2-16-2006

Oregon's Approach to Health Care Reform : an Analysis of the Role of the Business Community in the evolution of the Oregon Health Plan

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OREGON'S APPROACH TO HEALTH CARE REFORM: AN ANALYSIS OF THE ROLE OF THE BUSINESS COMMUNITY IN THE EVOLUTION OF THE OREGON HEALTH PLAN

by

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A dissertation submitted in partial fulfillment of the
requirements for the degree of

DOCTOR OF PHILOSOPHY
in
URBAN STUDIES

Portland State University

DISSERTATION APPROVAL

The abstract and dissertation of Peter Chuka Olemgbe for the Doctor of Philosophy in Urban Studies were presented February 16, 2006, and accepted by the dissertation committee and the doctoral program.

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ABSTRACT

An abstract of the dissertation of Peter Chuka Olemgbe for the Doctor of Philosophy in Urban Studies presented February 16, 2006.

Title: Oregon's Approach To Health Care Reform: An Analysis of the Role of the Business Community in the Evolution of the Oregon health plan.

On February 1, 1994, the state of Oregon implemented its landmark health reform legislation- the Oregon health plan. The plan was conceived as an insurance program which uses a prioritized list of treatment protocols to ration health care services to Oregon's poor residents.

During the planning and implementation process of the program, various groups (political stakeholders) participated to bring the program to fruition. Although it is commonly known that one of these stakeholders was the Oregon business community, it is not clear what form its participation took and the nature of its influence. While it is generally assumed that businesses are biased against government interventions, the kind of support given by the Oregon business community toward the program's evolution defies this commonly held view of business-political behavior. Given this state of affairs, the purpose of this research is to

analyze the role the Oregon business community played in the evolution and implementation of the Oregon health plan.

The research strategy that is used in this research endeavor is a case study approach and an historical analysis. It utilized both primary and secondary data sources. Primary data sources came from elite interviewing while secondary data sources came from state of Oregon archival records. Data collected from theses sources were analyzed qualitatively within a socio-economic, socio-political context.

The research finds that the Oregon business community supported the Oregon health plan, although the coalition within the business community supporting the plan was very fragile. The research also finds that the businesses community's "economic self-interest" was a primary motivator for that support and that fear of adverse legislation that potentially could threaten its interests was a secondary concern.

Overall, this research study concludes that the support given by the Oregon business community to the Oregon health plan's evolution was symbolic, strategic and political.

The study provides insights for other states considering similar health care reform legislation and it is hoped that this research endeavor would contribute to the literature of health care politics.

DEDICATION

To

My late parents Chief James Igbokpomadu Olemgbe and Mrs. Juliana Nwaikpeyi Olemgbe, who despite not having a formal education themselves, understood the value of education and insisted that their children attend higher institutions of learning. I wish they were here to see that their support and guidance paid off. I hereby salute them!

ACKNOWLEDGMENTS

The author wishes to express his sincere gratitude to the Chairperson of the Dissertation Committee, Dr. Sy Adler for his untiring efforts and guidance throughout the doctoral program. Dr. Adler went beyond the "call of duty". He was kind and gentle, but firm in his critiques and provided excellent guidance. Special thanks are expressed to Dr. Barbara Friesen, Office of Graduate Studies Representative whose encouragement and consideration were extremely helpful in this study.

Dr. Walt Ellis, a friend, teacher and a member of the Dissertation Advisory Committee deserves special recognition. His kindness, interest and challenging critique of my efforts will never be forgotten. My special gratitude goes to Dr. Dan O'Toole, also a friend and teacher, for his significant critique and guidance as a member of the Advisory Committee.Very sincere thanks are extended to Dr. Sherril Gelmon, a member of the same committee for her honest contribution to the efforts of this study.

The author wishes to express special gratitude to Dr. Loren Lutzenhiser, Doctoral program Director, Urban Studies Program, for his kindness.

The author is thankful to the following people: Dr. Sami Ibrahim and his wife, Dr. Lauren Ibrahim, who were special friends and colleagues, for all their encouragement and sustained interest to see me get through this endeavor. To our

"Special Mom", Mrs. Carrie Marcus who persevered and reminded me always to get this job completed. I say a special thank you for your prayers and encouragement.

Finally, the author wishes to express his appreciation to his brother Paul Olemgbe, and the author's son, Uche S. Olemgbe for their sacrifices, prayer and support while this dissertation was being written.

Thank you also to the many friends who I have not mentioned here but who provided me with moral support. I appreciate your special contributions to this success.

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Preamble:

Whoever provides medical care or pays the costs of illness stands to gain the gratitude and goodwill of the sick and their families. The prospect of these good-will returns to investment in health care creates a powerful motive for governments and other institutions to intervene in the economics of medicine --- Paul Starr, P. 235

Chapter 1: Introduction and Overview

For much of the last two decades, there has been a lot of discussion in the academic and political arenas regarding health care reform. Generally, these discussions have centered on escalating national health care expenditures and the problems surrounding those individuals who have no health insurance. However, there is not yet a nationwide health insurance policy that is focused on this segment of the population. Many special interest groups, such as the American Chamber of Commerce, and other conservative groups such, as the American Medical Association, oppose the idea for different reasons. For this, the failure of national health insurance legislation – a key element of health care reform in the United States – means that health care provision in the United States will likely remain predominantly private – hence, the status quo.

The plight of the uninsured is not a problem for government alone. It is also a problem for the business community. This is so because the business community must contend with the escalating cost of health care premiums for their employees. For example, former Chrysler Chairman Lee Iacocca, testifying in 1988 before a

congressional committee, stated that his company paid more for employee health benefits than it paid for steel (Dieffenbach, 2003). According to Dieffenbach, at the time of Iacocca's testimony, Chrysler's cost of providing health benefits was $700.00 per car manufactured in the United States versus $223 for the same car built in Canada. The question then is: Is Chrysler's experience typical of other American business? The short answer is: Most observers would agree that this is the case.

On a philosophical level, American businesses have a long held belief that most of society's social and economic problems can better be solved by a private sector, free-market approach. They contend that when government gets involved, such societal problems become exacerbated to the detriment of business. This is the conservative view of American business. However, liberal reformers would argue that there is something wrong with this mind-set. Those reformers believe that a public sector solution in health care has many advantages for business (Dieffenbach, 2003). In Walter B. Maher's "Rekindling reform: How goes business," there was the suggestion that "employers were the major cause of the failure of president Clinton's Health Security Bill"(Maher, 2003:92). He adds that the lessons that can be learned from the Clinton plan debate, if heeded by both employers and health care reform advocates, raise hope that key elements of the business community can play a positive role in the next comprehensive health reform effort.

What this dissertation is about

This dissertation is about Oregon's approach to health care reform. Specifically, the research is focused on the Oregon Health Plan and the role the Oregon business community played in the formulation and implementation of this particular health care reform program in the State of Oregon. To determine the role the Oregon business community played in this reform effort, this research examines the history, the legislative process, and the implementation stages of this health reform program. More importantly, it also focuses on various groups that interacted with the business community in achieving this ambitious reform that the State of Oregon embarked on starting in the early 1980s.

The Oregon health plan: Historical Overview.

The historical origin of Oregon's approach to health care reform goes back to 1987. In that particular year, the state of Oregon faced a budget shortfall in its Medicaid program. In addition to this, the rising cost of health care and the growing number of people unable to afford it presented conditions that threatened the social and economic health of the state. The state of Oregon responded to this situation by articulating a health care reform program to keep its citizens healthy. The program that resulted was popularly known as the Oregon health plan (OHP).

The Oregon Health plan (OHP) is the embodiment of Oregon's approach to health care reform. It is a unique plan in that it represents a significant change in the

way health care reform is implemented in this country. From 1989-1993, the Oregon legislature passed a series of laws (five in all) which created the program. According to Baker (1994:6), "Senate Bill (SB 27), the center-piece of the OHP created a Health Services Commission and mandated that the State provide a basic level of health care to all its citizens" whose incomes are "at or below the federal poverty level (FPL) through a reformed Medicaid program"(Baker,1994: 6). Baker (1994) further states that another Bill, Senate Bill (SB 935) created incentives for small businesses to make health insurance available to their employees. In addition, the bill mandated employers to give their employees and their dependant health care coverage with a benefits package equal to or greater than the one provided in the package to Medicaid recipients. This provision was to take effect in 1995. Another Senate Bill (SB 534) established the Oregon Medical Insurance Pool (OMIP) that would provide health insurance to Oregonians unable to obtain insurance on their own due to pre-existing conditions (The Oregon Health Plan, 1993, p.18). As this Bill was fashioned, it is a state subsidized risk pool and participants (i.e. enrollees) would pay premiums determined by Oregon's health insurance carriers. All together, these three statutes enacted into law in 1989 became the Oregon Basic Services Act, the forerunner of the Oregon health plan (OHP). With two more bills added later, i.e. Senate Bill 44 (SB 44) which expanded the Oregon health plan to include the blind, disabled, aged, and foster children, and Senate Bill (SB 1076) that related to health benefits plans, (i.e. requiring all insurance companies in the state to offer an insurance plan equal to the basic

package developed under Senate Bill 27) the plan went into effect on February 1, 1994.

Health care reform in Oregon

From its inception, the Oregon health plan (OHP) was, and is still an insurance program aimed at the States' uninsured low-income residents. As it was designed, the (OHP) was an expanded Medicaid program that in essence legalized health care rationing in the State of Oregon Medicaid program. This rationing program was an extension of a policy adopted in 1987 whereby Oregon ended public expenditures for organ transplants (Julnes and Mason, 1989). In particular, during the 1987 Oregon legislative session, an appropriations sub-committee cut off funding for such procedures as liver and bone marrow transplants. When this decision was made, the public did not seem to notice until the death of a seven-year old boy named Coby Howard. This boy's death aroused the conscience of the citizens of the state, and it opened a discussion regarding the issue of rationing health care for the poor in the state of Oregon. The proponents of rationing had maintained that it was unacceptable for a few individuals to receive expensive and costly treatments such as transplants whereas a vast number of people went without any health care at all.

In the real world, health care rationing takes on a whole new meaning when implementation is actually attempted, and this was the case with Oregon's experiment. During the 1989 legislative session, the Oregon legislature passed a bill – SB 27. This bill passed overwhelmingly in Oregon's bicameral legislature. According to Julnes and Mason (1989: 2), there was "no significant or organized opposition to the bill."

Part of the bill as it was passed would extend Medicaid coverage to all individuals at 100% of federal poverty level and below. Before this period, Oregon was providing coverage to those at 58% of the federal poverty level. However, after the passage of the bill, more low-income Oregonians had access to health care. But more access meant a significant cost to the people of the state and the state treasury. For one thing, the amount of money budgeted for Medicaid services was not proportionately increased even though coverage was extended to more individuals. For another, the increased enrollment in the program meant that the system of delivering care was overwhelmed resulting in, perhaps, inadequate quality of care for the consumers. The point here is that logically, the number of services provided for each enrollee decreased. The consequence of all these emerging situations is that the state had to grapple with which services would be covered and which would not, hence the state delegated responsibility to the States' Health Services Commission that was appointed by the governor to sort out a solution.

Statement of the Problem and Purpose of the Research

Before the advent of the Oregon Health Plan, there was no disagreement among Oregon's citizens that a large number of Oregon's low-income residents did not have health insurance. While this was the case, there seemed to be no consensus on how to address the problem. According to a report published by the State Office of Medical Assistance in 1993, the reasons for this were obvious: Oregon's health care system, just like in many other states across the United States, had evolved in a piece-

meal fashion instead of as a result of a long term policy vision. (The Oregon Health Plan, 1993). As a result of this situation, "independent, short term policy decisions benefiting special interests created enormous coverage gaps and contributed to a rising cost" (The Oregon Health Plan, 1993:1). The report further stated that politically, "each group focused on escaping costs rather than mutually controlling them" and that since no one was held accountable, the status quo was defended (The Oregon Health Plan, 1993:1).

Although it is commonly known that the Oregon business community participated in the formulation of the Oregon Health Plan, it is not clear what form that participation took. While it is generally assumed that businesses tend to dislike government mandates, during the formulation of the Oregon Health Plan, they seemed to actively support it. Given this state of affairs, the purpose of this dissertation is to analyze the role the Oregon business community played in the evolution and implementation of the health plan. For purposes of a detailed analysis of the role the business community played during the health plan's evolution and implementation, the following questions are examined in this study:

1. If they really supported the plan, what was the nature of that support?
2. What factors influenced the business community's support for the Oregon health plan? For purposes of a thorough exploration of question #2 the following subsets to that question are also examined:

(a) Did the Oregon business community support the health plan as a means to affect the legislation before the legislation affected the business community?

(b) Did the Oregon business community support OHP as a larger policy objective of controlling health care costs, thereby reducing its own expenses?

(c) Did the Oregon business community support OHP due to mutuality of interest?

(d) Did the Oregon business community support OHP based on its need for organizational survival?

3. Now that the program has been implemented, what are the current perceptions of the Oregon business community about the Oregon health plan?

In addition, this research also examines the political behavior of the Oregon business community by exploring the processes that contribute to business political unity and coalition building when its interests are at stake in the formulation and implementation of a public policy. By using examples of various coalition models in health care reform, the study also addresses the logic of business unity and coalition formation For purposes of clarification or definition, this research study defines the Oregon business community as comprising all Oregon businesses, whether large or small, that are affected by state regulation and/or legislation. In this context, it includes Oregon businesses whose primary business is health care and Oregon businesses whose primary business is not health care.

The significance of the research study

This research study is significant because it will enhance our understanding of what will likely be required for a continuation of support from the business community for the Oregon Health Plan. It will provide valuable insights for other states considering similar health reform legislation. Equally important, it will contribute to the literature of health care politics.

Chapter 2: Literature Review

This chapter provides a review of the literature discussing the concept of healthcare reform in the United States. It also examines healthcare coalitions, business-political behavior, and the logic of business unity. Furthermore, it examines the role major stakeholders play in health care reform at the national, state and community levels. Finally, it examines Oregon's business community's role in Oregon's experiment within the context of health care reform.

The Concept of Healthcare Reform

In the past few decades, there has been ample literature discussing the topic of healthcare reform in the United States. Various academic researchers have provided lengthy discussions explaining healthcare reform in the context of their own particular topics. As such, the concept of healthcare reform can be described as an amorphous concept having various meanings for different people. This is evident based on the works of various researchers and health policy experts. For example, Kronenfeld and Kronenfeld (2004) have described it as a modification of the United States health care system so that affordable, high quality health services are available to everyone. What is missing in this description is an understanding that health care reform has a broad and complicated meaning, and that much is dependent on what is involved in the reform, who is doing the reform and whom the reform is impacting. For instance,

when the federal government is dealing with the issue of health care reform, it might mean a prescription drug benefit for America's elderly and not the health insurance needs of the nation's poor residents. Reforming Medicare or Medicaid at the federal level could mean different things depending on the political philosophy of the party in power. Conservative administrations, such as the present Republican Party, have their own notions of health care reform, and perhaps, may actually believe that health care reform is a question for the market system to deal with and not for government. On the other hand, liberal administrations, as exemplified by the Democratic Party in the United States, might look at the issue of health care reform as a question for government action and not that of the market to deal with. Also, the poor, uninsured citizen may look at the whole issue from a different prism. Given these various contexts, health care reform can be hard to define, or rather, understand. However, what is important is not an all-inclusive definition, but rather an appreciation that health care reform can be viewed from a variety of perspectives.

The debate concerning the need for health care reform has moved beyond the dilemma of "to change or not to change," according to Silver-Wells (1987). In the 1970s, theoretical frameworks for health systems reform in the United States were proposed by Somers and Somers (1977), Laframboise (1973), Carlson and Cunningham (1973) and Fuchs (1977). At that time, reform entailed shifting the direction of the health delivery system from a predominant emphasis on care and cure of the sick to a positive health policy with a focus on promoting and maintaining good

health. However, putting this theory into practice presented a big challenge for policymakers. For one thing, achieving a national health care system reform involved changing the direction of national health policy. In addition, it also involved changing behaviors of governments, providers, and consumers whose needs were intricately linked to the health care sector. In the 1980s, this emphasis shifted to seeking and implementing reforms that especially catered to a growing segment of the population (i.e., the poor and uninsured citizens) that have over the course of several decades been marginalized or literally ignored.

Given this issue that never seemed to fade away from the political horizon of the United States in the 1980s, the perennial question for policymakers became: What should government do to ameliorate the problem of this segment of the population? Consequently, various levels of government (federal, state and even local) proposed programs that would in effect help to overhaul the nation's health care system under the rubric of health care reform. But the huge challenge confronting governments in enacting the reforms continued despite their best efforts to achieve some measures of success. Feldstein (2001) recently notes that "the rapid rise in medical expenditures" and its continuing consumption of the nation's resources represent a massive redistribution of wealth. According to Feldstein (2001), two groups in particular have benefited more in this scheme than any other groups in the American population. Feldstein identifies the two groups as the "aged"with the Medicare program and the other group as those employed in the medical sector such as health care suppliers and

providers, hospitals and physicians. Feldstein adds that the role of government (whether federal or State) in financing and regulating medical services is extensive.

