareness of the number, 160,000, had spread widely across the state.

Creating awareness of the problem through recognition of a number was clearly insufficient to move major policy change through the legislature. But it was an essential prerequisite that placed our opponents in a defensive and awkward position, forcing them to preface each statement in opposition with some variant of the phrase, "I agree that we need to do something about the problem of so many uninsured kids, but . . ." Increasingly, the second clause of the sentence would be irrelevant.

Policies. From the beginning of efforts to achieve universal health coverage, finding a meaningful, implementable, and politically viable policy had been the hardest challenge. While most people easily agree with the statement "Everyone should have health insurance," how does one accomplish this goal? In the fall of 1995, I spent lots of time thinking about this dilemma throughout the day, whatever else I was doing at the time: cleaning my house, driving the car, fixing up my yard—an intense mental distraction. On one weekday in October I was sitting on one of the high-topped, stiff black leather chairs at the front of the House chamber mulling this quandary, while the rest of the House membership was engaged in spirited debate over legislation to raise the state's minimum wage by one dollar. In spite of the Republican ascendancy in Washington, D.C., Democrats in the Massachusetts House and Senate remained firmly and lopsidedly in control of our respective chambers. Raising the minimum wage from $4.15 to $4.65 in January 1996 and to $5.15 in January 1997 was a plan vigorously opposed by most Republicans in both chambers and by Governor Weld, who promised a veto. Our reply was vintage Clint Eastwood: "Make our day!" Weld did, and we overrode his veto with pleasure and ease.

My mind turned back and forth between the one-dollar minimum wage hike and the 1988 employer mandate that would have required employers to provide health coverage to their workers or pay a $1,680 per worker tax for use by the Commonwealth to buy coverage for the

worker. A one-dollar-per-hour increase in the minimum wage comes to about 40 dollars per week for a full-time worker. I took out my pen and scratched on the white back of my copy of the daily House calendar:

$$
\begin{array}{rrl}
 & 40 & \textbf{dollars per week} \\
\times & \underline{52} & \textbf{weeks} \\
 & 80 & \\
 & \underline{200} & \\
= & 2{,}080 & \textbf{dollars per year}
\end{array}
$$

Why, I wondered, was it so difficult to sell my colleagues on a $1,680 employer health tax and so easy to sell these same legislators on a $2,080 mandatory wage increase on many of these same employers? Was there a lesson here? Gradually, I came to the conclusion the problem was part packaging and part substance. The 1988 requirement was perceived as Cadillac health coverage for workers, requiring employers to kick in the equivalent (in 1988 dollars) of 80 percent of the cost for full family coverage. What if, instead, we devised an alternative requirement that worked more like the minimum wage? What if, instead of setting a "maximum" mandate that would require new costs and compliance by most employers, we looked at mandated coverage as a minimum, a floor below which employers couldn't go? All workers should be offered—at a minimum—individual coverage by their employers, I thought, and those employers should agree to pay at least half the cost.

OK, but what about the low-wage, marginal employers for whom even a minimalist mandate could spell disaster? For low-wage employers, we could agree to implement Governor Weld's Insurance Reimbursement Program, which would assist vulnerable employers with tax credits and workers with subsidies to pay their share of the cost. We could even call the plan "the Health Care Minimum Wage." I disliked Weld's IRP because it gave no assurance that employers who didn't cover their workers would actually do so. But an IRP linked to a minimum health care mandate made a lot of sense to me.

I immediately went to work on the idea with my committee research director, Brian Rosman. Several months earlier, having just assumed the Health Care Committee chairmanship, I hired Brian as my research director. He was low-key and intensely effective, an attorney who had worked previously for a member of Congress and for former Senate Ways and Means Chair Patricia McGovern. Having just returned from two years in Israel with his wife, a rabbi, he was eager to reengage in serious

policy work. Over several weeks in October, we developed the substance of the proposal to establish the health care minimum wage.

Other elements of a legislative package also began to come together. Senior citizen advocates had been pushing unsuccessfully for about eight years to establish and fund a program to help lower-income seniors to purchase prescription drugs. I had known Manny Weiner, president of the Massachusetts Senior Action Council, since my days as an organizer for the Amalgamated Clothing and Textile Workers Union and his days as the president of a steelworkers' union local in Everett, north of Boston. Manny was now in his early eighties, slowing down and a little cranky but earnest and determined. He asked me to include a $30 million senior drug program in whatever health access bill we reported out. I was derisive. "I've got one bottom line, brick wall requirement from House leadership," I told Manny and his companions. "The bill has to be revenue neutral in terms of a hit on the state budget. Where the hell do you think I can come up with 30 million bucks? Get real! Who are you kidding?"

Here was one of my worst flaws. Other politicians learn to listen, nod, smile, shake hands, and then, after visitors depart, shake their heads. I've never been good at playing poker or keeping a straight face. Manny sent me a handwritten personal note the next day: "I have never been so disgusted at the treatment I received from any politician. . . . We're just trying to help people in need and you ought to be ashamed of yourself!"

I told the story to several House colleagues, one of whom gave me an important piece of information. The House chairman of Ways and Means, conservative and tight-fisted Tommy Finneran from Dorchester, who had personally beaten aside previous attempts by legislators and elderly groups to pass a senior prescription drug program, had recently appeared before the legislative senior caucus, a gathering place for legislators and advocates interested in issues affecting the elderly. Asked about his long-standing opposition to the establishment of the program, Finneran replied: "I have no objection to the program in principle. I agree with the need. If we could find a reasonable way to fund it, I would like to see it established."