Feldstein (2001) provides a theoretical framework for understanding and hence forecasting the type of health legislation or regulation this country has or will have. The competing theories Feldstein identifies are "public interest" and "economic" interest. Feldstein explains that the basic assumption underlying the public interest theory is that legislation is enacted because well-meaning legislators act according to what they believe is in the public interest. Feldstein says that dissatisfaction with the public interest theory led to the economic theory of regulation. He points out that the basic assumption underlying the economic theory is that political markets are no different from economic markets. According to Feldstein (2001:45) "political markets" have legislative benefits and usually the benefits that are provided to a group exceed the associated financial costs that the group incurs. In this context "individuals and firms seek to further their self interest"(Feldstein, 2001 p.9).

Besides economic self-interest of individuals and firms, the question therefore is: What are the real objectives of government and why does government have such objectives? Feldstein provides these two principal objectives for government behavior: "to improve efficiency and to redistribute income in a more equitable manner"(p. 6). According to Feldstein, the second objective, "redistribution causes a change in wealth"(p.7). This view has earlier been noted by public policy experts such as

Peterson (1979) and Wolf (1979). In particular, Peterson (1979) distinguishes three types of policy arenas in his analysis of expenditure patterns of national, state and local governments. The three Peterson identifies are: (1) Allocational policies (2) Developmental policies and (3) Re-distributive policies. Of all these three policy arenas, Peterson says that the re-distributive policies are the main function of the federal government hence, "welfare, social security, and other forms of social insurance, health and hospital care (p.311). Wolf (1979) contributes to this perspective by stating that governments will intervene in the market place because "left to its own devices" the market place will not entail re-distributive policies because of the free-rider problem associated with public programs.

Researchers also have focused on the question of the incentives that federalism creates for states (Peterson1995; Beamer 1999). For example, Peterson (1995) highlights the disincentives for states to invest heavily in re-distributive programs, but Beamer (1999) shows why States also have an incentive under a federal system to capture available funds and to promote policies that spread the benefits of public goods (like subsidized health care insurance coverage). Beamer's and Peterson's views are consistent with Feldstein's (2001) explanation of the role of national government in health care spending. In particular, Peterson's views from an economic perspective have implications for the federal government's interest in health care spending even though Peterson did not specifically refer to that kind of spending in his analysis.

Another important point is that even though the federal government plays an important role in health care spending, it has not been alone in harnessing the future of health care reform in this country by sheer means of its vast resources. Equally playing significant roles in health care reform have been the state governments through legislation and regulation. But legislation and regulation are not the only means that state governments have used to play important roles in health care reform, they have also played these critical roles by spending their own tax dollars. In short, when it comes to health care reform three important ingredients are always present: i.e. money, regulation and legislation. Consequently, the synergy for health care reform develops when there is cooperation between various levels of governments and other stakeholders.

The juxtapositions of health care reform are evident in health care legislation across the country as exemplified by the varying forms and standards for reforms. For example, Goldwater (2000), Lunch (2000), Weil (1999), Stone (1996), Immergut (1992) and Goldberger (1990) examined the juxtaposed frameworks in their works. As an example, Goldwater (2000) used the case of health care reform in the State of Maryland to demonstrate that state regulation of the health care delivery system is a form of health care reform. Although Maryland is not typical of other states when one considers that Maryland has the "highest number of mandated benefits in the nation," nevertheless what happened there did represent the kind of initiative that states take

when confronting the problem of reform in their respective communities (Goldwater, 2000:65). In the case of Oregon, Lunch (2000:33) notes that the desire to revise the "state guidelines for Medicaid funding in the mid-eighties to emphasize prevention of illness" was one of the catalysts for the formulation of the Oregon health plan. According to Lunch (2000:35), when the OHP was formulated in 1989 through legislation, the plan as formulated "proposed to expand the number of Oregonians who could qualify for public health care through Medicaid and it "did so by explicitly rationing the medical procedures available." Other states have also either used regulation to achieve reform of their own or legislation to accomplish the same purpose. For instance, Hawaii, a pioneer in health care reform, passed its Prepaid Health Care Act in 1974. This act provided the state with the impetus on reforming its health care system with the goal of moving in the direction of universal access. Consequently, in 1989, the State of Hawaii created its Health Insurance Program (SHIP) through legislation. This program put the state on the path to achieving universal access to health care for its population. Similarly, in New Jersey, a health care reform act was passed by its legislature in 1992 (Volpp and Siebel, 1993). This act, although not like what these other states had which was to ultimately achieve universal access, nevertheless, was designed to rein in the costs of health care in the state. Volpp and Siegal (1993) maintain that " under the legislation, price regulation and the DRG system ended" while hospital revenue caps remained in place for a one-year transition period. Further discussion on some States' initiatives in the area of regulation and legislation is in Chapter 5 of this study.

Although these states' initiatives have taken place, historically various politicians at the national and state level have proposed programs to overhaul the national health care delivery system. Starr (1995) and Stabrowski (2003) have documented this in their works. For instance, Starr (1995: 21) discusses President Clinton's health care reform proposal that failed and the effort made by a few senators prior to the president's initiative to overhaul the nation's health care system. Starr specifically noted that prior to Clinton's health care proposal, twenty-three Republican senators including then senate minority Leader Robert Dole, had cosponsored a bill in 1993 introduced by then Senator John Chafee that "sought to achieve universal coverage through a mandate –that is, a mandate on individuals to buy insurance."

At the micro-level, Paul-Shaheen (1998) indicates at least seven states whose politicians have taken the lead in the effort to overhaul their health care system. The states she mentions are Florida, Hawaii, Massachusetts, Minneosota, Oregon, Vermont and Washington State. In addtion, Bodenheimer (1997), Sipes-Metzler (1994) and Sperer (1993) also note that local policy makers implement health care reform programs at the state and community levels. In particular, Bodenheimer (1997) used the case of Oregon to demonstrate how an activist leadership at the state level or innovative leaders at local level can accomplish health reform. For example, when the OHP was formulated, then -Senator John Kitzhaber led the state in pushing for the reform. After OHP was implemented, there was concern about how to shift Medicaid patients from "safety-net providers " to "private managed care- plans" (Bodenheimer,1997:721). Bodenheimer points out that in Oregon's case, a group of

safety- net providers took the lead and provided this critical leadership. The group he identifies as leading this effort was Oregon Health Sciences University (OHSU), the Multnomah County Health Department (in Portland), and a number of community health centers. These groups formed one HMO, CareOregon, to provide care for patients in the Oregon Health Plan. According to Bodenheimer (1997:721), similar "alliances have been established in California."

On a more recent note, Swenson and Greer (2003), and Mintz and Palmer (2000) indicate that health care provision in the United States has changed dramatically in the last two decades primarily at the state level. However, Mintz and Palmer caution: "Business's role in this state-level process is not well understood" (p. 328). Elaborating on this, they state: "We assume that business was involved in the reform effort given their interest in containing their employee health insurance costs, but know little about the details of their participation" (Mintz and Palmer 2000:328). On the basis of this notion, Mintz and Palmer conducted an analysis of business involvement in health care reform in the 50 states in the 1980s. What they found was that business was divided into three main groups with regard to health care reform in the 1980s. According to Mintz and Palmer, there were non-health care firms championing reform, health care businesses resisting reform, and insurers seeking to channel reform in directions that preserved their profitability. They also found that each group contained both large and small companies with often differing views and objectives in the policy arena. For example, large health care corporations tending to view reform as inevitable generally cooperated with reform efforts while small health

care companies were more likely to defend the status quo. Since all these businesses (large or small) operate in the political arena, they are part of stakeholders in the high stakes game of health care reform.

Major Stakeholders in Health Care Reform

In the battle for health care reform there are many political stakeholders. Among these stakeholders are providers and consumers, business and labor leaders, insurers and lawmakers. In order for any of the stakeholders to succeed in their purpose, they usually co-opt members from the other groups and form a coalition. Johnson (1993) attempted to provide a framework for looking at and defining a coalition. According to Johnson, there are three characteristics important in defining a coalition. The three characteristics include (1) membership, (2) activities, and (3) the geographic influence of the coalition. However, Goldbeck's (1984) characterization of coalitions, although consistent with Johnson (1993) in a broad sense, has a peculiar interpretation in that it focuses on health care reform as it relates to membership interest. According to Goldbeck (1984), health care coalitions possess three characteristics: purchaser representation, promotion of local rather than national concerns, and the objectives of healthcare cost containment (as in Johnson, 1993: 557). The Dunlop Group defined coalitions as an "alliance of individuals and groups

who are concerned with issues involving costs, quality, and access to health care" (AHA, 1991). Webster's New World Dictionary of the American language offers another definition of a coalition. Webster's Dictionary defines it as "a temporary alliance of factions or parties for a specific purpose such as of political parties." The relevance of this definition to health care reform can be seen in the context of strategic alliances that are formed by disparate groups when they have a common business interest. Clearly, in American health care reform, the principal reason for a coalition is that reform leaders use the coalition as a base to articulate and bargain for their groups' business agenda. This view is consistent with Stern (1991) who argues that individuals or organizations join coalitions for their own individual reasons and their interests. This phenomenon is much more pervasive in the world of business than in any other organizational area. In real life situations, it is not unusual for businesses to form strategic alliances. A strategic alliance (coalition) is very beneficial for business, and for that matter, businesses also enter in to coalitions just like political parties do. Obviously, Feldstein (2001) would agree with this notion when he talks of legislative benefits.

Business Political Behavior

In American health care reform, there are various kinds of coalitions that form for specific business purposes. For example, The Washington Business Group on Health (WBGH) is a business lobby group for major national corporations on health care issues (this group is a spin-off of the Business Roundtable). Although there are various reasons health care coalitions form, the most important reasons they do so are

business and political. In a social choice context, coalitions act autonomously but will readily cooperate with others for strong advocacy within an adversarial environment (Shermerhorn, 2001). In this context, the emerging behavior can be described as typical business-political behavior –a concept that has been coined by Clawson, Neustadtl and Bearden (1986).

It has been suggested that the business community also forms coalitions to force change (Johnson, 1993). For example, the Central Michigan Hospital Council and the Chamber of Commerce in the 1990's pursued their common interest in affordable healthcare to benefit their coalition members (Coalition Perspective, American Hospital Association, March 1992, P.1). The Washington Business Group on Health and the Business Roundtable work together to develop legislative policy that affects the American business community and lobbies Congress for such policy.

Mintz (1995) discusses business participation in health care reform and examined business political activity by exploring those corporate characteristics that contribute to inter-corporate coalition formation. By using differing interests in relation to health care profitability, her study shows the difficulties inherent in corporate collective action. To illustrate this point Mintz (1995) argues that while certain firms clearly profit from the expansion of medical delivery systems, others with health care investments do not share equally in terms of profitability. She also points out that other lines of division exist between businesses. For example, unionized businesses often provide better health benefit packages to their employees

than non-union businesses. Apart from this, health care insurance companies have well defined interests in the continued expansion of health care services, as known today. However, they are also feeling the pressure from other segments of the business community as their overall profit margins are squeezed by the continued cost of one specific sector (i.e. hospitals and doctor groups). In addition to these situational analyses, Mintz's (1995) study also focused on the role of business self-interest and political behaviors. Mintz distinguished three sets of business interests in this study: (1) Narrow individual interests; (2) Broader self-interests and (3) Class-Wide interests. According to Mintz (1995), the broader self-interest of a business may overlap with the individual interests of other corporations. Mintz (1995) also argued that business political activity is normally based on the micro-interest of individual firms whereas when it comes to collective action, business behavior is temporary and non-enduring. Mintz's (1995) view is based on the assumption that the business community is divided on many issues and as Dahl (1961) and Polsby (1963) earlier observed, corporate action is based on the particular interests of individual firms.

Although businesses sometimes form alliances depending on the issues facing them, such alliances are usually fragile and they almost never occur unless the issue in question threatens their collective self-interests. For example, in matters of public policy, the business community may not see the need to unify and in point of fact may remain ambivalent unless such a proposed policy threatens its interests. As Bergthold (1993:804) points out, "As long as government is acting in ways that consistently protects business interests in a given situation, there is no need for business leaders to

intervene in a policy process." Bergthold's (1993) assertion has implications for the Oregon case. In the Oregon experience, the business community got involved with the planning and implementation stages of the program along with other citizen groups, government, and other political leaders as demonstrated with their support of Senate Bill 27 (SB 27). However, it is unclear whether their participation stemmed from fear that their non-participation might result in a legislation that could potentially threaten their self-interest and by extension, their organizational survival. This is one of the premises that this study has tried to examine.

Business Unity and the Avoidance of Political Conflict

In explaining the theory of business unity and the avoidance of political conflict, Burris (1987) contends that there is a difference between what he terms "core firms" and "peripheral firms." He states that core firms are relatively insulated from the competitive pressures of the market and therefore have a "bigger stake in the long-term stability of the system, and are better able to protect their profit margins by passing on any increase in taxes to their customers" (Burris, 1987:733). It is for these very reasons that Useem (1980:61) suggests that such firms "tend to favor progressive labor and welfare legislation as a means of ensuring the stability of their own workforce and more generally, domestic tranquility." On the other hand, peripheral firms confront a much different economic situation. Consequently, they are much more hostile to government regulation, taxation, unionization or even welfare spending (Burris, 1987). In the Oregon case, small businesses as well as large ones

participated in the formulation and implementation of the Oregon plan. However, no one is sure what level of support there was by the small business interests – a situation that Burris (1987) has alluded to in his analysis.

From another point of view, it is conceivable that the support offered by small businesses to the "core firms" in Oregon through the agency of the Associated Oregon Industries during the evolution of the Oregon health plan is due to what Clawson, Neustadtl, and Bearden (1986) see as typical business political behavior in their own study of the logic of business unity. In their study Clawson, Neustadtl and Bearden (1986) find that "corporations self –consciously avoid open political conflict" once a unified business position has developed (Clawson, Neustadtl and Bearden 1986:810). As they see it, it is no longer "pragmatic" for a corporation to oppose the rest of business, for the sanctions available to a unified business community are at least as great as those available to members of congress Clawson, Neustadtl and Bearden (p.810)."

The review of the related literature revealed a number of issues regarding health care reform. The discussion presented here has centered on the cost-containment issue, difficulty of access to medical care by the nation's uninsured in general and Oregon's low- income residents in particular due to the medical insurance conundrum and business-political behavior. The health care coalition movement as an aspect of health care reform strategy has been gaining momentum across the nation. The review of the literature also noted a few specific studies that focused on the

Oregon health reform as embodied in the Oregon health plan (OHP), Baker (1994; Gold 1997; Fox and Leichter 1993; Leichter 1997; Julnes and Mason 1989; Thorne 1997; Lunch 2000). Although the influence of the business community in the contemporary health care debate is extensively cited, there seems to be little information on the role Oregon's business community played in the reform effort as embodied in the Oregon Health Plan, hence this study.

For purposes of analysis, this study will apply the theoretical frameworks provided by Feldstein (20001), Mintz and Palmer (2001), Bergthold (1993) and Mintz (1995) that have previously been discussed in this study. Additionally, in the course of this literature review, different issues, categories, themes and patterns emerged that contributed to the researcher's understanding of the research topic and all of which will be helpful in the analysis that will follow in the course of this research effort. Consequently, the research will assess the type of Oregon businesses involved in Oregon's health care reform, the political positions those businesses took and the dynamics of creating and sustaining unity among them as they wrestled with the issue of health care reform in Oregon as embodied in the Oregon heath plan. Based on the literature review, it seems that the theory of self-interest of businesses as posited by Feldstein (2001), Mintz and Palmer (2000) and Mintz (1995) may have a wide application, although not in the orthodox sense. Also, Peterson's (1979) public policy domains are explored in the context of what happened in Oregon to determine their significance for Oregon's experience. For purposes of clarification, this researcher would like to point out that this research study is in no way intended to test theories.

Rather, the study is intended to be a policy history. Therefore, it utilized the theories as posited by these scholars to explore and understand what happened in Oregon and perhaps, by extension, what happened in a few other states whose experiences resemble Oregon's approach to reform. In this context, the study may have a limited generalizability.

Chapter 3

Methodology

This chapter presents in three parts the methodological framework for this study. The first part is the general context in which the study is conducted. The second part is the research design. It lays out the research strategy, data sources and collection methods, the study's scope and unit of analysis and sampling method. The third part describes both the analytical method and the significance of the research method chosen for this study. It also presents other analytical methods in the study. The analysis of the findings is discussed in chapter 6, and in chapter 7 there is a general discussion of the research effort and its implications for public policy. Chapter 8 deals with the limitations of the study and directions for further research.

The Research Strategy

The research strategy employed in this study is an exploratory case study as well as an historical analysis. An exploratory case study is necessary in order to develop more in-depth understanding of the phenomenon under study (Marshall and Rossman, 1995). It is also useful when the researcher has little or no control over events or behaviors and is the preferred method when the phenomenon being studied is contemporary (Babbie, 1986, Yin, 1984, True, 1983). Additionally, Yin (1984:23) stated that a case study is an empirical inquiry that: " investigates... when the boundaries between phenomenon and context are not clearly evident; and in which multiple sources of evidence are used."