Hmmm. In working with Rosman to craft the package, I had wanted to find a way to finance a major expansion of the Children's Medical Security Plan for uninsured kids. The governor's proposal would cover all kids in families with incomes below 133 percent of the federal poverty line (about $20,000 for a family of four) through expansion of the Medicaid program, but that left out well more than half of the state's unin-

sured kids who fell above that income line. The CMSP had been started as a small pilot program in 1991 by Carmen Buell (initially called "Healthy Kids") to provide a basic package of primary and preventive care services to uninsured kids under age six. While the package was limited (no inpatient hospitalization, no dental, vision, or hearing services, very limited drug and mental health coverage), it was a heck of a lot better than being completely uncovered. In 1994, eligibility had been increased to age twelve, but enrollment had topped off at about 15,000 kids due to funding restrictions; meanwhile, data showed about 160,000 uninsured kids. Wouldn't it be good if we could come up with a way to expand CMSP to kids up to age eighteen and provide sufficient additional funding so that every uninsured kid in the state could get in?

Conventional State House wisdom was that raising taxes was impossible during the Weld years. But my mind increasingly turned to tobacco taxes as a new and viable funding source. In the late 1980s and early 1990s, I had tried on several occasions to hike the cigarette tax to fund public health programs. In 1991, in the midst of our deep and damaging recession, I proposed during the House budget debate a four-cent cigarette tax increase that would have raised about $16 million to be used to avert serious cuts in public health programs. Flaherty and Finneran toyed with the idea and abandoned it. I moved the amendment on the floor anyway and lost by 115 to 41.

I knew that the public, though, had a different feeling about tobacco taxes. In 1992, the state branches of the American Cancer Society and the American Lung Association formed a coalition to promote a state ballot initiative to raise the cigarette tax by twenty-five cents, directing the funds toward smoking prevention and other public health purposes. Though the coalition started its campaign with over 70 percent public support in the polls, by election day it won its initiative by a margin of 54 to 46 percent, surviving a heavily financed opposition campaign by the tobacco industry. Clearly, the public had far less antipathy toward tobacco taxes than did the legislature.

A new twenty-five-cent cigarette tax increase would generate about $100 million a year over five years, according to our best estimates. If we gave $30 million to a senior pharmacy program, that would leave about $70 million for a kids' health expansion and other parts of our plan. Even if our cigarette tax estimates proved to be high, there would be a ton of money for the program. I tested the waters with Speaker Flaherty who was willing to see if the tax could fly and with Ways and Means

Chairman Finneran who had no problem with tobacco taxes and always appreciated legislators who proposed new spending programs that also included new revenues to pay for them.

By late October, the form of a legislative package began to take shape:

1. The Health Care Minimum Wage, requiring all employers to offer individual coverage to their workers, with employers paying at least half the cost;

2. To address business concerns about the cost of the new mandate, a proposed decrease in the recently approved increase in the state's minimum wage in January 1997—from $5.15 to $5.05;

3. The governor's proposed Insurance Reimbursement Program to assist employers in complying with the HCMW, funded from the Hospital Uncompensated Care Pool, as proposed by the governor;

4. Repeal of the 1988 universal health care employer mandate;

5. The restructuring of Medicaid envisioned in the administration's 1115 waiver to open eligibility to all families—adults and children—with incomes below 133 percent of the federal poverty line;

6. Major expansion of the Children's Medical Security Plan to cover all other uninsured kids, funded at $70 million;

7. The Senior Pharmacy Program, funded at $30 million;

8. A twenty-five-cent increase in the cigarette tax to finance the expansions (with the additional benefit of discouraging teenage smoking); and

9. Creation of a formal study commission to examine ways to restructure the financing of the hospital Uncompensated Care Pool, addressing concerns expressed by the hospital industry.

By early November, it was time to start testing the waters. My longtime personal aide, Liz Malia, bought a four-by-eight-foot, white, secondhand writing board that fit perfectly on one large wall in my Health Committee office. As I met with groups and individuals in November and December, I didn't want to give anyone anything on paper, knowing that it might immediately get out to the media before I was ready. And so, during those two months, on about fifty separate occasions, I wrote out the plan on the board, step by step, throwing in lots of numbers and arrows and other scribblings to explain the complex package to anyone who wanted to listen.

The reactions varied widely: physicians from the Massachusetts Medical Society—"great, we love it"; leaders from the Massachusetts Hospital Association—"intriguing, challenging, but we think our members have grave concerns about using the hospital pool to finance the IRP"; consumers and their advocates—"we love it!"; business groups—"thank you for presenting this to us and we'll have to take this back to our members, but you know that we can't support any kind of health care mandate"; nurses from the Massachusetts Nurses Association—"we're with you!"; commercial insurers and Blue Cross—"very positive, we can work with this"; senior groups—"yes!"; health maintenance organizations—"we can support this direction"; children's groups—"this is very exciting to us!"; Weld administration officials—"no mandates and no new taxes; except for that, we can talk"; Health Care Committee members—"this looks promising, let's see how it goes"; Marc Pacheco, my Senate cochair—"we'll get killed if we propose new taxes, and killed on any kind of mandate."

Health Care for All and the Massachusetts Medical Society, two groups that in earlier times had been antagonists, joined together to form the Coalition to Improve Health Care Access to establish a broad support network for the plan. Rob Restuccia led HCFA's involvement, and lobbyist Mike Kelly coordinated for the MMS. They told me they were finding interest among a number of organizations that wanted to participate in the coalition in order to have better access to me. I thought that was great.

The reaction from the important labor community, though, was more mixed. Union leaders were very positive in their support for an employer mandate but were extremely anxious about giving away any piece—even a dime—of the minimum wage increase they had recently won. At their request, in early December, I attended a meeting of the Massachusetts AFL-CIO executive board at the Boston Teacher's Union Hall in Dorchester. I sat there while fifty of the state's most powerful union leaders argued with each other about the merits of this one element of the plan. Knowing how difficult it would be to sell any kind of mandate, I had put the 10-cent decrease in my plan to mollify business complaints and to demonstrate our serious intent. After about an hour of intense and bitter debate, I threw in the towel on that element of the plan—the first (and not the last) to go. I needed strong and united labor backing to have a chance and could not risk an early rift with them.

By the end of December, I had tested the outlines of the plan enough to know it was time to go public. On our side we had: consumers, physi-

cians, nurses, community health centers, labor, seniors, and, most important to me, Speaker Flaherty. Likely against us: the Weld administration, tobacco interests, and business. Somewhere in the middle: insurers and HMOs, the hospitals, most of the members of the Health Care Committee, and, importantly, my Senate cochairman, Marc Pacheco. Flaherty agreed that early January was the right time to put a plan out for public discussion. I gave him a choice: "If you want to announce this as your plan, I'm with you all the way. If you want me to go out on the plank, and you watch how it goes, that's fine with me, too." The two of us held a well-attended press conference on the morning of January 11, 1996, in Nurses' Hall on the second floor of the State House where a large bronze statue to Civil War nurses stands at the bottom of two marble staircases, one leading to the governor's office and the other to the State Senate chamber.

In order to get maximum coverage for the press conference, especially from the TV stations, which were getting harder and harder to attract because of their ratings wars, I leaked the details of the access plan and proposed legislation ahead of time to Richard Knox, the respected medical editor of the *Boston Globe,* who had been covering health issues in the state for more than twenty years, and to Connie Paige, State House reporter for the *Boston Herald.* Both papers gave our plan top-of-the-front-page coverage that day, thus guaranteeing good media coverage of the event. "Democrats Push Health Coverage, New Proposal Applies to All Mass. Workers," headlined the *Globe.* "Let's make the minimal provision of health care benefits part of the minimum wage, and see how it sells," I was quoted as saying. "Maybe it won't, but we're going to give it a try." Weld, asked on camera for his reaction, smirked and said, "Mandates and taxes! What is this, bring back Dukakis week?" An effective retort, I had to admit. The next day, the *Globe,* which was especially generous to my plan, titled its lead editorial of the day, "Rep. McDonough's Sound Health Plan."

The press conference, which came off without a hitch, represented the beginning of an external sales strategy. After two months of off-the-record, nothing-in-writing discussions in my Health Committee office, I spent the next three months moving all over the state, meeting with business, consumer, physician, senior, and other groups, making presentations to newspaper editors and reporters, using the same pitch and the same lines five to fifteen times per day. On Tuesday, January 16, five days after the press conference, the Health Care Committee held a daylong hearing on the new plan, with U.S. Senator Edward Kennedy, Boston

Mayor Tom Menino, and Attorney General Scott Harshbarger as my leadoff witnesses in support of the plan. On Martin Luther King Day, I appeared on a public radio talk show, *The Connection,* bracing myself for whatever. Talk radio is not for the meek but for those who can take it; the experience is enormously energizing as the calls come from all directions. Much to my surprise, out of about a dozen calls during the hour, only one was distinctly negative.

Much to their surprise, I went out of my way to meet with business groups across the state, making my pitch, hearing their comments and concerns, answering their questions as best I could. They genuinely appreciated my approach but respectfully disagreed. I recall meeting in late March with members of the Neponset Valley Chamber of Commerce. Sitting quietly through my presentation was the owner of a Domino's Pizza Shop, wearing his uniform of various shades of blue. "You just don't understand," he finally said. "I compete against pizza stores that pay everything and everyone under the table. I pay unemployment, workers comp, FICA, you name it, and you want to add one more thing that I have to dig up while my competitors pay none of those things? Come on. . . ." To lots of critics and questioners, I had ready answers. But to Mr. Domino's, I had to admit that his point cut through.

The noted political scientist Charles Lindblom suggests that the pluralist explanation of how politics works—that it's open season, and anyone can join the game to shape the outcome—misses the trump card the corporate community gets to play: business most always brings a larger degree of influence in political contests than other groups do. It's an observation that makes intuitive sense: politicians usually do better in good economic times than bad ones, and our fates are most closely tied to the fate of our district's and state's businesses. That dynamic was certainly in evidence in this situation and conformed to my own awareness of the heavy influence of business views in Massachusetts health policy discussions for more than thirty years. After three months of heavy outreach between January and March, a large amount of media coverage and favorable publicity, promising poll numbers, and the beginnings of an effective lobbying effort inside the State House by consumer, senior, and labor groups, I had moved nowhere in influencing the business community and, by extension, the legislators who listened to it. Those reps and senators who opposed the 1988 employer mandate had already heard from their local business groups and had no inclination to view my Health Care Minimum Wage plan in a more favorable light.

On March 27, in order to move the issue forward, I convinced a ma-

jority of the seventeen Health Care Committee members to allow the bill to be reported from the committee favorably. I had far less than a real majority of votes, but most members, including my new Senate cochair, Mark Montigny of New Bedford, "reserved their rights" out of respect for the work I had done (Marc Pacheco supported the losing candidate in a battle for the Senate presidency in late 1995 and had been removed as Senate Health Care chairman in January 1996 as a result). I knew there was zero chance for this bill to become law but wanted the Health Committee, which I chaired, to go on record in support of the kind of reform really needed to address the needs of the uninsured.

At the end of the afternoon executive session, Rob Restuccia, the executive director of Health Care for All and my ideological twin and ally in countless health access battles, pulled me aside. "We can get a lot of good things done now," he said. "But holding out for the mandate will kill it all. I've supported it as long and hard as you have, but it's time to let it go." He felt momentum building for an expansion of children's coverage in particular through the work of the Children's Access Coalition. He had a much clearer perspective on emerging events than I did, and he was right. We had an open window of opportunity to win some important health care access expansions, but a package that included any kind of employer mandate would be too large to fit. We were already thinking of what the new bill should include. Our original bill was now moving on to the House Committee on Ways and Means, and we would need to recommend a modified bill for its consideration.