The role the Oregon business community played during the planning and implementation of the Oregon health plan is the focus of this study. The researcher embarked on this project on a hunch rather than from his prior understanding of the subject. To elaborate, the term "hunch" is used here by the researcher to reiterate that the Oregon Health Plan was created through a political strategy. This researcher was initially unaware of the different participants in this political strategy. But in reviewing documents related to the evolution of the health reform plan, the researcher had the "hunch" that the political strategy succeeded because it enlisted the support of different constituent groups (stakeholders) of which the Oregon business community was a part of. Hence, this researcher's interest to study the Oregon business community's role in the process of the evolution and implementation of the health plan.

Because the Oregon health plan is an on going program administered by the State of Oregon, it is deemed contemporary by the researcher. Apart from applying a case study approach to this study, the researcher equally employed an historical analysis because this method of analysis provides new insights into events of the past with emphasis on social meanings and the relevance of the social context (Klegon,1981). Further, Klegon (1981) also suggests that such an approach to research can provide new data to develop and test theories. In addition to this, it can aid in predicting the future. Equally relevant to this research method are Marshall and

Rossman (1995:90) who state that an "historical analysis is particularly useful in obtaining knowledge of previously unexamined areas and reexamining questions for which answers are not as definite as desired." In addition to this view, Yin (1984:19) states that historical analysis is the preferred strategy when "an investigator must rely on primary documents, secondary documents, and cultural and physical artifacts as the main sources of evidence." On the basis of these advantages of the historical method, the researcher embarked on this scientific research study with the conviction that an historical method of case study approach is the most appropriate for this study.

Data Sources and Collection Methods

Multiple data sources were utilized in this study. These included official government documents from the Portland State University library and the State of Oregon archives, personal interviews, and content analysis of secondary data. Louise Kidder (1981) indicated that although a personal interview approach has its disadvantages, "it is relatively among the best in terms of obtaining a good sample from a population; establishing rapport with respondents; ability to ask complex questions at length and in-depth, and the ability to get full, detailed answers for clarifications and probing (Kidder, 1981:149)." In this research endeavor, the researcher interviewed key individuals who either participated in the legislative process leading up to the formulation and implementation of the Oregon Health Plan or had good knowledge of the process or access to the process during the period. It was important to the researcher that these interviewees' perspectives on the subject matter be obtained and analyzed. The researcher was particularly interested in their

accounts of events as they unfolded, their responses to and interpretations of those events and how and why the State of Oregon negotiated with the business community to gain its support and cooperation over time. Marshall and Rossman (1995:83) call this kind of interviewing "elite interviewing." It is a special kind of interviewing that "focuses on a particular type of interviewee" (Marshall and Rossman, 1995:83). In an attempt to describe the type of individuals who can be selected for elite interviewing, Marshall and Rossman offer this explantion:

> Elite individuals are considered to be influential, prominent, and well-informed people in an organization or community and are selected for interviews on the basis of their expertise in areas relevant to the research (Marshall and Rossman, 1995:83)

In-depth interviews with multiple respondents (both bureaucrats and other State and community leaders) were conducted in order to give the researcher the ability to triangulate the findings across sources and maximize reliability. In addition, secondary sources of data for this research included the State of Oregon Department of Human Services records that are pertinent to this research (i.e., publications and statistics). Most of these records were in the Office of Medical Assistance Programs and the State Office of Health Policy and Research. Other sources of secondary data utilized in this research included legislative hearings records from the State of Oregon

Archives and public description, (for example, medical sources including newspapers, academic journals and electronic coverage).

Primary research question and the interview process

The primary research question for this research endeavor is: What was the role that the Oregon business community played in the evolution of the Oregon Health Plan?

In order to scientifically examine this topic, members of several main groups were interviewed to elicit pertinent information in an effort to draw various perspectives on the formulation and implementation of the OHP. Consequently, it is hoped by this researcher that these multiple perspectives subsequently would provide good quality data for this research endeavor.

The researcher decided on five groups to focus the interview process. These five groups are: (1) the business community, (2) the bureaucratic elite, (3) labor, (4) social advocacy groups and (5) political executives. Several key individuals were interviewed from each of these groups for their unusually good insights, knowledge, and personal experiences with the process in the development and implementation of the OHP. The number of individuals interviewed from each of these groups were: three from the Business community; four from the Business elites; two from Labor; three from Social advocacy groups; and three from Political executives. Individuals

from each of these five diverse groups were asked specific interview questions tailor-made to fit their roles related to the OHP and the Oregon business community. A definition of each of these groups is shown in Appendix A.

It is important to note that prior to gaining access to the aforementioned key individuals and scheduling an interview date, the researcher sent out a letter of introduction, followed by a telephone call to further explain this particular academic study of OHP. This further telephone call also included a clarification of what period the researcher was interested in studying. Specifically, the researcher made it clear he was interested mainly in the period of late 1980s to mid 1990s. Subsequently, a date, time, and location were scheduled to carry out a face-to-face interview. Interview questions were either faxed or mailed to participants in advance for two main reasons: (1) Time management –respondents could more efficiently utilize the time spent during the interview, and (2) Memory recall-respondents could provide better quality information and richer data regarding the OHP and the business community. After each interview, the researcher sent a "Thank You Letter" to each of the interviewees for sharing their time and insights.

There were a total of fifteen interviews conducted in this particular study. The number of interviewees was not predetermined in advance. The researcher employed the "snowball technique" which is often used in qualitative social science research. To elaborate, this technique involves interviewing as many participants as possible

until the researcher decides that the information obtained from the respondents is deemed to come "full circle."

Sample Size

It is important to point out here that qualitative research methods do not require large sample sizes. What most qualitative scientists recommend is to conduct interviews until theoretical saturation has been reached, a point this researcher has just noted above. Also, in the interest of transparency of the process undertaken in this data-gathering phase, it should be noted that the researcher's time constraints and concerns regarding the volume of material to be analyzed also contributed to the decision to stop at fifteen interviews.

The fifteen interviews were conducted in different settings, and the various locations were selected by the respondents. For example, four of the interviews were conducted in local area restaurants; eight interviews were conducted in the offices of the participants, one interview was conducted in an exclusive athletic club; one interview was conducted in a local library; and one interview was conducted in a local University conference room.

The type of information sought was purely descriptive and qualitative in nature. The data was recorded and transcribed in order to provide for an adequate and accurate analysis. An informed consent form was given prior to commencement of the interview that explained the purpose of the study and thus provided the participants with assurance as to the integrity of the research. A copy of the informed consent used for the study is provided in Appendix B. Invariably, data were collected as per

"respondent #one", "respondent #two", "respondent #three", and so forth and hence grouped into "clusters" in order to better analyze the qualitative nature of the data. Furthermore, presenting the data in this format provides for anonymity and confidentiality of the participants' responses by not using "him" or "her."

The Study's Scope and Sample

In order to address the research question that is proposed in this study, the research focused on the business community in the State of Oregon. There are several types of businesses in Oregon. These businesses are considered as small, mid-sized, or large. All are scattered throughout the state in different counties. Each of them has different interests, needs, and expectations. Moreover, some are located in urban areas, while others are situated in rural Oregon. Some compete with each other across the state whereas others contend within their immediate environment. This competition inevitably leads to different expectations and levels ofsupport for the States' health care reform program.

Unit of Analysis

Babbie (1986:74) argues that in social science research, "There is a wide range of variation in what or whom is studied." He describes what and whom is studied as the unit of analysis. As he defines it, units of analysis are "those units we initially describe for the ultimate purpose of aggregating their characteristic in order to

describe some larger group or explain some abstract phenomenon" (Babbie 1986: 74). Yin (1984:31) added that a unit of analysis "...can be some event or entity that is less well defined than a single individual." In the present research study, the unit of analysis is the Oregon business community. The Oregon business community is in the view of the researcher, all the business organizations and their surrogates involved in the planning process and implementation of the Oregon health plan. Thus, the business community included the following: large and small corporations, hospitals, insurance firms (both medical and non medical) the provider community, and doctor groups in the State of Oregon. Since the researcher could not possibly collect data on each and every one of these groups, their umbrella organization was used as a surrogate unit to gather the data, hence Associated Oregon Industries (AOI). AOI, according to its current legislative lobbyist on health care affairs, Lisa Trussel, has in its membership 23,000 companies.

Data analysis

The data analysis for this study began during the data collection phase and it continued throughout the course of the study. The reason for this approach is for the researcher to be able to filter out early in the process any of the unusual elements not germane to the research. The researcher hoped that such an approach would be helpful in striking a balance between efficiency and design flexibility- all necessary qualities for good qualitative research. This view is consistent with Marshall and Rossman (1995). According to them, "data collection and analysis go hand in hand to promote

the emergence of substantive theory grounded in empirical data" and they expanded on this view by adding the "researcher is guided by initial concepts, and hypothesis, but shifts or discards them as data are collected and analyzed" (Marshall and Rossman,1995:112).

Data analysis entails data reduction. The usefulness of this is to bring the collected data into manageable chunks and to provide meaningful interpretations to the data that has been collected. One analytic technique employed in this study is the use of graphic displays for examining the data.

It is important to reiterate that this case study is done in the tradition of qualitative research. According to Morse and Richards (2002:147), the whole process of a qualitative method in research "is not linear, not stepwise but interactive" (Morse and Richards, 2002:147). Therefore from the beginning, the researcher has had this analytical mindset as this research was conducted.

Chapter 4

The Legislative Process and business involvement

The purpose of this chapter is to discuss the historical basis of business involvement in the development of the Oregon Health Plan. The chapter also discusses the legislative process, the evolution of the States' insurance reform, and the development of some specific bills that were vital to the formulation and successful implementation of the Oregon plan. Further, it chronicles the work of the Health Services Commission (HSC) and the business community's involvement in the work of that commission. In addition, the chapter delves into the political significance of the postponement of the "employer mandate" and the role Oregon businesses played in persuading or not persuading Congress to grant Oregon a waiver. Finally, the chapter discusses the impact of the failure of President Clinton's health care reform on Oregon's health care reform plan.

The Oregon Health Plan (OHP) as originally designed is a blueprint for universal access and affordable health coverage for Oregon's uninsured, poor residents. Oregon's low- income residents were not only the unemployed, poor, or the disabled but also included the so called "working poor," i.e. those residents who have employment but whose employers could not offer them health insurance. Usually, the

majority of employers who could not offer insurance to their employees were the small businesses in the state.

Based on the transcripts of testimonies from the state archives and the personal interviews that this researcher conducted, initially when the Oregon Health Plan was being discussed the Oregon business community did not show much interest and therefore did not actively support it. But over time their interest blossomed for reasons various scholars would describe as business's "self-interest" (Bergthold, 1993), Maher (2003), and (Mintz, 1995). For example, Mintz (1995) reminds us that business-political behavior depends on the micro-interests of individual firms and when it comes to collective action, business behavior is temporary and non-enduring. This kind of business- behavior is also noted in Swenson and Greer (2002). Swenson and Greer (2002) posit that when it comes to health care reform, there is a "damaging shift in position by business organizations" as exemplified by the United States Chamber of Commerce. Swenson and Greer maintain that this situation occurs because "forces external to the organization" make them change their position often in the health care debate. As an example, Swenson and Greer (2003) state that "cross-lobbying" by the National Federation of Independent Business (NFIB) is one such external force that the Chamber of Commerce must contend with continually. As noted previously in this research study, the NFIB represents mostly small employers and in certain crucial matters affecting American business, the Chamber of Commerce frequently changes its position. The reason for this business behavior is obvious: The Chamber acquiesces

to NFIB's demands because the NFIB as a member of the Chamber of Commerce could potentially threaten to cause defection of large number of its business members. Therefore, when it is clear to small business that the chamber is not representing its interests, it usually does not join it in a coalition to fight for certain causes. No place is this statement more true than in Oregon's case.

In Oregon, Associated Oregon Industries (AOI) appears to be the closest thing that resembles a chamber of commerce for the business community. Apart from that business association, there is no other unified body called " Oregon Chamber of Commerce." Instead, different localities maintain their own Chambers of Commerce. However, when there is a cause that requires a collective action within the business community, Oregon businesses usually will join a coalition either to support the cause or to oppose it. That is precisely what happened with the Oregon Health Plan during the formulation and implementation phases of the plan. For example, during the formulation of the Oregon Health Plan, the Oregon business community raised its suspicion when Senate Bill (SB 935) was introduced. Consequently, some business entities in the business community were for it, others were against it. (A full discussion of this particular bill will follow later in this chapter). However, at this juncture, it is important to reiterate that the business community in Oregon is not monolithic. Clearly, there are different segments and they have different interests. On the question of the OHP, one respondent interviewed for this study put it this way:

> The large businesses that are in the business of health care, hospitals and health systems, insurers, had one perspective. The very large

> businesses like Tektronix and NW Natural, US Bank and US West – they all had another perspective, and midsize businesses had even another perspective.

The different perspectives of the Oregon business community as described by this respondent showed up in the way the businesses lent their support for the health plan. Originally, the business community seemed supportive of the concept of the state having the kind of health reform that it was about to embark on beginning in 1987. This was when Senate Bill (SB27) was introduced. However, when Senate Bill (SB935) was debated and passed, the business community gave it qualified support, sensing that it might not survive the scrutiny of the federal government. This kind of business approach is what Mintz (1995) has described as business –political behavior.

Not surprisingly, the politics of health care legislation in Oregon has followed this theory of business-political behavior as provided by Mintz (1995). In a different study, Bergthold (1993) suggests that business leaders intervene in the public policy process when they suspect that government will not protect their interest. This assertion by Bergthold is consistent with Oregon's experience with health care reform in the late 1980s and early 1990s. The legislation that passed through the Oregon legislature during this period were many. However, this research study will focus mainly on those that have relevance to the subject of this study, which is the analysis of the role of the Oregon business community in the evolution of the Oregon Health Plan. The pieces of legislation that were central to this study's focus were mainly SB 27 and SB 935 – a point this researcher has previously noted in this study. However,

between these two bills, SB 935 was the most controversial. The evolution of these specific bills and their dynamics are discussed in the subsequent section of this chapter.

The Evolution of the State's insurance reform

The process for Oregon's health insurance reform started in 1987 when Neil Goldschmidt was the state's governor. In that year, Oregon established an agency it called "Insurance Pool Governing Board" (IPGB) through (HB2594). The purpose for establishing this board was to offer the uninsured and self-employed individuals and small businesses (1-25 employees) the opportunity to purchase small group health insurance that is affordable to them from private companies. In the same year, Senate Bill (SB 583) was passed by the Oregon legislature. This senate bill established the Oregon Medical Insurance Pool (OMIP). It was designed to offer benefits to people who could not buy individual health insurance because of their pre-existing conditions. Although the OMIP was a quasi-public agency, the legislature provided it with no funding (OHP Overview, 2004, p.4). Besides these two bills, not much impacted the business community at this time and, therefore, the Oregon business community did not have the kind of coalition that it mobilized in the 1989 legislative session.

It was during the 1989 legislative session that the Oregon business community's involvement in the health reform debate started to take shape. In that

year, the Insurance Pool Governing Board (IPGB) had made insurance available to uninsured business in the state and offered them a tax credit for participating in the program. During the same period, "employer mandate" was established and it was scheduled to take effect by January 1, 1994. This employer mandate required employers to provide medical insurance to those employees working 17.5 hours or more per week and their dependants. For businesses unable to comply with this law, the alternative was to pay into a special state insurance fund that offered coverage to their employees. This special state insurance fund was established by (SB 935).

The evolution and development SB 27 and SB 935

Senate Bill (SB 27). This is the bill that created the States' Health Services Commission and it is also the bill that mandated that the state provide a basic level of health care to all citizens with incomes at or below the federal poverty level (FPL) through a reformed Medicaid program. The bill was enacted in 1989 and it provided the foundation for the Oregon Health Plan. The bill as written contained four basic premises:

- The state would be responsible for insuring legal state residents with incomes below the federal poverty level, without regard to categorical criteria.
- The state would develop a prioritized list of health services (ranked according to clinical effectiveness and social values). It directed that the scope

of benefits would be tied explicitly to the budget process. Services above the cut-off line would be funded; those below the line would not be covered.

- The state would set reimbursement rate levels sufficient to cover costs, thereby eliminating cost shifting and increasing provider participation.
- The state would make an overt commitment to managed care where feasible.

Senate Bill (SB 935). This is one of the companion bills that was passed with Senate Bill (SB 27) that allows for an "insurance pool" which established group medical coverage for employers with 25 or fewer employees. As the Oregon health plan included the "pay or play" option, the law required all Oregon employers with full time employees who were then not providing their workers and their dependants with health insurance to make a tax contribution toward their health care premium- the "pay" option, or to directly purchase insurance for their employees and their dependants - the "play" option. Under the then existing statute, employers electing to pay must pay 75% of the premium cost for full time employees and 50% of the premium cost for their dependants. The statute did not prescribe minimum contribution standards for Oregon employers who during this time provided coverage or elected the play option in the future.

For employers who have employees working fewer than 17.5 hours per week, or who have temporary and seasonal employees, the law makes an exception. In addition, under this law, new businesses were given an 18 month exemption from the law. The statute was to take effect on March 31, 1997 for employers with more than

25 employees. For employers with 25 or fewer employees, the law was to take effect on January 1, 1998. These dates were subject to Oregon receiving an exemption from the federal ERISA law.