The mandates, new and old, had to go. The governor's IRP, with its phony estimates and its elaborate tax credits and subsidies taken from the Hospital Uncompensated Care Pool, was also out. The package Brian Rosman and I put together included the following key elements:

1. Restructuring of the Medicaid program along the lines envisioned in the original Weld 1115 waiver, making all families with incomes below 133 percent of the federal poverty line eligible for Medicaid;

2. Expanding children's eligibility for Medicaid further to all kids in families with incomes below 200 percent of the federal poverty line ($32,000 versus $20,000 for a family of four at 133) to be phased in;

3. Providing sufficient funding to open the Children's Medical Security Plan to all other uninsured kids who would not be eligible for Medicaid;

4. Establishing the Senior Pharmacy Assistance Program, funded at $30 million;

5. Raising the cigarette tax by twenty-five cents to seventy-six cents to finance the senior and children's health expansions;

6. Creating a Special Commission to develop a new way to finance the hospital Uncompensated Care Pool; and

7. Repealing the 1988 universal health care employer mandate.

By early April, we had our final package assembled. We had created a genuine sense of a compelling public problem in need of resolution. We finally had developed a viable, implementable, road-tested, and funded policy proposal. From here until the end of July, it would be all about one thing . . .

Politics. Moving the political stream in a favorable direction, and keeping it going that way, was a formidable challenge—on numerous fronts. Some of the challenges included: instability in both the Senate and the House because of resignations by the presiding officer in both chambers, the President (in January 1996) and the Speaker (in April 1996), respectively; the need to develop and demonstrate support among the public; the need to counter an expected avalanche of opposition generated by the tobacco industry; the urgent need to develop an effective support coalition that could lobby inside the State House and generate public support on the outside; the dilemma of how to work with and move the business community; and, of course, the puzzle of how to deal with his excellency, the governor, who had other things on his mind.

In November 1995, Governor William F. Weld ended months of speculation by announcing that he would challenge two-term incumbent U.S. Senator John Kerry in the November 1996 general election. In his announcement, Weld stressed that his campaign would focus on three issues: crime, welfare, and taxes, and he began immediately to emphasize differences between himself and Kerry on these matters. It was widely recognized that this would be a bare-knuckle brawl between two experienced public figures. Knowing Weld's long-standing commitment to help his lieutenant governor, Paul Cellucci, become the next governor, and Weld's love for the national scene, I had felt for some time he would enter the race. My immediate thought, though, was how this race would affect our chances to pass the nascent health bill, still in development at

the time of Weld's announcement. Many smart people advised me it was now foolish to entertain any thoughts of a health bill that included new taxes. Weld could never afford to violate his no-new-taxes pledge, repeated firmly and directly in his Senate-run announcement. He would surely be able to use the visibility provided by the race to scare legislators away from voting for a new tax on cigarettes and certainly would be able to scare up enough votes to sustain a veto in either the House or Senate. Maybe, I thought, and maybe not, wondering to myself if I was being naïve and foolhardy.

One way to gauge our chances was to ask the public. Lou DiNatale is a tough, Democratic street fighter, a political operator who had retreated from the field of campaign battles to the more serene atmosphere of the John McCormack Public Policy Institute at the University of Massachusetts in Boston. In the past, he had offered me the free services of a polling operation available through the institute. Together, we devised two questions for a February 22, 1996, poll. The first was on the health care minimum wage: "A 'health care minimum wage' proposal would require employers to pay half their employees' health insurance premiums, give employers a tax credit, and provide subsidies to employees who don't earn enough to pay half their premiums. Would you support or oppose this plan?" The second dealt with the other elements in the plan: "A proposal has been made in the State House to raise cigarette taxes by 25 cents to fund health insurance for children who don't have it and help buy prescription drugs for elders who can't afford such coverage. Would you support or oppose such a plan?"

We had the survey numbers by late February. Over 65 percent supported the health care minimum wage plan (77 percent of Democrats and 44 percent of Republicans), about the same proportion that had always supported the 1988 mandate. They were nice numbers, but not high enough to move anyone inside the State House. The results on the second question were much better: 77 percent agreed, while only 19 percent opposed; importantly, even 73 percent of *Republican* voters agreed with our plan. We waited until the end of March to release the poll results at the same time as the Joint Health Care Committee reported the health care minimum wage bill favorably. From then on, we constantly reminded all 160 representatives and 40 senators about the numbers for the second question. "Even 73 percent of *Republican* voters," we would say.

We knew the tobacco industry would spare no expense in opposing a cigarette tax hike, having demonstrated its willingness to invest millions to defeat legislative and ballot initiatives everywhere in the nation.

(The industry had spent $7 million in an unsuccessful effort to defeat the 1992 ballot question, versus $1 million spent by proponents.) We expected, and saw, what's referred to as "astroturf lobbying." Gathering thousands of names from promotions, coupons, and other public relations devices, the industry breaks the names down by state legislative district. Paid phone callers reach the individuals, ask if they would oppose a cigarette tax hike, and then directly connect the individual to his or her legislator's office. Warning legislators ahead of time to expect this ploy was one effective countermeasure, but the more vital one was building a huge support coalition of our own.

At the epicenter was the consumer advocacy group Health Care for All. Formed in 1985 to advocate the health needs of low-income people, its focus broadened as health system problems affected larger segments of the population. Executive Director Rob Restuccia, bearded, articulate, and fortyish, rejected more doctrinaire forms of advocacy in favor of "what we can get." He became accustomed to hits from more ideological health advocates who wanted a Canadian-style, tax-financed, single-payer health system, and nothing else. (One single payer advocate wrote: "The McDonough bill is so watered down, it resembles homeopathy.") Joining him in the newly formed Campaign for Children were leaders and operatives from a broad array of forces: provider groups, consumer and advocacy organizations, senior citizen groups, and health insurers. Key supporters included the Massachusetts Medical Society, Children's Hospital, Harvard Pilgrim Health Care, the Massachusetts Teachers Association, Blue Cross, and smoking prevention groups such as the American Cancer Society—all of whom backed up their verbal support with significant dollar commitments to enable this grassroots campaign to function at a skilled, professional level. At various points, one or another group would suggest to me adding something to the legislation that would invariably alienate one or another part of the coalition. For example, the Medical Society, which abhorred managed care, suggested adding a tax on health maintenance organizations to finance additional expansions. My answer was, "No. We need to keep as big a tent as possible to beat the tobacco industry and Bill Weld. I want the HMOs with us, not against us." It was the same answer I gave to every group—with the exception of the senior citizens. Adding the senior pharmacy program to the bill gave us an enormous political boost with senior groups and virtually no loss in support from anyone else.