The essential feature of this bill (SB 935) is that business participation was based on eligibility. By implication, the bill essentially targeted the small business community since it was the small business community that did not provide insurance to their employees. But it also required a congressional exemption to the Employee Retirement Income Security Act (ERISA) before it could take effect. It is worth noting that it was during the course of establishing this Senate Bill that most of the debate and business opposition emerged. The opposition came mainly from the small business community. For example, during the debate about SB 935, Mr. John Wilkerson, President of Oregon's 7-Eleven Franchise Owners, testifying before the House Human Resources Committee on May 12, 1989, stated:

> At the outset I want to acknowledge that Oregon, as well as the rest of the Country, faces the problem of a significant number of people who have no health insurance or financial ability to obtain adequate health care. At the same time I must tell you that Senate Bill 935 is the wrong solution and that we are opposed to SB 935.

Mr. Wilkerson's group was opposed to the bill for specific reasons. As he further explained during the course of his testimony:

> First, let me describe to you the economics of my business. On average, each new 7-Eleven franchise pays a franchise fee of approximately $40,000. In addition, each franchisee must purchase inventory, costing about $38,000.
>
> Labor is the largest single cost in my business and in the store of my fellow franchisees that represents approximately 74% of the cost of doing business.

> On average, we employ 10 full and part-time people in each of our stores. The average pre-tax income of 7-Eleven franchisee is about $29, 853 per year and is usually a family business with the spouse and sometimes, another family member working in the store.

Mr. Wilkerson's concern was purely based on the cost burden, which the Senate Bill would impose on his business and those of his group. As he later added in his testimony:

> The annual budget for the federal government is over $7 trillion --and the federal government is not able to fund universal health care. The annual budget for the State of Oregon is over $7 billion, and the state says it cannot afford to provide health care for those who need it. Physicians who earn an average of more than $100,000 per year say they cannot subsidize health care for the uninsured. So what gives anyone the idea that fellow franchisees and I are better able to absorb the cost of providing health care? Quite simply, we cannot.

Some of the dire predictions Mr. Wilkerson uttered in his concluding remarks were that the bill would destroy the opportunity for many to start small businesses, force many of the existing small businesses to close, and deny those who the bill was intended to help the opportunity to have employment. On the same day of Mr. Wilkerson's testimony, the National Federation of Independent Business of Oregon (NFIB) also testified in opposition to SB 935. The principal reason the NFIB was against the bill was the mandate clause in section 5 of the bill. Specifically, Section 5 read:

> ORS 653.775 is amended to read:
> 653.775 (1) Part 1 covered [*shall focus on episodic acute care and recovery care for catastrophic illness or accident. The coverage*] applies to eligible covered employees only.

(2) The plan shall have a [*deductible and high*] stop loss to insure that no employee is required to pay the costs of the deductible and other reasonable cost-sharing requirements and that Part 1 coverage can be obtained at a low enough cost to insure accessibility.
(3) Subject to subsection (4) of this section, employers shall pay the premium of Part 1 coverage up to a maximum of $40 for each eligible covered employee per month.
(4) All covered eligible employees shall participate in and be covered by at least Part 1 coverage. An employer may require a minimum employee contribution of not to exceed 25 percent of the premium or $15, which is lesser, for only Part 1 coverage described in this section.
(5) Part 1 coverage shall include at least those health care services described by section 1 of this 1989 Act.
(6) The amount specified in this section apply only to those employers who qualify for tax credits under ORS 316.096, 317.113 or 318. 170.

Jim Bernau who testified on behalf of the NFIB before the House Human Resources Committee complained that SB 935 would discourage participation in the small business health plan (HB 2594) which his group had already signed off on. As he puts it, "many businesses will see the mandate coming and will not act until 1994". Mr. Bernau stated that if the mandate were deleted from the bill, his group would again be a partner in a unified effort in expanding the access to health coverage.

There were other small business owners who also testified during this hearing. Those who could not make it in person submitted memoranda to the committee in opposition to the bill. By all accounts, the bill was very controversial. However, even though the small business establishment was opposed to the bill, there were other business groups that supported it. For example, the Associated Oregon Industries (AOI) and the Oregon Association of Hospitals were among the many large business interests that testified before the committee. The individual who testified on behalf of

AOI was Karl Frederick. Mr. Frederick was the legislative director for Associated Oregon Industries at the time. According to Mr. Frederick, "the vast majority of Oregon employers want their workers to have access to good, affordable health care." He quoted Oregon Congressman Ron Wyden who previously had written an opinion piece in AOI's Business Viewpoint, a publication of this particular business lobby group. Quoting Congressman Wyden, Frederick said, "It's the morally right approach and it's good for business. Business can't prosper when its most important asset- -the employees - - are laid up."

The business lobby group that testified before this House Human Resources Committee of the Oregon legislature was the Oregon Association of Hospitals. Ed Patterson, Vice-President of Government Relations for the association on May 10, 1989, gave its testimony. In his remarks to the committee, Mr. Patterson said that SB 935 is a "first step to eliminating the health care crisis in Oregon." Mr. Patterson stated that there is "little doubt that our system of cost shifting to finance health care for the uninsured is beginning to collapse." The problem of uncompensated care according to Patterson, would lead inevitably to access limitations by hospitals and other health systems for individuals who rely on such benevolence. In summary, Patterson and his group voiced strong support for Senate Bill (SB 935). Appendices I and J are Inpatient Exhibit of graphic displays of Expense Components of a Non-Medicare/ Medicaid Bill for 1985 and 1987 respectively in Oregon's hospitals during these periods. The exhibits are attachments to the testimony submitted by Mr. Patterson the committee. In

short, these patients' costs problems illustrate how desperate Oregon's hospitals were in the period prior to the formulation of the Oregon health plan.

As a footnote, many other individuals from other business groups and professions either testified in favor or in opposition to the bill.

For Senate Bill 27 (SB 27) there seemed to be less opposition and even the business community seemed to be united behind this particular bill. Oregon's major business lobby- AOI- and the NFIB supported it, and so did non -business groups. For example, the Oregon Health Action Campaign and Oregon's American Federation of Labor/Congress of International Organization (AFL/CIO) testified in support of the bill. The Executive Director of the Oregon Health Action Campaign, Ellen Pinney, on June 2, 1989, testified before the Senate Ways and Means committee on behalf of her group. During her testimony she described SB 27 as a "bold and innovative beginning to a solution of the health crisis in Oregon." Elaborating on what she saw as health crises she stated these statistics:

> In 1986, 400,000 Oregonians had no health insurance, close to 1 in 5 of the state's population. 75% of the uninsured are workers and their dependents. One third are children. The numbers are increasing as businesses which provide 84% of the insurance in the state, faced with premium increases of 20% last year and another 20% predicted for this year, are forced to drop employees or their dependents from coverage

Ms. Pinney stated what she described as some positive points about SB 27. According to her, SB 27 is the "first bill in the nation that admits Medicaid is a catastrophe and proposes to do something about it". The Oregon AFL/CIO also testified during this hearing in support of SB27. According to Amy Klare, labor's representative testifying before the committee, the process set forth in SB 27 was a vehicle to:

Correct the irony that three –fourths of those denied access to health care in this
State are workers and their dependents.

Establish the population for which the state is responsible, and in doing so, prescribe the population for which employers must be responsible

Initiate an equitable health care policy to reduce costs now being shifted to employers and individuals who purchase health insurance, with insurance companies using this shift to justify rate hikes.

Identify the health care services, which are most cost effective and beneficial for the greatest number of people

Serve as the impetus for additional legislation to provide universal access to health care for the working uninsured with insufficient personal resources to obtain adequate health care services.

So in essence, on SB 27, there was a unified business position. Even social activists and the labor unions were in support of this piece of legislation.

As noted previously, it was during this period that the Oregon Health Services Commission (HSC) was created. The commission was created to develop a ranking for medical services from the most to least important to the low- income segment of the population. After the commission developed its list, the legislature defined the health care package from that list.

The evolution of the work of the Health Services Commission (HSC)

This researcher noted earlier in this chapter that the governor of the State of Oregon in 1989 was Neil Goldschmidt. As governor, Mr. Goldschmidt appointed the members of the Health Services Commission. The eleven member body was chaired by Mr. Gregory, a timber mill entrepreneur from Glendale, Oregon. The commission had a

membership of five physicians, a public health nurse, a social services worker and four health care consumers. It started its work in September 1989, and had three subcommittees. Those subcommittees were Health Outcomes, Social values, and Mental Health and Chemical Dependency. The great bulk of the Commission's work was to be performed by the Health Outcomes and Social Values Subcommittees. It would also develop the priority list. As previously noted, the commission was charged with the responsibility of providing the legislature with a prioritized list of health services. This list would be generated from public hearings and research as to the effectiveness of treatments and would be due March 1, 1990. If the federal waiver was granted, the program would go into effect July 1, 1990. However, securing the federal waiver was a formidable task. The task was formidable because of the "prioritization of list" requirement that the law charged the independent commission to create. As Thorne (1997:132) observed " No one had ever tried to prioritize the vast array of available services before." It is important to note that the "prioritized list" developed by this commission could not be altered by the legislature but it "could only decide where to draw the line"(Thorne 1997: 131). Consequently, the legislature had the authority to define the benefit package and the program's budget.

Another important factor in the way the commission did its work was the adoption of "cost-benefit methodology" in arriving at the decision it made as to treatment services. With this kind of methodology, the commission considered four factors in arriving at its decisions. The four factors were (1) Cost (2) net duration of benefit (3) physician estimates of the likelihood that treatment could alleviate

symptoms or prevent death, and (4) citizens' views on the seriousness of symptoms and functional limitations.

In February 1991, the HSC made public its first "prioritized Health Services List"(Leichter 1997:148). As was expected, the list reflected both the current wisdom among the medical community and many of the values expressed in the community forums conducted by the commission. For example, on the list preventive medicine was given a high priority. In April of that year, an independent actuary firm hired to determine the costs and values of the different treatment options in the prioritized list submitted its report to the commission. According to Leichter (1997), the commission recommended to the Oregon legislature to fund a benefit package that included at least all "essential" services and most "very important services." As reported in the list, essential services were in categories one through nine in the seventeen –category list. Consequently, on June 30 1991, the Oregon legislature approved a budget that included an additional $33 million for the Medicaid program. This legislative action allowed the state to add 78,000 new Medicaid recipients and thereby extend health services to them through line 587 out of 705 condition/treatment pairs. With funding now secured, the state needed federal approval to implement the plan.

Business community's involvement with the work of HSC

As previously noted, the Chairman of the independent commission appointed to develop the prioritized list was a businessman. It also included five physicians who

as a matter of course were "small businessmen" in the context of the American health care environment (Starr, 1982). On August 19,1991, Oregon requested a waiver from the federal government so that it could implement a demonstration project built around the principle of universal access to a basic package of health care services. In late 1992, twenty national organizations representing persons with disabilities publicly urged President George Bush not to grant the waiver. Consequently, on August 3, 1992, Secretary of Department of Human Services Louis Sullivan informed the State of Oregon that he would not grant the waiver because the state's plan was in conflict with Americans with Disabilities Act (ADA) of 1990 (Fox and Leichter, 1993). In particular, the Secretary mentioned the statewide survey in which Oregonians rated various health situations and concluded in the survey that the value of a person's life with a disability is less than the value of a person's life without a disability (Ota, 1992).

In consultation with federal officials, the Oregon Health Services Commission responded to the waiver rejection by revising the methodology for the list. With the ascendancy of Bill Clinton to the presidency, Oregon finally was granted the waiver it had sought for so long. This was in 1993 and the Oregon legislature at this time had in the House of Representatives a Republican majority. Although Democrats still controlled the Oregon Senate and the Governor's office, things were not the same any more. As Thorne (1997:134) indicated, when the approved waiver was brought to the legislature in 1993, "Oregon lawmakers began to back off from their commitment to

universal coverage." Although they eventually funded the Medicaid expansion, the Medicaid changes became tied up with the debate on "employer mandate" – an issue that basically had divided the employer community. It is worth noting that it was this issue that was one of the major reasons the Oregon legislature had a marathon session in 1993. By the time the 1993 session was adjourned, the Medicaid plan was funded but the employer mandate was delayed with a statutory requirement that if a congressional exemption from Employment Income Security Act (ERISA) was not obtained by January 2 1996, the mandate would expire automatically. Ultimately, that was exactly what happened. According to Leichter (1997), the mandate was initially intended to take effect in 1995 and because of legislation passed in 1993, its effective date was delayed to 1997 or 1998 depending on the number of workers employed by a business (p.141). The statutory language inserted into the bill to let the mandate expire if congress did not grant the exemption by a certain date was a political compromise between the state and the business community. After this compromise was reached, business opposition to the mandate softened.

Other Bills relevant to the implementation of the Oregon health plan (OHP).

Another important bill that was passed in 1989 (i.e., the year SB 935 was enacted into law) was Senate Bill 534 (SB 534). This bill provided a funding mechanism for the State agency that was created in 1987 by Senate Bill 583 (SB583). That agency, the Oregon Medical Insurance Pool (OMIP), offer a health insurance for people who could not buy insurance coverage for themselves due to pre-existing

medical conditions. While the debate for the SB 935 amendment was going on in 1989, a framework for phase 1 of the OHP Medicaid demonstration developed in the context of SB 27.

In 1991, Barbara Roberts became governor of Oregon and that same year several insurance reforms were legislated including a guaranteed-issue policy that all small –business insurance carriers in Oregon must offer. To elaborate, guaranteed issue meant that as a condition of doing business in the state, insurance carriers under SB 1076 were required to make available to small employers an approved basic health plan with benefits that were "substantially similar" to those provided in the Medicaid "Demonstration" portion of the Oregon Health Plan. Also, the insurance carriers could offer additional health benefit plans as options on an accept or reject basis but the Guaranteed issue plan must be offered when optional plans were rejected. Under SB 152, all health benefits plans offered by an insurance carrier or a Multiple Employer Welfare Arrangement (MEWA) must be marketed and offered on the same guaranteed issue basis as required for the basic health benefits plans. In addition, MEWAs and other professional insurance/ trade associations established to provide health care benefits must accept any individual who applies for coverage and who meets membership requirements. There are other provisions under SB 1076 not elaborated on here because it is the judgment of the researcher that those provisions are not relevant to the discussion being carried on in this study.

To a large extent, the centerpiece of the business community's involvement in the OHP had been SB 935 and to some extent SB 27. Due to the controversial nature of the "employer mandate," its full implementation was postponed until July 1, 1995, with the enactment of (SB 1076). In pursuing these small business insurance reforms, the Oregon legislature recognized that eighty-six per cent (86%) of all Oregon workers who were not offered health insurance by their employers work in firms with fewer than 25 employees. This acknowledgement provided the impetus for the legislature to enact SB 1076 which went into effect in 1993. As it happened, SB 1076 was designed to level the playing field for small business employers by mandating reforms in the underwriting, rating and marketing policies of health benefits. In 1993, the small business insurance went on sale. In the same year, the employer mandate was postponed until March 31, 1997, with HB 5530.

In 1995, John Kitzhaber became governor of Oregon and in the following year, the employer mandate was repealed. It was repealed because Congress did not grant an exemption the State wanted from the provisions of the Employment Retirement Income Security Act of 1974 (ERISA) by the deadline the State had sought.

The political significance of the postponement of "employer mandate" and the role business organizations played in persuading Congress not to grant Oregon a waiver

A number of states as well as the national government have considered employer mandates as one of the many means of financing universal coverage. Under an employer mandate, employers are required to contribute toward the health insurance costs of eligible employees. In Oregon, the employer mandate and small business insurance programs were separate from the Medicaid demonstration and they were deemed very important for the success of Oregon's health care reform efforts. The waiver cost estimate for the Medicaid program assumed that Medicaid beneficiaries who were employed would shift to employer coverage by February 1997, but this did not happen as planned. The problem was that even before the effective date for the implementation of the mandate, the ERISA controversy had scuttled the law.

The failure of the mandate had a political history. From 1989 through 1996, the state's political landscape had changed. For example, in 1989, Democrats controlled both houses of the legislature as well as the governorship. Oregon's Senate President John Kitzhaber and Vera Katz, Speaker of the State's House of Representatives were powerful allies. Both left the legislature the same time –in 1991. Moreover, the Democrats lost control of the House in 1990 and emerged from November 1992 elections with a slim majority in the Senate. Meanwhile, no one had emerged to fill the leadership vacuum Kitzhaber's departure had created on the Oregon Health Plan's

implementation. In addition, during this period, bipartisan support for the Oregon plan was eroding. Not only was this a problem, but one-third of the members of the 1993 Legislative Assembly had no personal investment in or experience with the plan. Before this time, in the 1991 legislative session, the employer mandate had been postponed until July 1, 1995, with (SB 1076).

The weakening of legislative support was exacerbated by apparent disarray among its allies outside the legislature. For example, at the beginning of the 1993 legislative session, Governor Roberts proposed raising most of the funds to implement the health plan through a health provider tax. That tax was to be 1.5 percent on gross hospital revenue, 0.9 percent on physicians and dentists, and also increased cigarette taxes. Both proposals -a tax on hospital revenues and a tax on physicians and dentists, were opposed by such original supporters of the health plan as the Oregon Medical Association and the Association of Oregon Industries (AOI). In particular, the Oregon Medical Association (OMA) opposed the provider tax and the AOI opposed both taxes (i.e., the provider tax and the cigarette tax). In the midst of all these, the employer mandate was postponed again until March 31, 1997 (HB 5530).