The coalition raised over $300,000 in three months, organized itself into fund-raising, lobbying, and grassroots organizing committees, ran

four telephone banks, and sent out over 30,000 legislative alerts bulletins. Blue Cross contributed funds that enabled the coalition to hire a senior public relations professional, Geri Denterlein, who generated newspaper and television stories across the Commonwealth.

One major health interest (which to this day prefers anonymity) bought us the lobbying services of Judy Meredith, a fiftyish, hard-boiled pro who cut her lobbying teeth in the 1970s as a naïve suburban mom advocating reform of adoption laws. She caught the lobbying bug and quickly became a respected and skillful operator within the State House. Meredith billed herself "the poor people's lobbyist," and she and I had worked closely together in the early 1980s lobbying for tenant protection laws. Each of the major groups participating in the coalition sent their own lobbyist to coalition strategy meetings where Judy carried the bullwhip. As the chair of a key legislative committee whose ear they all needed, I would occasionally show up to remind the thirty or so lobbyists that Judy reported to me every day who was carrying out their assignments—and who was not.

One major group we were unable to attract to the coalition was business. Adamantly opposed to the 1988 employer mandate and the health care minimum wage proposal, business was poised to block whatever it didn't like. This was a change. Back in 1988, two major business groups, Associated Industries of Massachusetts and the Massachusetts Business Roundtable, stood on the stage in front of the State House applauding as Governor Michael Dukakis signed the universal health care bill into law. By 1994, under pressure from small business groups and in the context of the national health reform disaster, both groups had withdrawn their support. Now, about thirty business groups, including AIM and MBR, met together on a regular basis to plot common strategy on health care issues.

The most likely break in the business chain appeared in the form of the Success By 6 Coalition, the business-backed group formed by the United Way to promote better health care and child care for kids through age six. With some of the most powerful business leaders in the state in the group, and some influential allies of mine among them, this was the first group to move if any movement on new taxes was possible within the business community.

On the morning of Wednesday, April 3, more than fifty Success By 6 leaders held a meeting in the Senate Reading Room. I made my offer to the group: we would repeal the 1988 employer mandate and not propose the health care minimum wage—or any other requirement—in its

place; but we would raise tobacco taxes by twenty-five cents and raise Medicaid eligibility for uninsured kids up to 200 percent of poverty, expanding the Children's Medical Security Plan to cover the rest of the kids; we wanted to cover all kids, not just kids up to age six. And we would set up the program to help seniors buy prescription drugs. I asked for their support.

Paul O'Brien, the former head of NYNEX, a powerful and respected business leader in the state for many years, stood first and addressed me. "To us," he said, "employer mandates are mortal sins. Cigarette taxes are more in the category of venial sins. I think we can all live with that kind of sin."

Shortly after my part, Senate President Thomas Birmingham walked in to address the gathering. Working-class from the streets of Chelsea, Harvard- and Oxford-educated, Birmingham had prevailed in a bruising fight to become Senate President the preceding January by effectively using his power over the budget as chairman of Senate Ways and Means. Once in power, he removed Mark Pacheco, who had backed his opponent, as Senate Health Care chair and installed New Bedford's Mark Montigny in his place. Birmingham had issued mildly sympathetic responses to my January proposal but on other occasions had clearly stated that no new taxes would be considered by the Senate in 1996. Standing before the Success By 6 group, Birmingham was visibly taken aback to hear O'Brien, a business voice, ask if he would support a cigarette tax hike to finance health coverage for kids. A chain smoker, Birmingham hesitatingly replied, "That would be very difficult to pass especially in an election year."

After Birmingham departed and the meeting ended, some of the group's leaders approached me in the back of the room to express their disappointment at his response. I was delighted. "What he means is, 'Show me the support is there, and we'll see what we can do.' It's just what he should say, and it's *great* news."

During this same period, the political situation in the House of Representatives became wildly unstable. Back in December 1992, a group of legislators led by House Speaker Charles Flaherty traveled to Puerto Rico for the expressed purpose of attending the winter meeting of the Council of State Governments but instead made their way to a luxury resort on the other side of the island, accompanied by a select group of high-powered lobbyists and unbeknownst to them, the *Boston Globe*. A front-page exposé appeared in May 1993 with a full-color picture of the Speaker in his bathing suit. That series convinced the U.S. attorney's office

in Boston to begin an extraordinarily intensive series of investigations designed to bring Flaherty down. While other legislators and lobbyists were fined and embarrassed by the Puerto Rico affair, nothing was found illegal on the Speaker's part. Instead, investigators focused on a house on Cape Cod at which the Speaker had stayed with a friend for a vacation in the early 1990s, a house owned by a parking lot operator with an interest in various legislative matters. By March 1996, leaks and rumors had reached a feverish pitch, suggesting Flaherty would plead guilty to a minor violation, pay fines, and relinquish the Speaker's gavel.