The AOI is the State's major business lobby and at this time, it had become a serious obstacle to the health plan's implementation. According to Fox and Leichter (1993), the organization accused the state of reneging on two promises. One was that the plan was to be financed through general funds, not special taxes that could be

passed back to employers in the form of higher insurance premiums. The other promise was that the waiver conditions the state accepted prevented it from reducing the basic benefits package. This situation according to AOI was inconsistent with the law's original intent, which was that the state should adjust benefits in line with its financial situation. But the most important element of all these gradual retreats was the additional or potential threat of the "employer mandate." Many members of AOI were from the small business community. The original law provided that once the waivers were obtained to cover the Medicaid population, employers would be required to either offer their employees a benefits package substantially similar to that established by the Health Services Commission (HSC) or to pay into a state insurance fund pool, which would be used to subsidize alternative insurance programs for uninsured workers and their dependents. As originally conceived in the law, all these were to happen by July 1995.

It is important to note that during this uneasy period the business community, the state's small business leaders and some legislators also worried that after the play-or-pay mandate went into effect, some low-wage workers would be shifted from Medicaid to employer –provided or subsidized insurance, thereby putting a new financial burden on small businesses. Politically, the postponement and /or rescinding of the employer mandate would not have invalidated the federal waiver, but it could have made staying within the Health Care Finance Administration expenditure cap difficult. Roger Auerbach, Governor Roberts' adviser on health care issues

commented that the mandate was "a major policy issue because we need to hold everybody together in support of the plan if we are to achieve our goal of getting this Medicaid expansion plan financed" (Mackenzie, 1993: D02). Despite these political maneuverings, the employer mandate was eventually repealed in 1996 because of the failure of the state to get the exemption from Congress regarding the ERISA law. From the look of things, business was reluctant to support the mandate even though strategically, it seemed to embrace it. Politically, the fact that there was a health benefits mandate was sufficient for business not to be actively supportive. For example, Oregon businesses are philosophically conservative; they tended to align more with the Republican politics than Democratic Party politicians. Not surprisingly, one lobbyist interviewed for this study had this to say:

> They don't like the idea of mandates and like my group for example... I'm the executive director of now. Individually, for example, almost all of them provide mental health benefits but collectively they oppose a mental health mandate and it's anything that gets mandated they tend to oppose and so that was a big part of it

From the research, it is not clear what role the Oregon business organizations played in persuading Congress not to grant Oregon the exemption that it needed. What is clear, however, is that the Oregon business community was not very enthusiastic about the mandate. For example, one political executive interviewed for this study commented about a rumor that circulated around Salem at that critical time in reference to the employer mandate. The rumor was that then Governor Barbara Roberts once walked into a room where House Speaker Larry Campbell and Senate

President Bill Bradbury were having a meeting during the last few days of the 1993 legislative session arguing what to do about the waiver application regarding the employer mandate and said to these two legislators, "You guys need a mother. You need to come to some agreement." Shortly afterwards, an agreement was struck according to this respondent. The respondent said that in the agreement that was struck, the business community as represented by AOI got what it wanted without having to specifically say they killed the employer mandate. According to this respondent, it was the language that specifically said "we have to request a waiver of ERISA from congress" before the mandate would take effect. The agreement also explicitly stated that if the exemption was not granted by congress before a certain date, i.e. by January 2 1996, the agreement was null and void. This respondent maintained that:

> Everybody knew we weren't going to be able to get the waivers. But it was a way for AOI to say, "Oh, we didn't kill this." The state just couldn't get the waivers so every one was able to save face.

This respondent further commented:

> So, I think that all of these things, AOI as a business was very supportive of this in the beginning but then when it came time for business to do their part, was not willing to support that.
>
> (Interviewed by author, December 5, 2003).

This attitude and or business behavior mirrored closely what was taking place at the national level at the time. For example, in a study published in Management Accounting (USA) 1993, Susan Jayson indicated that nationally, business's mood about employer mandate was that it would hurt business financially and so it was not enthusiastic of its prospects. In discussing business attitudes toward the Clinton health care plan, Jayson (1993) stated that Buck Consultants, an employee benefits, actuarial, and consulting firm monitored the reaction of representatives from Fortune 500 companies and found that more than half (54%) of the panelists they talked with said that in general, "mandated health care benefits" would hurt their organizations. Specifically, these panelists argued that a payroll tax to fund national health care would result in decreased medical benefit levels (75%) and other employee benefit reductions (47%). Thirty-five percent believed that it would reduce employment. When the question became: what would these panelists prefer? The answer was that the status quo should be maintained.

It is worth noting that during this national debate, small companies that did not offer medical benefits to their employees predicted that the Clinton plan would devastate their bottom lines. Some business entrepreneurs said that the burden of the mandate would slow hiring, force salary reductions, and lead to business failures (Jayson,1993). Jayson (1993) even quoted Jack Faris, president of 600,000 –member National Federation of Independent Business at the time who agreed with the assessment of the small business companies. According to Jayson (1993), Faris predicted that there would be a loss of as many as 1.5 million private jobs.

Furthermore, Jayson quoted Faris as saying, "small business payrolls have little elasticity to accommodate higher costs associated with employee benefits."

It is important to recognize that what went on at this time at the national level was also going on at the state level. The parallelism is that the issues and concerns that divided the business community at the national level also were the same issues and concerns that divided them at the state level. The range of concerns business had whether at the state level or national level made it difficult for the waiver process. This is so because the politics of the waiver process has many dimensions. On the one hand, there is the executive branch and the legislative branch of government at the federal level. On the other hand there is the industry group which as a collective does what has been described as "cross-lobbying" to these two branches of government. For instance, the White House and the Office of Management and Budget get lobbied by industry groups from time to time. At the same time, Congress also gets lobbied on the same issues by the same groups. Whenever these situations arise, the immediate practical problems that states must contend with in the context of health care reform become difficult to resolve. The difficulty becomes much more problematic when Congress assumes a more active role in establishing specific boundaries for state waiver activities. The ERISA issue demonstrated how congressional and executive branches of government made the waiver process difficult for Oregon. Consequently, due to congressional and White House inflexibility with the ERISA requirement, Oregon's lawmakers, through the sunset provision written in the law establishing the employer mandate in the Oregon Health Plan, had to repeal that mandate.

In summary, of all the bills passed in the Oregon legislature leading up to the evolution and implementation of the Oregon Health Plan, a few bills had real impact on Oregon's business community. Those few bills, namely SB 935 and SB 27, became mainly the centerpiece of the Oregon business community's involvement in the formulation and implementation of the health plan. Basically, they were the ones that generated the most interest either for or against in their support for the Oregon Health Plan (OHP) besides the employer mandate.

The impacts of the failure of Clinton's health care plan on Oregon's health care reform.

The failure of Clinton's health reform in the 1990's impacted what was going on in Oregon in that particular era. For instance, during the early of 1990's, the country appeared on the verge of supporting comprehensive health care reform. Also, in the same period of the 1990s managed care was just exploding. By the time the mandate was officially turned down, the Clinton plan had failed. In Oregon, everyone's attention was on managed care. With managed care, it was hoped that the cost of care was going to be dramatically lower and Oregon employers were celebrating because the cost of health care was the lowest it had been in 15 years. The problem is that with the emergence of managed care, many citizens were confused about what managed care was and what was the Oregon Health Plan. Some in the Oregon business community were equally confused. Consequently, the failure of Clinton's plan became a major setback for the Oregon plan. However, what should not

be forgotten is that Oregon and Dr. Kitzhaber started their health reform program before President Clinton began his health care reform effort.

The Oregon Health Plan and managed care were not dependent on each other. They just happened to co-exist at the same time. Fortuitously, managed care ended up making the Oregon Health Plan work more effectively, but at same time it also ended up in large part doing it in. It stopped working in the sense that some of the early participants in the managed care program in Oregon ceased accepting enrollees when their reimbursements were slashed because of cost control measures initiated by the state.

Chapter 5

National Significance of Oregon's Approach to Health Care Reform

In the period Oregon was initiating and implementing its health care reform, health care in Oregon received intense national media scrutiny. Julnes and Mason (1989) indicate that starting with the transplant funding controversy and the passage of Senate Bill 27, such diverse publications as The Dallas Morning News, Los Angeles Times, The New York Times, The Boston Globe, The Village Voice and a host of other national publications carried opinion pieces on Oregon's health care reform program. They add that some national broadcast media such as McNeil/Lehrer News Hour, Night-Line, GoodMorning America, and Larry King Live ran stories of Oregon's initiative in their programs. In addition, specialty publications such as The New England Journal of Medicine, HealthWeek, and The Physician also ran stories of Oregon's bold experiment with health care reform. It is therefore the researcher's contention that this particular health policy innovation in Oregon has national significance when it is considered within the framework of what was going on in many other states at the time and the overall national debate regarding health care in the United States.

Julnes and Mason (1989) state that there are two perspectives in health care reform. According to them, one perspective is "comprised of national solutions to the health care dilemma" (p. 5). This approach is articulated in terms of expansions of Medicaid or adoption of a Canadian-style health care system. The other perspective

comes from the state level. Some states such as Massachusetts used the tax code to advance its reform effort. It mandated health care insurance for all full-time employees in the State. Massachusetts' plan also established an insurance pool to cover the otherwise uninsured. The State of Washington established a pilot project to give coverage to as many as 30,000 uninsured individuals by contracting with prepaid health insurance plans. Numerous other states were either looking at ways to expand and vary their respective Medicaid programs or they already had done so.

Chapter 5 therefore examines how Oregon's approach to healthcare reform is similar and/or different to what happened in other states during the period of the late 1980s and early 1990s. In particular, the chapter focuses on three states that underwent healthcare reforms but with different approaches. For this effort, three states – Massachusetts, Florida, and Hawaii are discussed. None of the three ever used Oregon's unique approach, which in some sense was revolutionary.

The researcher begins the discussion by first narrating a brief historical account of each of these States' health reform programs spanning the period this research effort is focused on. The researcher's period of interest for this study was noted earlier in Chapter 3 and subsequently has been reiterated in this chapter as well. Following is the order of the States for purposes of the discussion.

Massachusetts

The major healthcare reform in Massachusetts in the 1980s was the Massachusetts Health Security Act of 1988. In 1988, Michael Dukakis was still the Governor of the state although by that time, he had gotten deeply involved with

Presidential politics – having been nominated the Democratic Presidential candidate for President. The Massachusetts' Health Security Act of 1988 as it was designed promised to every resident in Massachusetts "access to affordable health care by 1992" (Goldberger, 1990:857). This precedent –setting legislation in Massachusetts had its detractors prior to passage. Although the Massachusetts business community was a major force in passing the legislation, the coalition it had built several years earlier that eventually helped to lay the groundwork for the passage of the legislation had gradually begun to fracture. The fracturing became more intense when Governor Dukakis introduced the bill that included new mandates without adequate consideration for the business community's needs. As Goldberger (1990:875) noted: "The business groups had expected significant accommodations of their member's interests in exchange for their unprecedented acceptance of new employer mandates, but felt they got none in the Governor's bill." Instead of accommodating their interests, they saw the Governor appeasing the hospitals and consumer interests at the expense of other business entities.

The accommodation Governor Dukakis made to the hospital community was to loosen the cap on hospital charge increases from 1 percent cap above inflation that had been promised to business to 2 percent above inflation. This affront to the business community notwithstanding, Dukakis also reached accommodation with consumer groups. He added language to the proposed legislation banning the sale of insurance policies with pre-existing conditions exclusions on coverage. He made these concessions to consumer groups despite business protests. Hitherto, businesses

had been grumbling that the benefits package in the bill was already too rich and that the move to universal coverage was getting too hasty. At this point, insurers concurred with the notion that the cost to business had become unacceptably high. Furthermore, they felt that their particular concerns were not addressed.

At these critical moments, the Governor's concessions to hospitals were not enough to mollify the hospitals even though that was costing him the support of the larger business community. Consequently, the hospitals launched a massive lobbying campaign intent on derailing the bill. With the business community unhappy with the way the bill was shaping up, it also launched its own campaign similar to the hospitals own campaign to kill this "costly bill". In particular, organizations representing small businesses whose members would bear the brunt of the new mandates, stepped up their opposition. Despite all this bickering, the bill finally passed the legislature with the narrowest of margins. This came about after the bill had been watered down considerably from what Dukakis had originally proposed.

Florida

As pressure for healthcare reform began to intensify in the 1980's, Florida was equally eager to establish itself as a state where healthcare reform was a major public policy concern. While in 1988, Massachusetts became the first state to legislate a state-wide play-or-pay plan, in 1984 Florida enacted the nation's first state-based revenue assessment on hospitals to create a trust fund to finance the expansion of the state's Medicaid program and the expansion of Primary Care Services. The revenue assessment on hospitals, also known as the 'Sick Tax', was designed to fund the

Medicaid and Primary Care Services in response to the state's recognition that the tribulations of the state's uninsured required significant action by the State of Florida. The genesis of Florida's action was that in the early 1980's hospital charges were getting out of control. For that reason, both the organized elderly and business coalitions of Florida decided to petition the state's legislature for relief through some kind of state regulation. In their effort doing this, both of these groups targeted the hospitals for government intervention. During this period of cost-control euphoria, 40 percent of Florida's hospitals had become for-profit, according to Brown (1993). To make matters worse, the for-profits allegedly were shirking their fair share of the state's sizeable burden of uncompensated care. As Brown (1993:10), quoting one observer from an interview noted, "a two-class system of care was developing in Florida and everyone knew it." According to Brown, this one observer stated that the "for-profits hospitals would give the uninsured guy who showed up in the ER fifteen dollars for a taxi and send him to the nearest public hospital" (Ibid).

Given what was going on both the voluntary agency hospitals and public hospitals pressed their case against the for-profits and demanded fiscal relief from the state. In 1983, a task force was appointed on competition and consumer choice. This task force was headed by former Senator Bob McKnight. Following its appointment, the task force started drafting a blue rint for statewide policy changes. As it was doing its job, the task force quickly became a center for citizen group presentations, ventilating issues of concern to the press and the public. Ultimately, the task force

made its recommendations to the Florida legislature. The legislature after receiving the recommendations debated and negotiated a settlement by a complex bargaining strategy that blended benefits with costs in ways that gave all major participants some measure of victory.

The political style that resulted in this compromise is summed up in the following comments attributed to Gary J. Clarke – an important figure in the 1992 reform. As Brown (1993:10) noted:

> The provisions of the Law reflect both the comprehensive nature of the approach as well as the compromises and consensus of all concerned. Businesses were assured an upper limit on hospital cost increases but were left free to negotiate their own best deals with hospitals. Hospitals escaped the dreaded burdens of either full-fledged budget/rate regulation or mandated charity requirements. Voluntary hospitals, and especially public hospitals were guaranteed that their increased burden of Medicaid care would be relieved in direct proportion to the amount of such care they provide – more than offsetting the increased tax to which they were subjected. Advocates for the poor and Medicaid program expansion were able to increase overall revenue by at least a third, without resorting to any apparent increase in direct citizen taxation (sales or income tax). And issues that were too complicated or for which there was insufficient time were left for further study. As the 38 to 0 and 122 to 0 votes in the Senate and House respectively demonstrate, the hard-fought program was in the end supported by all interested parties in the state, and most legislators and lobbyists (except those from some individual hospitals) left the Capital that spring well pleased with their efforts.

The political style of negotiation as summarized by Gary Clarke first worked for Florida in 1984, and again in 1992. The 1984 Health Access Act had among other provisions a Public Medical Assistance Trust Fund. This was initially sustained by a tax of 1 percent of net hospital operating revenues and rising to 1.5 percent in subsequent years. With the new law, Florida envisioned that it would get at least $200 million dollars annually since its Medicaid Federal Matching rate was 56 percent at

the time. With these additional new monies, it would expand and improve Medicaid and Primary Care Services in the state. However, time, reality and circumstances challenged Florida's innovation of 1984. As time progressed in the 1980s the innovations of 1984 did not enable the state to improve markedly its payments to physicians and hospitals. However, other developments were occurring as well in that period and they adversely impacted the progress of this piece of legislation. The Trust-Fund-assisted payments to providers increased as the program's enrollment doubled between 1985-1991. Consequently, overall spending for the program soared.

A few events of the era unleashed these intractable trends: The recession of the later 1980, swelled the ranks of the unemployed, the uninsured and those on Welfare. With new Federal mandates, new groups were added to the program. New immigration to Florida did not help matters it exacerbated the situation. As Brown (1993:11) observed, "various pathologies (Acquired Immunodeficiency Syndrome (AIDS), drug abuse, mental illness and others) got medicalized and Medicaidized" and the consequence of these emerging situations was increased utilization of services.

Florida, being a state that has tourism as one of its main industries, added jobs in this period but the jobs were created in an industry that did not as a matter of its business circumstance extend health care coverage to it workers. Programs like Medicare and Medicaid reacted by shifting costs as their fiscal plight worsened. As business saw its health care spending grow, so did its cry for help from the Florida legislature. Anxiety among the elderly grew as the cost of care grew. Uncompensated care became more burdensome for hospitals and other health systems even with the

trust fund in place. Suspicions grew about unnecessary medical treatment and services being provided by the medical-industrial complex of Florida. As a result of all of these situations, voices rose in every corner of the state that something needed to be done to bring some measure of control to the chaotic situation.