As early as mid-1995, two highly placed Democrats began quietly lining up votes to succeed Flaherty. The moderate liberal majority leader, Richard Voke, held the position which normally precedes that of Speaker and used his years of favors and service to line up a solid majority of votes—including mine—in the House Democratic caucus. Ordinarily, the winner in the caucus proceeds to election in the full House with the backing of most or all Democrats, as the Republicans support their own leader in a final predictable piece of theatre. But Voke was challenged by the moderate conservative House Ways and Means chairman, Tom Finneran, who used his intense, aggressive style and ability to hand out budget favors to build a team of committed loyalists. Despite his challenge, Finneran could not shake Voke's solid lock on control of the caucus.

Just hours after the Success By 6 meeting on April 3, Flaherty announced to a stunned House Democratic caucus that he would plead guilty to a minor tax violation and step down as Speaker on June 30. Pressure built immediately from the media and public for him to step down at once, and he agreed to do so. On Monday, April 8, Finneran held a press conference to announce a lock on 82 of the 160 votes to be elected Speaker. With quiet support from Weld, he convinced every one of the 32 House Republicans to commit to voting for him and not one of their own. Combining these with his solid 50 Democratic votes, he successfully employed an end run around the Democratic caucus and was elected Speaker of a bitterly divided House.

I felt a unique perspective on these events: would the bitter, ugly division within the House and the inevitable leadership changes derail what were becoming increasingly promising prospects for passage of major health reform? This was my primary concern—everything else was secondary. Shortly after announcing his vote lock on the Speakership, Finneran told reporters the names of several Voke-supporting committee chairs whom he intended to put on his new leadership team, with my name mentioned first on the list. I read his words carefully and knew his

word would be good for the rest of 1996 but implied no commitment after January 1997 when he would once again reorganize his leadership team at the start of a new term. He waited until May 21 to call a Democratic caucus to ratify his recommendations for leadership changes. Every member who supported Voke was either left in his or her current position or demoted, about half and half; nearly all Finneran backers were promoted, with a few left in place. A hard core of the Voke faction—very good friends of mine—became the active opposition within the House, challenging Finneran's control at many turns, mostly losing. To attain more than two-thirds support of the House membership for my health bill, I desperately needed strong support from both sides of this divide. I shut my mouth, bit my tongue, and felt like dirt.

In terms of the legislative process, I saw one major thing that could go wrong, something I had worried silently about for months. According to the rules of the institution, anything, *anything,* can be proposed as an amendment to an "appropriations" (or budget) bill: death penalty, agency reorganization, gay rights, you name it. Floor amendments to all other bills had to be "within the scope" of the bill's subject matter; but in a budget bill, everything and anything was "within the scope." We were scheduled to debate the House version of the coming fiscal year 1997 budget during the week of April 8–13, and if Republican members acted true to form, at least one of them would file an amendment to repeal the 1988 employer mandate. Were that to pass, and were the Senate to add a similar item to its version of the budget (and the Senate supported repeal more strongly than did the House), there would be no compelling need for any health bill (much less mine) to reach the governor's desk before July 31, the day before scheduled implementation of the 1988 mandate. This would be fatal. I could plead with members to wait, assuring them that a repeal bill would reach the floor but lose because of many members' unwillingness to be recorded publicly against repeal of the mandate.

To avert this threat, I filed early my own amendment to repeal the mandate and let the Republicans know it. Because they, along with most other House members, were distracted by the leadership struggle and other matters, they neglected to file an amendment of their own. After the deadline for filing amendments had passed, I quietly withdrew my amendment, eliminating any chance for the matter to be inserted into the House budget. After that, even had the Senate added it during their debate, it would have been deleted in the budget conference committee by the Democratic conferees who supported my position.

To me, this was a quiet, unobserved, and yet critically important win in dealing with the business community. Political scientist and game theorist William Riker made the key observation that legislative bodies only process alternatives in a *pairwise* fashion, two at a time. For example, suppose there are three proposed solutions to a given problem with varying degrees of support: option A has 45 percent, option B has 35 percent, and option C has 20 percent. Assume that everybody who supports option C supports option B as a second choice and that option B supporters break half and half for A or C as a second preference. If the choice is between A and C, A wins, 62.5 to 37.5; but if the choice is between A and B, B wins 55 to 45. Thus, the ordering of the presentation of choices can have a decisive impact on the legislative outcome.

The business community—hostile to any new mandate and any new tax, with the exception of Success By 6—saw three health policy choices arrayed before them in April 1996, presented in their order of preference. Option A was simple repeal of the 1988 employer mandate. Option B was my new bill, repeal of the mandate plus the cigarette tax increase that they didn't like. Option C was implementation on August 1 of the 1988 employer mandate, if nothing passed. By ensuring during the House budget debate that the House would not have the option of a simple mandate repeal—option A—I gave the business community a choice only between options B and C. On May 13, Brian Rosman and I met with about thirty of them at the offices of the Greater Boston Chamber of Commerce. Much to their dismay, Success By 6, Associated Industries of Massachusetts, and the Massachusetts Business Roundtable were already with us or moving in our direction. The association representing convenience stores and the groups near New Hampshire (which lured Massachusetts smokers with lower cigarette taxes) were bitterly opposed to our plan and sought every angle to attack my bill. But by early June, shortly before the House of Representatives took up the health access bill, we had won official support from the MBR, AIM, the Greater Boston Chamber of Commerce, and the *Boston Business Journal*. The solid wall of business opposition had broken, and we began letting everyone know it.

With the conclusion of the Special Commission back in September 1995 and the start of Governor Weld's Senate campaign in November, the Weld administration abandoned any pretense of interest in enacting major health reform legislation in 1996. In meetings with Human Services Secretary Whitburn in November 1995 and February 1996, the message was simple and clear: no mandates and no taxes, take it or leave

it. They knew that the legislature would not allow the 1988 mandate to become law, figured they could block any new taxes, and thought I was being, in the words of Medicaid Director Bruce Bullen, "excessively ideological." They even seemed to have lost interest in enacting their own proposals that were part of the Medicaid 1115 waiver.

An April 30 *Boston Globe* article gave the administration a severe jolt. A Richard Knox piece, "Weld Trails Pack on Cigarette Tax," reported that

> a high visibility group of business and community leaders that strongly supports raising the state cigarette tax to provide health insurance for children has at least one dissenting member: Gov. William F. Weld, who has vowed to veto the bill. Lt. Gov. Paul Cellucci and Charles D. Baker, the Weld administration's secretary of administration and finance, are also among the 56 members of the Success By 6 Leadership Council, which lobbies for programs benefiting young children. The situation illustrates how the Weld administration is becoming isolated on the health insurance issue, which is attracting support from leaders of both big- and small-business sectors. Opposition is currently expected only from the tobacco industry and convenience-store owners who sell cigarettes.

Within days, Baker called reporters into his State House office to announce that the Weld administration was hard at work developing a new alternative health plan—without mandates or new taxes—that would be "more kid friendly."

Key to the emerging Weld strategy was wooing the hospital industry to the governor's side, away from what was now called the "McDonough-Montigny Health Access Bill," by promising an immediate restructuring of the hospital uncompensated care pool. The pool, as originally devised in 1985, had all hospitals kicking in a proportionate share of about $300 million, money which was then diverted to hospitals that provided disproportionately high amounts of care to uninsured persons. Almost half of the funds went to two urban hospitals, Cambridge City and Boston City. Hospitals passed their pool liability onto their customers, similar to a meal or sales tax. But hospital rate deregulation in 1991 ended the inclusion of an explicit "uncompensated care surcharge" as a direct pass-through and instead left it to hospitals on their own to recoup their pool liabilities in rate negotiations with individual payers. By the mid-1990s, the reimbursement environment for hospitals had become perilous, as an overcapacity system left health insurers and businesses who paid the bills in the driver's seat. In the spring of 1996, a forceful coalition of community hospitals, angry at their subsidization of the two public hospi-

tals, broke ranks with the Massachusetts Hospital Association and began to lobby the State Senate for a new $200 million tax on health insurers and a reduction in their liability to the pool by the same amount.

In late May, Weld and Cellucci proposed their own alternative to the McDonough-Montigny Bill, including a new $200 million assessment on hospital payers. But the administration's hopes that the proposal would break the hospital community away from support for McDonough-Montigny backfired. First, while the MHA thanked the governor for his recognition of the hospital community's concerns, the association's leaders did not believe that the governor's alternative would win and did not want to alienate House and Senate leaders; they refused to withdraw their support for our bill. Second, the governor's plan enraged business and insurer community forces who recognized they were being asked to pick up what amounted to a new $200 million tax on health insurance premiums. The plan served one useful function for the governor: for about six weeks, when asked why he opposed the McDonough-Montigny Bill, Weld replied that he had his own better plan—no mandates, no new taxes, $200 million in new funds to help hospitals, plenty of coverage for kids. For the uninitiated, it sounded fine, but why was he so adamant against a cigarette tax?

"Tax increases are a no-brainer for me," he told the *Globe* in early June. Later that month, asked if he felt uneasy being in league with cigarette manufacturers, Weld replied, "No, not at all. I don't brake for tax increases."

To demonstrate that we had viable support to pass the bill over a now-certain veto, we needed to win initial House approval not just by the necessary 81-vote majority but by at least two-thirds, or 107 votes out of 160. The Children's Access Coalition worked aggressively at getting its participants to lobby their legislators. While Judy Meredith and her team of lobbyists had divided up the House and were polling and probing members daily, I kept my own tally based solely on my own one-on-one conversations with colleagues. I ranked them 1 to 5, 1 solidly for, 2 leaning for, 3 undecided, 4 leaning against, and 5 solidly against. By late May, I counted nearly 100 "1's" but couldn't move the final batch, who were waiting for a signal from the new Speaker.

Speaker Finneran put me up before the House Democratic caucus on Thursday afternoon, June 6. I had been in this position only once before, for the 1994 campaign finance legislation, but felt confident. I could tell the Speaker had not yet made a final decision on moving forward, or on the final shape of a bill, and this caucus would be his test. I spent

about ninety minutes explaining the plan, fielding questions, and taking hits from antitax and New Hampshire border reps. One tough line of questioning suggested that we should put the tax increase on the ballot to let the voters decide. Aside from the fact that the state constitution would allow us to make it only advisory and nonbinding, I suggested a more personal motive for members to reject that idea:

> In 1992, the tobacco industry spent about $7 million dollars to defeat the last tax increase. Most of that money was spent trying to convince voters they couldn't and shouldn't trust the Legislature, namely *you,* to use the money appropriately. If you want to give the tobacco industry an invitation to spend another $7 million attacking Y-O-U, be my guest.

That idea soon dropped from sight. Another group started complaining that we should not pick on the tobacco industry and let other societal vices such as alcohol and gambling off scot-free. I remembered an interesting fact from a book I had just finished reading on the history of the tobacco industry, *Ashes to Ashes.*[5] There were two principal reasons, I suggested:

> First, we can generate enough money from tobacco taxes, and quite frankly, opposition from that industry is more than enough for me, thank you. Second, about five to ten percent of alcohol users become problem drinkers, and about the same number of people who gamble become problem gamblers. But there is no known safe level of cigarette smoking. By definition, all smokers are problem smokers. That's a big difference.

On Monday, June 10, after about three hours of debate, the House voted for the access bill 115 to 42, more than enough to override a gubernatorial veto with ease. Finneran's lieutenants had rounded up enough votes in the final days to ensure safe passage. For the Speaker, this had become one of his new Speakership's defining battles, showing that he could promote and pass a big "D" Democratic policy initiative and that he would not knuckle under to the wishes of Governor Weld. Importantly, 11 of the 32 House Republican members deserted Weld and voted for the bill. Without their help, we would not have had sufficient votes to override.