Eventually, in July 1989, the Florida legislature created two multi-member task forces – one on Private-sector Health Care Responsibilities and the other on Government Financed Health Care. These two task forces were required to report their findings to the legislature by March 1991. In conclusion, the issues for health care reform in Florida seem to mirror what happened in Oregon during the same era: unemployment, bad economy, cost-shift, uncompensated care and rising healthcare costs. The business community of Florida got into the act to tackle these problems with the state's legislature out of concern of how the situation was affecting it financially.

Another development added impetus to this scenario. By 1990, an activist ex-Senator, Lawton Chiles had wrestled control of the governorship from Republican Governor Bob Martinez and from that time on, Florida's process of reform continued toward its goal of universal coverage, the same goal that the Oregon Health Plan has envisioned from its inception. Throughout the process, the business community in Florida was very active in the reform effort. However, its participation was to protect its own "economic interest" just as other business communities in most other states had tried to do.

Hawaii

In most of the United States of America, the State of Hawaii is known among health policy analysts as a pioneer in state health policy innovation. This distinction has earned the State the nickname "the health state." Neubauer (1997:166) in "Hawaii: The Health Care State Revisited" stated: "For the most of continental America, Statehood is but a dim aspect of its received history. For those living in Hawaii, it is a recent and important experience. She added that for Hawaiians, statehood has historically been associated with their moral commitment to a tradition of political liberalism. This political philosophy fostered an atmosphere in which Hawaii's State leaders were able to take bold initiatives in reforming their health care system in ways no other state had thought of years before.

Starting in 1974, when Hawaii enacted its Prepaid Health Care Act, to 1989 when it enacted its State Health Insurance Program (SHIP), to 1994 when it came up with another reform by implementing its HealthQuest program, the State of Hawaii has played a leading role in State health policy reform. Part of the reason the State of Hawaii has been able to succeed in these efforts is that its leaders have been strong believers in the role of government to solve society's social problems when market forces alone cannot be trusted to deal with them. Another important point to make is that since Hawaii became a State in this country, and including the time it started its health reform programs, the State had been overwhelming a Democratic Party State. As a matter of fact, in some political circles, the state has been described as a "One Party State" because of its Democratic Party leanings.

Although Hawaii has for long been in the forefront of State health policy innovation, something very remarkable happened in Hawaii in 1986 that influenced the intensity and direction of further reform the State later had to embark on in the late 1980s. The 'remarkable' thing that happened was the rise of John Waihee in 1986. In November of that particular year, John Waihee, a native Hawaiian, a graduate of University of Hawaii Law School, and a major player in Hawaii's last constitutional convention in 1978, was elected the Governor of Hawaii. Following his election as governor, Mr. Waihee was determined to make his mark on Hawaii's history by initiating new and bold governmental action in the area of Hawaii's health policy. In his effort to accomplish this goal, he appointed Dr. John Lewin, a physician who had practiced medicine in Hawaii for about ten years, to head his Department of Health. Dr. Lewin subsequently led the department's effort to shepherd the governor's agenda in the process of passing the State Health Insurance Program (SHIP) in1989. In a sense, SHIP was a major legislative achievement of the governor and one that the history of its adoption would always be associated with the era of his leadership.

Despite this accomplishment, some observers of Hawaii's health policy scene state that SHIP was not comprehensive enough to deal with the population it was aimed at. When it was designed, SHIP was supposed to cover individuals who were uninsured by public or private health care coverage programs and who were at the low end of the states income levels, but could not access existing health care coverage due to a variety of other factors. This group was sometimes described as the "gap group." According to Neubauer (199:34) the size of this group when SHIP was passed "was

estimated at 30,000 to 35,000." Originally, SHIP was a temporary program, a "hand up" for those in need most of whom it was assumed would become eligible through employment coverage under the Prepaid Health Insurance Act of 1974. However, things did not quite work out this way as many people had hoped. The reality according to Neubauer (1993) is that SHIP enrollment ballooned much more than the 30,000 to 35,000 that was estimated at the beginning of the program. In the words of Neubauer (1993:35) " Splitting the differences in estimates, one may be left with the reality of 50,000 uninsured persons in the state and the policy of uncompensated care they represent."

Neubauer (1997) states that the prevalence of this "gap group" was caused in part by the structural changes in the economy. The increased number of workers not covered by the provisions of the Prepaid Health Insurance Act, especially part-time workers, made the situation especially important for the type of legislative action embodied in the SHIP Act. According to Neubauer (1993) SHIP lasted from its introduction in 1990 until almost twenty thousand of its members were absorbed into Quest in August 1994.

By every account, it can be argued that SHIP was a big program for a State as small as Hawaii. For that reason, its limited success was unique. It was unique not because of its presumed universality (that did not eventually happen), but rather for "its combination of elements of universality, comprehensive care and attention to prevention," Neubauer (1997, p.172). In addition, it was also a unique program

because it laid the groundwork for the next 'big thing' in Hawaii's health care reform agenda.

Hawaii's next program for health care reform was its HealthQUEST, implemented in 1994. Hawaii's HealthQUEST was a capitated, managed care program that served many of the former Medicaid recipients and all of SHIP's. It shifted publicly funded health care insurance from an entitlement structure to an insurance-based system. It emphasized cost control within the conventional structure of managed health care plans that already had dominated Hawaii's health care market.

Before HealthQUEST, or HawaiiQUEST, as it was sometimes called, came into being, there was a general realization among the residents of Hawaii that various components and key participants in Hawaii's overall health care system lacked integration. This general concern became the impetus for the Governor, who was already known for his passion for health care reform, to spring into action. Consequently, in 1990, governor John Waihee appointed a Governor's Blue Ribbon Panel on Health Care. This panel was directed to develop a more comprehensive health care system through widespread community consultation. It was also directed to develop recommendations to facilitate more effective cost control measures and the delivery of health care.

Although there was general agreement that the Prepaid Health Care Act and the combination of coverage established by SHIP have been of great benefit to the people of Hawaii, the State's lawmakers were convinced there were some inadequacies in those existing programs. For example, such things like Community

Nursing Program, and the Certificate -Of -Need (CON) process were not addressed within the existing program. Also, what to do with the increasing elderly population, a growing shortage of certain health care workers, acute and long-term bed shortages, escalating health care costs, and the cost shifting from uncompensated care were among the shortcomings of the existing system.

Membership on the Blue Ribbon panel consisted of a cross-section of Hawaii's economic and social elites. These economic and social elites included business representatives, insurance providers, consumers, and academia. After several months of public hearings and deliberation, the panel made its recommendations in July 1992. According to Neubauer (1993), the number of recommendation they made was thirty-six of which they designated eight as "Key change" proposals. In broad, general terms, the recommendations focused on five areas: administrative costs, health care resources, medicals costs, consumer expectations, and cost shifting. The implementation of some of the changes proposed by this panel ran into some strong opposition by the business community. Most of its opposition was based on the fact that an "entity" would be created to implement the recommendations which they saw as another "increment of public sector regulation" (Neubauer 1993:37). However, the labor community in Hawaii saw it differently. Labor's point of view was that without a strong governmental authority, none of the recommendations would come to fruition, hence its support for the creation of the separate entity to implement the recommendations. The State governments view in all this was simple: The creation of the new entity would signal a further commitment of the State to "partnership" in the

development of quasi-cooperative, quasi-regulatory approaches to health care system development and cost control, according to Neubauer (1993).

Despite all these protestations, the Blue Ribbon Panels work did not result in a legislative victory. Neubauer (1993:37) speculated that the "failure to act legislatively resulted from a breakdown in the political coalition that supported both SHIP and the panel." Neubauer explained this coalition as consisting of Jim Shon who was Chair of the House Health Committee, Dr. Lewin, the Director of the Health Department who was increasingly out of town because of his involvement with President Clinton's Health Care Task Force, and others on the board who originally were strong supporters of the administrative proposals, but later became reluctant partners when the political coalition started to crumble. In particular, State Representative Jim Shon lost his Chairmanship of the House Health Committee due to a sweeping reorganization of the House prior to 1993. According to Neubauer (1993), the new committee chair, Representative Julie Duldulao, was either unwilling or unable to forge a new coalition to support health reform. Despite these developments, in 1994, the State of Hawaii enacted a new health care reform called HealthQuest. The enactment of this health reform program has been noted earlier in this section.

According to Neubauer (1997), HealthQuest, which some times is referred to as HawaiiQuest, was a product of external consultants who were working with Hawaii's Department of Human Services. The Department of Human Services administered the Medicaid program. When HealthQuest was being formulated, only

minimal input was sought from the legislature, the Department of Health or the community. By the time this program was brought to the attention of the legislature for ratification, it was essentially a done deal. At that point in time, the legislature had the choice of either playing a spoiler role, or going along with its ratification. It chose the later.

HealthQuest revamped Hawaii's two previous health reform programs, Prepaid Health Care Act (Prepaid) and SHIP. As mentioned earlier in this section, it shifted publicly funded health care insurance from an entitlement structure to an insurance-based system. It also combined recipients of Medicaid and those on general assistance including families with dependent children and SHIP into a large purchasing pool. This new configuration was then bid to private health plans that provided a common benefit package at a capitated rate. As Neubauer (1997:179) indicated, HawaiiQuest continued thus the "Hawaii practice of providing a "rich" benefit package for Medicaid recipients, with former SHIP recipients gaining increased benefits, including increased numbers of physician visits and hospital stays." The plan was meant not to incur costs greater than those of the fee-for-service system that it replaced.

In conclusion, Hawaii's 1994 HealthQuest and its earlier reform programs such as SHIP (1989) and the Prepaid Health Insurance Act of 1974 were major examples of how publicly supported health programs could be administered and delivered in this country. As a pioneer in State health policy innovation, Hawaii set the stage for other states like Oregon, Massachusetts and Florida to become big players in the State health reform movement.

Lessons learned from these states.

The lessons learned from discussing these state programs is that when it comes to health care reform, there are some similarities and differences between states on how they conduct their health care innovations. Although not all states are discussed in this research study, the researcher focused on three specific states to demonstrate how what happened in Oregon might have had national significance. For example, Oregon's health care reform, which was personified in the Oregon Health Plan based most of the conditions that led to the enactment of laws enabling reforms in all these other states. The one constant in these state innovations is the eventual goal of universal access, even though that goal is still elusive.

Another similarity is that in each of the states, the business community played a pivotal role during the formulation and eventual implementation of the State program, even though at times it was a reluctant partner. For example, in Florida, Paul-Shaheen (1998) indicates that individuals representing Associated Industries of Florida, the Florida League of Hospitals, the Florida Medical association, seven insurance companies, and Blue Cross-Blue Shield of Florida formed a lobbying group that was highly instrumental in working out the final compromise on the Health Care Reform Act of 1992. In Oregon's case AOI, with a membership that included businesses with a health- related focus, was also very much involved in the early stages of the formulation and implementation of the health plan.

Another important similarity in these states' health reform program is the role of legislative leadership and the states' bureaucracy in these reforms. Paul-Shaheen (1998) also noted this in her work. As she puts it: "The support of these individuals – the major gate keepers of states' policy agenda – was critical for moving the process forward" (p. 347). According to Paul-Shaheen, in Massachusetts, Representative John McDonough credited Mr. Charles Flarity as absolutely critical to Massachusetts' reform effort. Mr. Flarity was a Democratic State Representative and at the time of Massachusetts' reform, he was the house majority leader. According to Rep. McDonough, Rep. Flarity played the key role in the house garnering the needed votes for passage (Paul-Shaheen, p. 347). As Paul-Shaheen, in quoting McDonough, noted, "the original vote for the bill was 77 to 75. If one vote had changed, it would have killed the bill" (Ibid). In Oregon, the then- Senate president played this pivotal leadership role while agency heads such as Jeane Thorne and Chad Cheriel played the supporting roles. Mr. Cheriel was Director of the Office of Health Policy, while Ms. Thorne was Director of the State's Medicaid program at the time.

In Oregon, executive leadership was critical for the evolution and subsequent implementation of the reform that took place. During the early critical period, Barbara Roberts was governor, and she led the state through the waiver process and the "employer mandate" controversy. Later, former Senate president John Kitzhaber became governor of Oregon and continued the process of providing this critical leadership. Similarly, in the other three states, executive leadership was equally

critical to their success. Michael Dukakis provided this leadership in Massachussetts, Lawton Child in Florida, and John Waihee in Hawaii.

Despite these similarities, there were a few differences. Oregon's approach was a political strategy. This political strategy involved different stakeholders who came together at the urging of the states' political leadership to map out a program to solve the states' chronic problem of lack of access to health care by uninsured low-income residents. On the other hand, in Massachusetts the timing of national events played a role. The presidential bid of Michael Dukakis arguably was a key factor that led to the enactment of the Massachusetts Health Security Act. Paul Shaheen (1998:335), quoting Catherine Dunham, stated:

> As Michael Dukakis's star rose in the presidential primaries, it allowed the democrats in Massachusetts to rally together so that Massachusetts could be the first state after Hawaii (to achieve reform) and the best."

Paul-Shaheen (1998) further stated that a Democratic state Representative John McDonough had this to say about the situation:

> Some in Massachusetts felt that the bill would never have been enacted if Dukakis's had not been running for president. House members did not want to mess up Dukakis' presidential aspirations (ibid)

According to Paul-Shaheen, Dukakis himself put it this way:

> The presidential campaign also played an important role. I started making real progress in the early primaries. I talked a lot about our efforts in Massachusetts. I think there was a genuine sense of excitement about the campaign and about the leadership role that Massachusetts had taken on a whole host of important issues during the previous three to four years: welfare reform, urban revitalization, child care policy, plant closing notification, and many more. Unemployment in the state had dropped to below three percent. Universal health care was, in a sense, the crown jewel of a remarkably creative

> period in the states' political history, and the presidential campaign helped to crystallize that feeling in a very special way (Ibid).

In Oregon presidential politics did not affect its reform directly as none of its leaders had presidential aspiration. However, in some sense, it can be argued that national presidential politics was a latent force that affected Oregon negatively in that as Oregon sought a key federal waiver for its Medicaid obligation, there were unanticipated delays due to the timing of the presidential politics in that period. Oregon needed the waiver to implement a major provision of its Basic Health Services Act. Because of the presidential election of 1992, there were delays in providing this waiver by the federal government.

It is important at this juncture to clarify and to an extent emphasize that it was not that Governor Dukakis' presidential aspiration and involvement in 1988 had a direct impact on what was happening in Oregon at that period. The point this researcher is making is that presidential politics, political party control of the state legislature, and which party controlled the governor's mansion were all key factors that influenced State decisions to initiate and implement health care reform. In the three states discussed in this chapter, including Oregon, these reforms took place under Democratic governors and almost in all cases, when Democrats were in the majority in those state houses.

During the period Oregon implemented its health care reform in 1994, the Florida legislature defeated Governor Childs' Health Security Proposal. In the words of one observer, "That session, no one in the Republican camp wanted to enact Florida

Health Security because no one wanted to give Childs a 'platform' to run on for governor"(Paul-Shaheen, p.334). In effect, the timing of state elections had its own effect on getting reforms through the state legislature in most of those states.

Another difference between Oregon's reform and these other states was that Oregon's reform was championed by an individual who came from a health care background. John Kitzhaber's background as an emergency room physician helped shape his vision and insight into what Oregon needed to accomplish its health care reform. In these other states, their leaders came from other professions and had politics as almost their life career. Consequently, they become involved in the health reform crusade out of their desire to combine personal commitment with political opportunity. Such was the case with John Waihee in Hawaii, Michael Dukakis in Massachusetts and Lawton Childs in Florida. They were all long-term legislators in their respective states and in the case of Lawton Childs, a United States Senator, prior to seeking gubernatorial office.

Finally, among all these states, Oregon's health care reform as embodied in the OHP was the only one with a specific process for setting priorities for health services - in short, an explicit form of rationing. On the other hand, the State of Florida with its own reform in 1984 was the first state to enact state-based revenue assessment on hospitals to finance the state's Medicaid program and the expansion of primary services. Although Florida followed this tack in 1984, Massachusetts in 1988 became the first state to legislate a "play-or-pay plan" in their reform effort.

In summary, these three states discussed here had their unique differences and similarities with Oregon in their reform agenda. The major thing is that Oregon's experiment started before President Clinton came to office. Clinton's crusade to reform the health care system failed just like the efforts of other presidents before him. It failed not because it lacked popular citizen support, but because it lacked the political support of a powerful coalition of business leaders in this country that in essence represents the business community. On the other hand, Oregon mobilized political support through a coalition of business, political and social advocacy groups and so did these other states, hence their success in their reform agenda. The Oregon approach, albeit, "prioritization" and "rationing" of health care, is therefore one of a set of emerging models of modern health care innovation in the United States that health policy scholars and the nation's political elite interested in health care reform will be watching closely in the years ahead.

Chapter 6

Analysis and the Presentation of Findings

This researcher noted in chapter 3 that the data analysis for this study would begin at the data collection phase. The researcher also indicated in that chapter that this process of analysis would continue throughout the course of the study. The researcher has so far followed through with this process. Equally relevant to mention is the fact that this research approach is consistent with the method various qualitative researchers have suggested. As they see it, the purpose for using this approach is to strike a balance between efficiency and design flexibility as noted by Marshall and Rossmam (1995).

Maxwell (1996), and Yin (1984). In particular, Marshall and Rossman (1995:111) suggest that one of the essential qualities of a good qualitative research is "design flexibility."

Apart from promoting efficiency, this approach to research also enabled the researcher to filter out early in the process any of the unusual elements not conducive or germane to the study. Based on these premises, this researcher began the data analysis during the data- gathering phase and has continued the process as the research effort progressed.

Given that the analysis for this study started at the data- gathering phase, the organizational framework for chapter 6 is to continue that process, and, as an adjunct to the process, present the findings in an interactive manner. At this juncture, the

researcher wishes to note that the use of the term "adjunct" does not in any way denigrate the importance of reporting the findings in a qualitative research. Instead, the point the researcher is making is to emphasize that the qualitative research process is not linear, and not stepwise but an interactive process, according to Morse and Richards (2002). This researcher previously stated this point in chapter 3. With this as a backdrop, the data analysis for this study began as soon as the researcher started the data gathering from various sources such as personal interviews, public documents and other publications related to the topic of this study. Part of this process was listening to interview tapes prior to transcription. This process enabled the researcher to rewrite and reorganize what information was captured in the interview tapes as well as the rough notes of what he observed or heard during the interview. This process helped the interviewer to develop tentative ideas, patterns, categories and relationships of what was emerging and the direction the research was going. For example, the memos enabled the researcher to reflect on the method or methods that were being pursued, and what theories could emerge from the study. It also enabled the researcher to assess what purposes the information gathered during this data collection phase could serve. This process not only provided the researcher the ability to hone his analytical thinking about the data gathered, but also facilitated the researcher's analytical insights on the topic of this study.

This chapter reports the findings obtained through the various interviews with the different groups as described earlier in this study. These findings are not reported as quantitative results but rather, to reiterate, in terms of a case study approach in

examining the role of the business community in the evolution of the Oregon Health Plan (OHP). The chapter also utilizes information gleaned from other official records and other multiple sources such as legislative hearings, testimonies, libraries, and newspaper articles in addition to other sources already mentioned earlier in this chapter. The advantage of using these multiple sources has been noted in Yin (1984:20) as a case study's "unique strength" based on its ability to deal with a full variety of evidence. It is also advantageous in "contextualizing strategies" for narrative analysis in individual case studies (Maxwell,1996:78).

Given the narrow focus of this study, the analysis and presentation of this study's report attempts to provide an understanding of the business community's role, what is it that they did and why they did it during the Oregon health plan's evolution and implementation. It is important to add at this juncture that often times, qualitative researchers present their findings and conclusions in a mixed form, using the existing literature as an explicit data source to triangulate the field based findings, and integrating existing theory into the presentation of the results of their analysis. This hybrid approach to report presentation has been employed by this researcher at appropriate times in this study. The researcher's rationale for doing so is that the analysis of key informants' (respondents) interviews conducted for this study fits the format described here, with a mixture of references to and constructs from existing literature as well as constructs and relationships that arose from the interview data themselves. Given these considerations, this researcher utilized the theoretical conversations from the literature review and related the findings of this study against

the existing frameworks. It is the expectation of this researcher that this approach is the best way to get to the core task of this study – i.e. to understand the role Oregon businesses played in the evolution and implementation of the Oregon health plan. It is also the best way to relate, verify, challenge, and / or expand existing theories of business-political behavior in the formulation of a public policy in such a way as to empower those wishing to promote health care reforms in their localities to bring about a desired change.

Having stated these considerations, we now turn to the task of continuing the analysis and presenting the findings of this academic research. For purposes of clarity, the researcher wants to reiterate that this specific research study is not about Oregon's health care reform in general or the Oregon Health Plan (OHP) in particular. Instead, the purpose of the study is to analyze the role the Oregon business community played during the evolution and implementation of the Oregon Health Plan.

1. Business "self-interest" was paramount

Four respondents who shared their perspective on this question had similarities in their answers. They seemed to agree that the Oregon business community was divided, especially at the beginning of the health plan's evolution. To elaborate, one of these four respondents stated: "some businesses were more reluctant than others to support the OHP." This meant that even though there was some reluctance, those businesses opposed to the OHP at the very beginning became supportive of it at the end. This respondent also stated that the support each business group gave was

dependent on the type of business that the business group was involved in. For example, those businesses that were engaged in health care related enterprises supported the health reform effort from the very beginning. Those that were not supporting the health reform originally did not get involved supporting it actively until they sensed that the legislation coming out of Salem might impact their business adversely unless they got involved to influence the outcome of things. In particular, Oregon hospitals and health systems, the Oregon Medical Association, and health insurance companies were among the early partners of the reform effort whereas non-healthcare related businesses such as 7-Eleven, The Oregon Restaurant Association, and the Goodwill Industries of the Columbia –Willamette were later supporters. In the case of big business support for the OHP, its support occurred through the instrumentality of the state's major business lobby- Associated Oregon Industries.

It is worth noting that the four respondents who were in agreement in their responses to the question of what role they thought businesses played in the formulation of OHP were from two different clusters: three were from the Business community and one from the Bureaucratic elite. This finding is consistent with Bergthold's (1993:811) assertion that businesses have "few interests that link them solidly together" and that in the absence of such interests, they would have no interests on which to act. Therefore, their support depended on what they sell, where they are located, how large they are and who leads them. In light of theses considerations, businesses "will continue to act autonomously"(ibid).

2. The business community's national interest is not the same as its local interest

This research found that the Associated Oregon Industries (AOI)'s support for the Oregon health plan is inconsistent with Mintz and Palmer (2000) study of the causes and consequences of American business involvement toward healthcare reform. In their study of business and health care policy reform in the 1980s, Mintz and Palmer found that American business was divided into three main groups in the matter of health care reform. Their study showed that on a national scale, non-health care firms (businesses) championed reforms, health care businesses resisted reform, and insurers sought to channel reform in directions that preserved their interests. They also found that each group contained both large and small companies, with often differing views and objectives in the health policy reform agenda. On the contrary, in Oregon this researcher found that during the formulation and implementation stages of the Oregon Health Plan, Oregon's health care companies were in the forefront championing reform instead of resisting it. This study also found that Oregon's non-health care companies that were large employers just like their health counterparts were in the vanguard for this reform although they were in it for different reasons. Among those reasons was business "self interest" at the state or local level. As one political executive (respondent #13) interviewed for this study did indicate: "...the role that each one of them played depended on what their self-interests were." In a similar fashion, another political executive (Respondent #14) pointed out that there were some specific factors in the OHP that appealed to business, particularly the "prioritized list concept." This respondent further stated that this prioritized list

concept "essentially opened a whole new idea of controlling costs" and that if the idea worked, it could be brought into commercial insurance." Adding to this view was the observation from another political executive (respondent #15) who stated:

> One of the reasons is that they were concerned about costs-shifting from un-insuring employers and from the persons who just had no health care coverage, and the other one was that because they felt that OHP provided a mechanism for controlling expenditures. It had within it a way for modifying the benefit package in order to control costs and so those two factors were the primary things that attracted the business community.

3. Economic Incentive, Self-Interest and Business –Political Behavior

Feldstein (2001) remind us that "political markets" have legislative benefits and that when the benefits that are provided to a group exceed the financial costs the group incurs, that group or individuals affected would "seek to further their self-interest"(p.9). This "self-interest" paradigm has been noted in the preceding paragraph. From a different perspective, Mintz (1995) discusses the business community's behavior when it is engaged in any kind of political activity. Feldstein's perspective intersects with Mintz's perspective in that legislators operate in the political markets and business –political behavior is fed into this market. For instance, legislators are the suppliers of legislative benefits, and with these benefits, they can shape the political behavior of the business community. In this context, Oregon's large companies supported the Oregon health plan's evolution and implementation partly because they initially saw in that plan a potential to reap "legislative benefits" when the plan is fully implemented. This situation is also consistent with Feldstein's theory of "economic interest" of business organizations. In addition to this view of Feldstein,

the prospect of the Oregon business community taking advantage of what economists call "economies of scale" is another example of this legislative benefit since under this scenario, as costs of providing insurance to employees would be lowered if more people were covered under the government's program and more employers participated in the program as well. On the basis of these considerations, this researcher found that there was an interrelationship between economic incentive, self-interest and business-political behavior within the framework espoused by Mintz (1995) and Felstein (2001). For instance, given the tax breaks and a variety of other health insurance reform measures that the state of Oregon granted some businesses that qualified, it is clear why many of Oregon's health care companies supported the reform. Even non-health care companies in Oregon benefited as well. For instance, the "prioritization" or "rationing" of care as people have variously called the Oregon Health Plan benefited the business community as a whole from an economic point of view. For Oregon employers that were serious about cost control, rationing of care was an important incentive.

4. Public Interest theory

Although this research study is not designed to test theories, this research study confirms what Feldstein's (2001) has said were the basic assumptions about public interest theory. As Feldstein (2001:5) points out, the underlying basic assumption of the public interest theory is that "legislation is enacted because well-meaning legislators act according to what they believe is in the public interest." In the Oregon

experience with health care reform, Oregon's legislators under the leadership of then Senator John Kitzhaber, the architect of the reform process, embarked on the reform agenda with a common purpose: to "keep Oregonians healthy" (The Oregon Health Plan: An Historical Overview, 2004, p. 1). However, after the process of reform got underway, there was some dissatisfaction within the legislature as well as within the business community as to the efficacy of the program. As Feldstein (2001) stated in his analysis of the public interest theory, it is dissatisfaction with the public interest theory that leads to the economic theory of legislation. The researcher is not in any way suggesting that it was dissatisfaction within the business community of Oregon or among the citizens of the state that led to the creation of the health plan. Instead, the researcher is simply stating that the public interest theory as explained by Feldstein (2001) has implications for the Oregon experiment with health care reform when it is put in context. For example, various events such as the escalating health care costs that were occurring in Oregon and across the country during the period of the late 1980s and early 1990s were the primary reasons that most state governments got serious with health care reform. But once these reforms got underway, regulating the "market" became inevitable. As this researcher noted in chapter 2, government intervenes in the market when it suspects that the market is failing or not working. This view is held by many economists, among them Wolf (1979). One way governments have been known to intervene in the market place is through regulation. The other way is by legislation.

Feldstein (2001) explains that businesses or industries that are quite large are most likely to be regulated and this exposition can partially explain why there was a flurry of state regulations on health care during those periods. Since health care is big business in America, there is no question that the delivery of health services is also an area that large health care companies dominate. Hence the purpose of the regulation is to prevent them from using their size to orchestrate monopoly abuses in the health care market place. This situation did not appear to be case with Oregon's experience. This is because during the period of the Oregon health plan's evolution and implementation, Oregon's medical community did not seem to be heavily regulated. Its involvement with AOI, combined with its strong lobbying ability, made it less of a target for government regulation. More importantly, because of its size, they were less likely to have competitors.

5. The business community was a beneficiary of Oregon's health reform.

Again, Feldstein's view that there is a legislative benefit associated with government regulation is consistent with what happened in Oregon. The Medicaid expansion was an economic driver in some local communities in Oregon. One Political executive (respondent #14) noted this point as well and so did one Bureaucratic elite (respondent #7). The political executive gave the example of Coos Bay - a small coastal community in Oregon as a place where this "economic driver" concept was manifested. This tied in with the economic development argument that Peterson (1979) makes when he discusses his three policy domains in the formulation

of a public policy. He associates this kind of situation as a developmental policy of local governments in the context of public policy formation. The bureaucratic elite (respondent #7) cited the attitude of the Oregon hospital association that portrayed the health plan sometimes as an "economic development tool" for Oregon.

6. Logic of business unity.

This research confirms that there is really no logic to business unity. In order for the business community to unite on any issue, the issue on hand must be one that will impact directly the operational dynamics of the businesses involved. If there is no overarching need for businesses to unite such as to seek favorable legislation or a proposed public policy, business will choose to remain ambivalent and in most instances will not unite behind the cause. The Oregon business community's reaction to Senate Bill (SB) 27 at the beginning of debate to establish the Oregon Health Plan and its reaction to Senate Bill 935 (SB 935) later is instructive. In looking through the archival records and also through testimonies from members of the Oregon's business community, there seemed to be wide spread support for Senate Bill 27. However, when it came to Senate Bill 935, their reaction was vastly different. Senate Bill 935 was very controversial and consequently, it was the bill that drew the most opposition and actually the one that divided the business community. From the perspective of the business community as a whole, Senate Bill 27 (SB 27) did not present a major threat to most segments of the business community in that with the bill, the business community felt that there was going to be expanded coverage; there would be less

cost-shifting and that they would not have to pay the cost shift. Also, the business community equally felt there would be better control over Medicaid costs because of the "prioritized list" that the bill promised. The whole climate of cost – consciousness and accountability for cost of operation would reduce their cost directly or indirectly. Therefore, business was willing to step up under those circumstances and support a program of insurance that would make it possible for all Oregonians to have access to health care coverage. This kind of business behavior as exemplified by the Oregon business community during the evolution of Senate Bill 27 (SB27) underscores what Mintz (1995) has described as broad-self interest of business firms that may overlap individual interests of individual firms. It also illustrates what Mintz (1995) terms "Class-wide" interests of the business community when there is no major profitability gap between businesses within the same community. In particular, Mintz (1995) discussion of the business community's "broad-self interest" and "class-wide" interest indicates how important the profitability gap is to individual business decisions. As she points out, when there is no major profitability gap between business firms, the business firms will have narrow-self interest. On the other hand, when there is a major profitability gap between business firms, the business firms will have a class-wide interest. This class-wide interest leads them to collective action.

This researcher has already noted that with SB 27, the Oregon business community seemed united, but when it came to SB 935, it appeared to be divided because of the individually perceived threats posed by these legislation to their

bottom-lines. However, the lack of cohesiveness within the business community again illustrates how the self-interest paradigm which Bergthold (1993) discusses shows up in the behavior of the Oregon business community. For instance, during the formulation of the Oregon health plan (OHP), Oregon's large health care companies tended to view reform as inevitable, and generally cooperated with the reform efforts, whereas small health care companies most often were disposed to defending the status quo. Again, this dynamic is what Mintz (1995) has described as business-political behavior. Martin (1993) indirectly alluded to this characterization when she noted that when it came to collective action, the business community seldom rallies together because of individual self-interest. This point is further underscored by a response given by one business executive interviewed for this study and who was involved with AOI during the evolution and implementation of the Oregon Health Plan. When the researcher asked the question: "In Oregon, it is known that AOI lobbies for the interests of "big business." What mutual interests did your organization have with Oregon's small businesses in reference to the OHP?" In answer to this question, this respondent replied that big business and small business in Oregon did not share a lot in common or mutual interests in reference to OHP. According to this respondent:

> Their interests diverged there because small businesses, which made up the vast majority of payrolls in the state of Oregon - -about ninety-percent of payrolls had fewer than twenty employees at the time.

This respondent further explained:

> There was a very lopsided division between small and large business in Oregon. On one hand, it is the larger businesses that tend to be more focused on things like public policy and the health care policy ...the smaller business owners have less time to focus on those things and even to focus on one thing like how to purchase health benefits for their employees.
>
> (Respondent #1, Interviewed by author on November 18, 2003).

On the same question, another respondent from the business community described "common" interest between Oregon small businesses and big businesses in reference to OHP in slightly a different tune. This respondent replied that both did not have common interest but that they had a "mutual objective" to prevent cost shift. Elaborating further, this respondent added:

> Big business typically provide health care benefits to employees whereas small businesses many of them don't --- several of them don't because it is so expensive, whereas the larger companies are sort of shifting cost or absorb those costs easier than the smaller companies
>
> (Respondent # 2, Interviewed by author, November 24, 2003)

Admittedly, Oregon's small companies in general did not quite embrace Oregon's health care reform despite the fact that some of the proposals that were contained in the legislation were designed to benefit them. AOI, apparently an active supporter of these bills was at times a reluctant partner to the reform agenda. This behavior also illustrates how uneasy businesses could find themselves feeling when they want to or have the desire to engage in public policy making and at the same time attempting to remain loyal to their core constituency.

Although the cost-shift issue seemed to be one of the many thorny issues between Oregon's large and small businesses, from the perspective of one of large business's representatives, cost –shift was less a problem for the business community

relationship with the small businesses in the state. This respondent, albeit indirectly, addressed the same question of mutual interest this way:

> One of the things that people don't understand about AOI is that it is perceived as big business, with 23,000 members though we are not big business. Our demographics represent the demographics of the state of Oregon. So two percent of our members employ over one hundred people just as two percent of businesses in Oregon employ over one hundred people. In the cost-shift, we didn't. We've never separated big business and small business. They are the same issues. They just have different impacts based on the size of the business. I mean the dollar value is going to vary on size, but it's the same issues whether you're a large or a small one and proportionately, it's the same whether you're large or small.
>
> (Respondent #3, Interviewed on January 9, 2004).