On Tuesday, July 2, after six hours of debate, the State Senate voted to pass the bill by a margin of 31 to 8, comfortably more than the 26 votes needed for an override. After fighting the bill fiercely for hours, six of the chamber's ten Republicans voted for passage, again providing the critical margin needed to override a veto. Many of those six had been personally lobbied by the Success By 6 big business leaders who lived in

their well-heeled districts. Mark Montigny, who took over Senate leadership of the Health Care Committee in January in the wake of the Birmingham Senate Presidency election, and who resisted my entreaties to support a version of the Health Care Minimum Wage, had come into his own during this process. At times brash and quick on the trigger, he basked in the attention that came to him by carrying the major legislative initiative of the two-year session and pulling it off flawlessly. At one point, several senators close to the community hospital coalition proposed an amendment to create a new $200 million tax on insurers to refinance the uncompensated care pool. Montigny quickly filed a substitute amendment to create a special study commission on the issue and prevailed. Oftentimes Mark would drive me crazy. But watching him on the TV in my office on the day of the Senate vote, I thought, "God, is he good!" I called him at home that night to leave a sincere congratulatory message on his tape machine.

The rest of July resembled ritualized Kabuki theatre, a play without surprises, where all the moves are well known ahead of time—with one exception. Once we knew we had sufficient votes to override a veto, and the administration knew it would lose, the tension and interest rapidly diminished. The Massachusetts Teachers Association, which had been an active participant in the Children's Access Coalition, began running radio ads ridiculing the governor for his inevitable and increasingly foolish-looking veto. For a brief period of days, Weld's lieutenants lamely suggested that they might use the governor's constitutional prerogatives to delay the final legislative steps so that the House and Senate would be unable to vote to override Weld's veto before the July 31 end of our session, running out the clock. But when the business community heard of this stratagem, they rose in united outrage reminding the governor that this move would trigger implementation of the despised 1988 universal health care mandate. Red-faced, Weld and his aides abruptly retreated. The trap we had laid way back in November 1995 by delaying the mandate's implementation until August 1, 1996, sprang perfectly.

On Friday, July 19, Weld returned the bill—as he is permitted to do once—with amendments that would have made our bill into a new version of his own late May proposal. At a rare Saturday session on July 20, the House and Senate rejected his amendments and returned the bill to him. As promised, he vetoed the bill early the next week, and both branches voted by wide margins to override his veto on Wednesday, July 24. The legislative fight was over.

The Children's Access Coalition organized a sizable celebration that week in front of the State House, the same spot on which Governor Michael Dukakis had celebrated the enactment of the universal health care employer mandate in 1988. Now we were celebrating the new law that included its repeal, an irony that few beyond me and Rob Restuccia recognized. The featured guest was Marian Wright Edelman, head of the national Children's Defense Fund. We were already thinking that our formula—children's health expansion funded by new tobacco taxes—had national implications, and Marian's presence reflected that intent.

A week later, the new law received its official chapter number, given numerically in the order that laws are passed each year. Brian Rosman gave me the news. "It's Chapter 203 of the acts of 1996," he said. "In other words, it's Chapter 23 with a hole in the middle for the employer mandate."

AFTERMATH

Four years later, most of the major elements of Chapter 203 had been implemented, some more successfully than others, but not badly considering the scope and complexity of the programs involved. Mark Montigny, Charlie Baker, and I served as the cochairs of a special commission on hospital uncompensated care and in January 1997 came up with a compromise plan agreed to by the hospitals, business, and insurers that was signed into law in July 1997 in one of Bill Weld's last official acts as the Commonwealth's chief executive.

In November 1996 Governor Weld lost his U.S. senatorial race to incumbent John Kerry who savaged him in voluminous television ads for his veto of the children's health law. In the spring of 1997, President Bill Clinton announced that he would nominate Weld as the new U.S. Ambassador to Mexico, a choice that ran into immediate trouble with Republican U.S. Senator Jesse Helms, chairman of the Senate Foreign Relations Committee. Weld resigned as governor in July to fight for the job and to make way for Paul Cellucci to run for governor in 1998 as an incumbent. In September, Weld withdrew his name from consideration for the ambassador's post.

Right after the November 1996 election, Brian Rosman, Dr. Barry Zuckerman of Boston Medical Center, and I spent several hours with U.S. Senator Edward Kennedy discussing our legislative fight and the extraordinary synergy that we found between the issues of children's health care access and new tobacco taxes. Kennedy told us he was doubtful any

kind of cigarette tax would be feasible in Washington, D.C. We didn't argue with him but just gave as much information as we could about our experience. Zuckerman later told me that within several weeks, Senator Kennedy was repeating the same lines we had used with him. In February 1997 Kennedy and Republican U.S. Senator Orrin Hatch announced their own bill to hike federal tobacco taxes by forty-three cents, using most of the money to expand children's health insurance coverage. Their efforts directly led in July 1997 to the passage by Congress of Title XXI, the State Children's Health Insurance Program (SCHIP), which now provides $24 billion to states to provide insurance to uninsured kids.

FINAL COMMENT ON KINGDON

Using Kingdon's model *retrospectively*—how most people use it—gives the impression that the three streams are fixed and not subject to human control or manipulation. If this story does anything, I hope it dispels that erroneous impression. The streams are constantly subject to change and manipulation by self-conscious political actors determined to achieve their objectives. My colleagues and I did it. Using the Kingdon model *prospectively* allows one to appreciate this important dynamic. The model can help to assess one's current status and progress and point to areas most in need of attention and improvement.

The other important element is that while windows of opportunity open, they just as surely close, often quite suddenly, for reasons no one might see coming. It's important to be thoughtful, methodical, and careful in planning and executing political strategy. But it's also foolish to squander opportunity and to waste valuable time. Opportunity and luck will surely come around. The challenge, as Pasteur suggests, is to make oneself ready for when they do.