7. The Business community did not initiate policy.

This research found that the business community of Oregon did not initiate policy. It instead reacted to policy. This point was corroborated by a comment made by one of the bureaucratic elites (respondent #4). In his comments, this respondent asserted that when businesses said, "we're worried about cost shifting, we're worried about rising insurance premium," Dr. Kitzhaber made it clear to them that he has heard them and that he was going to incorporate their concerns into the OHP design. According to this respondent, as soon as the business community became convinced of this, "they could not then take an active role in designing what it was going to look like, but only continue to provide advice to the governor and then react to what he came up with." In this context, the business community of Oregon did not initiate policy but rather, it reacted to policy, unlike the political behavior of their national counterparts such as the Business Roundtable in Washington, DC – a national business lobby group that usually gets involved in public policy formation.

8. In Oregon, there was no typical health care coalition presence .

This research found that there was no typical health care coalition in Oregon in general or within the business community in particular during the period prior to the formulation of the OHP. When the process of formulating the OHP started gathering momentum, different groups started getting organized and subsequently AOI reacted by incorporating the issue of the OHP in its business and political agenda. It was at that moment that something like a health care coalition was created within the business community of Oregon under the auspices of AOI.

9. Business community felt disappointed

This research found that the business community was later disappointed with the way OHP was being implemented after it had been designed. For instance, at the very beginning of the discussion regarding the formulation of OHP, the business community showed a desire to support the program. At the time, the business community supported the program's evolution because of what it had hoped it would get from the program. In particular, the medical –industrial complex of Oregon, such as the Oregon Medical Association, the hospital systems, health care suppliers, insurance companies, dentists, and the nurses associations were very supportive of the program. They were supportive during the public hearings leading up to the establishment of the Oregon Basic Health Services Act, the forerunner of the Oregon health plan. Their support of the program was based on the assumption that the OHP

would be an opportunity to reduce cost shifting that was occurring with the state's medical delivery system, including uncompensated care, and that the OHP would assist in the control of costs in that area. As an incentive to support the program, the choice of the business community was to have benefits reduced for program recipients, -an idea that was embraced by then Senate President John Kitzhaber when it came down to controlling some of the spiraling costs of the program. For instance, the employer mandate as originally conceived contained provisions that would have made employers provide some health insurance for their employees. Instead of this, the business community pushed for a basic benefit package (especially something more affordable for smaller employers of Oregon). Since the Oregon business community is not a monolithic community, differences still existed within the community even with all the concessions and incentives granted to it by the state in the legislation establishing the program of health reform. As this researcher has noted earlier in this chapter, while Oregon's large businesses have health coverage for their workers, the majority small businesses in Oregon did not provide their workers with any form of health benefits until there was legislation passed by the Oregon legislature. For example, the National Federation of Independent Business (NFIB) of Oregon opposed the plan early when the issue of mandates came up. This was unlike their counterpart, Associated Oregon Industries (AOI), that took a supportive stance early when its fears were allayed. It is important to note that this Oregon business lobby group represents many of the Oregon's large companies and it has a

membership of about 23,000 companies, according to its current legislative lobbyist on health affairs, Lisa Trussel.

It is also worth noting that the medical community as a group is heavily represented by the AOI and therefore exerts major influence in that organization. Feldstein (2001) has said that there are two groups that have benefited most by the rapid rise of medical expenditures in the United States. Apart from the "aged," which benefits from the Medicare program of the federal government, the other group is individuals and groups employed in the medical sector such as health care suppliers and providers, nurses, hospitals, and physicians among others. When looked at from this perspective, the Oregon business community benefited from the OHP although this benefit was not universal for the entire community. However the disappointment that business had with the implementation of OHP arises out a big misunderstanding of what OHP was all about and what the government's role ought to be.

Feldstein (2001) reminds us that there is a distinction between "public interest" and "economic interest." Business organizations do things because of their "economic interest." This point has been noted earlier in this chapter. On the other hand, governments do things in the "public interests." Based on this framework as postulated by Feldstein (2001) it appears conceivable that the real reason Oregon's business community supported the OHP was because of its "economic interest" and not because it was enamored by "public interest" undertakings. In particular, because its medical –industrial members pay dues, it was not ready to alienate that segment of its membership. However, when the costs of OHP escalated, business was disappointed.

This feeling of disappointment is summed up in the words of one executive from the business community:

> OHP "has not succeeded in containing costs. It has not succeeded in floating the benefit line to match the financial circumstances of the state. That has never been more apparent than it is now when the states economy is in desperate situation and yet the benefits that are being provided under OHP are still very rich and very unconstrained in terms of costs.
>
> Interviewed by author, November 18, 2003.

10. OHP: An economic development tool

This research found that some members of the business community saw the OHP as an economic development tool. In particular, one Bureaucratic elite (respondent#5) interviewed for this study made this observation about the business community:

> AOI really has been the only organization that has been involved too much with the health plan. Hospitals, the hospital association as an employer, as well as a business, has been very focused but on trying to get funding for the health plan because health care is a huge industry in the state. So the hospital association, really have portrayed the health plan as an economic development tool
>
> (Interviewed by author, December 5, 2003).

This particular respondent added, "I guess, they've been out there, again, more as business than as health care providers in supporting the health plan because of it's more money for their bottom line." One political executive interviewed for this study lamented:

> It's often times not appreciated what an economic driver Medicaid is. It's a very substantial economic driver. Again, especially in communities ...You look at a community like Coos Bay where three out of the five largest employers are hospitals or medical groups and one-third of the patients, - they're Medicaid patients. So, and almost one-third of the folks are uninsured at some time during the year. So, tackling any of those problems can have a substantial effect on the area's economy
>
> (Interviewed by author, December 18, 2003).

Although these perspectives were almost universal among all the respondents interviewed for this study, there was equally a general agreement among all the interviewees and from the transcripts of legislative records that the Oregon small businesses did not support the OHP in the ways that AOI did. In fact, in their eyes, they did not think the economic development argument was persuasive. Instead, they felt like their interest was not represented in the OHP. Here is how the same bureaucratic elite summed up her feelings regarding the small business community of Oregon with regard to the formulation and implementation of OHP.

> NFIB has always been opposed. They're small business, so were opposed at the beginning, they've been opposed because they generally don't provide health coverage to their employees.

11. Political support of Social advocacy groups.

In the process of conducting this research study, it became apparent to the researcher that the OHP had many constituents, not just the business community when the program was evolving and during its implementation. Each of the constituents had its own agenda, but all were united in their hope that Oregon's residents would

eventually be provided with universal coverage – an ambitious goal that all protagonists of the reform had set. One social advocacy representative interviewed for this study, when asked what galvanized her group to lobby for the OHP, responded:

> During the consideration of changing the Oregon's Medicaid system, Ecumenical Ministries became involved, one, out of historic concern for the provision of health care. Most Oregon hospitals started out as religious institutions. The Church in Oregon has been very, very active in promoting access to health care, so it was part of what we called "our social principle" at Ecumenical Ministries. We wanted to achieve through a public/private partnership, access to health care for all of those who were in need. So we came to those discussions about OHP, playing defense because we didn't want to have fewer services - -that fewer essential health care services available to the needy. We also wanted to make sure that there was an expansion of health care to those who were not part of the categorical system.
> As it was, in Oregon you had to be pregnant, you had to be on welfare, you had to be disabled, in order to have health care and that was something that was not acceptable to the faith community because they knew that there were a lot of adults and a lot of people that we categorized as the "working poor" who did not have access to health care. So in answer to your First question, health care had been part of our concerns over many years and so it wasn't something that we came to because of SB 27.
>
> (Interviewed by author, January 29, 2004).

Another leader in the social advocacy coalition who was asked a similar question responded this way:

> And I have to say that my recollection ... is that most of our testimony around the OHP before this particular senate committee was cautionary. We were not full- fledged supporters of Senate bill 27. We had a lot of concerns and our biggest concern and probably our first point of serious impact on that committee was when the John Kolinsky's group was prioritizing, was kind of trying to figure out if we could if we could actually do this. He had conveyed a group in private. There was no public allowed. Nobody had heard of this kind of process, and all of us who understood that what they were doing was prioritizing the most cost effective services, – services that would be most cost effective for the most people. We were very concerned about what that would mean for high cost services for very vulnerable individuals or small groups of the population for whom a very high cost procedure might make the difference

> between life and death or in some cases, employment or unemployment. So to that particular committee at that point, we were engaged in the process. We went to them and said, "please do not vote on this bill before you see the results of John Kolinsky's work. You have no business voting on a bill that was maybe half a page long because senate bill 27, when it started, was a concept as opposed to many pages". We said you have no business voting on this bill until you really understood what you were moving ahead with. And that caused then Senate president John Kitzhaber to become very angry with us.
>
> (Interviewed by author, December 4, 2004).

This respondent went on to describe the membership of her organization this way:

> We are a coalition of organizations. Our coalition members include labor, and seniors, and low-income advocacy groups, and faith-based groups, and some providers.

This group's political support came after some arms twisting by then Senate president John Kitzahaber. As this respondent recalled:

> He called my board members to the table in a private meeting and I remember, it was a Saturday, over coffee and he said, "Do not jeopardize this bill because if you do, I can guarantee you there are things you want that won't be moving ahead. And at that point because we are a coalition, and we have many members that are active with us, we decided to continue to articulate our concerns about a process that created a prioritized list of services that no one at that point had seen, and did not have any designation of what was appropriate health care. At some point we believed that there needed to be a line below which the state could not be allowed to go above – a list of services that was basic and fundamental.

The implication of this political maneuvering or arms twisting by the senate president was that the coalition of this advocacy group was not initially supportive of the OHP at the very beginning. Their non-support at that time was not that they did not like the concept of Oregon providing universal access to its low- income residents but it was due to the secrecy surrounding the initial organizational meetings that was

deciding on the prioritization and rationing of health care services- a concept no one has ever heard of in the United States with regard to health care reform. Another implication of this particular political pragmatism on the part of the Oregon Senate president is that in the policy formulation process, leaders never act alone no matter how popular they are. Consequently, policy entrepreneurship is facilitated by individuals and groups who serve in critical supporting roles. This realism was not lost by the then president of the Oregon Senate. Hence, his desire to enlist the support of groups such as this group in his strategic plan with the view to winning approval for his legislative priority in the context of the OHP.

12. OHP was a misunderstood program.

Based on the reading of the legislative transcripts, personal interviews and other records dealing with the OHP, it is apparent that these disparate groups did not realize at the conceptualization process of the OHP that public programs are usually designed to redistribute the resources of society or to use Feldstein (2001) and Peterson's (1979) words, to "redistribute income" in a more equitable manner in society. Specifically, Feldstein (2001) thinks that to redistribute income is tantamount to "redistribution of wealth"p.209. Hence, Medicaid and Medicare program are designed for the poor and for the elderly by the federal and state governments. The Oregon business community certainly did not see it that way and neither were the different coalition partners that offered their support to the political leadership of the

Oregon government. This basic misunderstanding initially led to mistrust and a sense of deja`vu among various actors in Oregon's health care reform drama.

13. The value of incentives for political support.

So in effect, this respondent's observation ties in with the economic development argument that Peterson (1979) makes. Coupled with some incentives such as tax breaks and a variety of other health insurance reform measures that the state of Oregon granted some businesses that qualified, it is clear why many of Oregon's health care companies supported the reform. Even non-health care companies in Oregon benefited as well. For instance, the "prioritization" or "rationing" of care as people have variously called the Oregon Health Plan benefited the business community as a whole from an economic point of view. For Oregon employers that were serious about cost control, rationing health care was an important incentive to do so.

Summary and conclusions

The analysis and findings of this research effort has been made in the tradition of a qualitative research. That means it did not test theories or hypothesis. Rather it applied theoretical constructs from the works of a few researchers such as Mintz (1995), Bergthold (1993), Mintz and Plamer (2000) and Feldstein (2001) to help clarify and understand the context in which the central issues that emerged from this academic research occurred.

The core findings of this research study have been articulated and presented not in any particular linear fashion or stepwise but rather in an interactive mode. In the process each of the findings has received a complete and detailed discussion. Since this research endeavor did not involve quantitative analysis or hypothesis testing, the findings and conclusions reached with it are rather tentative and speculative and should be interpreted as such.

This research study noted several key findings. Some of the findings touched on economic self-interest of business, the logic of business unity, and how the business community reacts when it's interests are not served in the context of a public policy. Other findings of the research demonstrated the misunderstanding the business community has as to the intent and purposes of government when it is making a public policy decision especially at the state level. Given all these findings and analysis, the conclusion of this chapter is that the Oregon business community is not a community at all in the orthodox sense. It is also not a reliable partner when it comes to health care reform because of the disparate interest of its individual members. What seemed to be the case in Oregon during the period of the evolution and implementation of the Oregon Health Plan is that the Oregon business community was a pseudo- business community made up of the "coalition of the willing." Thus its support for the Oregon Health Plan cannot be taken as a definite sign that in the future the community is prepared to support any new or similar initiative by the state of Oregon in the area of health reform.

Chapter 7

Discussion and policy implications

In order to fully understand and appreciate what happened in Oregon, one needs to revisit Feldstein (2001). In his analysis of government behavior, Feldstein (2001:9) theorized that "political markets are no different from economic markets" and thus individuals and firms seek to further their self-interest. The way Feldstein sees it, business people pursue investments in the private market to achieve a maximum rate of return for their firms. Therefore, if business people could behave this way in order to maximize their return, why would they not invest in legislation if it also offered them maximum rates of return? The short answer is: yes they would invest. By the same token, Feldstein has also argued that organized groups are willing to do the same and that they would be willing to pay a price for legislative benefits and political support. Johnson (1993) adds to this perspective when she argues that different interest groups form coalitions to achieve the group's agenda. In terms of policy implication, the actions or inaction of an interest group toward a proposed public policy is a statement of how the group sees that particular public policy. In Oregon's case, different interest groups, the business community notwithstanding, came out and supported the proposed reform because they saw in the reform a potential for achieving success in an issue that their coalition partners have big interest

in. The Oregon Health Action Campaign was the embodiment of this kind of coalition structure with respect to the OHP.

Feldstein (2001) argues that the price of political support for a coalition and policymakers is the expectations both sides have in the "political market." In other words, the expectations bring together demanders and suppliers of legislative benefits. In Oregon's case, cost shifts and the escalating costs of health care in general were huge issues in Oregon in the late 1980s and early 1990s. Therefore, when the issue of health reform surfaced in the public policy debate in Oregon in those intervening years, both the business community and various coalition groups saw an opportunity to work with the state government to deal with an important issue that seemed to dominate political debate across the nation. To these various groups, Oregon's health care crisis needed an Oregon solution and not a federal answer. The immediate policy implication for this prevailing attitude was the attempt by Oregon to solve this public policy problem by legislation. However, this was not an easy choice for the state or the citizens of the state because finding the right mix of regulations was the tricky part of the whole reform process. Hence there were various public meetings and forums held around the state, legislative debates, and consultations with expert professionals to try to come up with the right solution to the problem.

Business was an early partner in the evolution of the OHP. However, this early partnership of business involvement was in some cases done with some reluctance on the part of business. In particular, businesses that did not already have health insurance were worried about the mandate and its impact on their costs. On the other hand,

businesses that already did provide health insurance were more willing to support the mandate and less concerned about it.

There is no question that company size and the amount of internal resources a company has at its disposal do influence whether a company would support a public policy. Small companies generally attempt to resist getting involved for fear that their involvement may strain their resources.

This research study revealed that even though the business community supported the Oregon health plan during its formulation and implementation phase, there were divisions within the business community. But even when this was the case, the business community was still able to mange its differences. In what Clawson et.al (1986:810) describe as typical business-political behavior, they argue that "corporations self–consciously avoid open political conflict" once a unified business position has developed. In terms of policy implication for this business behavior in the Oregon situation, one political executive (respondent #14) familiar with the situation at the time and who was interviewed for this research explained this business political behavior this way:

> ...business is savvy from a political point of view and business understood the politics of John Kitzhaber. It's important to understand that in Salem there's a certain point at which it's time to either get on the bus or get off the bus, knowing that the risk of staying off the bus are substantial and my sense is that in the late 80s and early 90s, there was a very politically popular and powerful bus that was labeled "health care reform" that John Kitzhaber was driving.
>
> (Interviewed by author on December 18, 2003)

According to this respondent, "business didn't want to be off that bus even though at times I'm sure they weren't very comfortable being on it"

Considering that the Oregon business community was divided especially around SB 935 they still pulled together at the end to let the program move forward. This behavior indicates how the business community's lack of unity or cohesiveness is not a calculus in its disposition to participate in the making of a public policy. In short, what it reveals is that it is still pragmatic for the business community to participate in the making of a public policy even when there is disunity within it. In terms of public policy implications, this behavior is worthy of note by Oregon policymakers when they are seeking cooperation from the business community regarding governmental action in addressing a public problem.

This researcher has previously mentioned that the plight of the uninsured is not a problem for government alone. Their problem is also a problem for society and by extension for the business community. For example, Karl Fredrick, vice-president and Director of legislation of Associated Oregon Industries (AOI) during a May 10 hearing on SB 935 stated that his association viewed the passage of SB 935 and SB 27 as a "bold and innovative step toward reducing the number of citizens in this state who are without health coverage," adding that the vast majority of Oregon employers wanted their workers to have access to good, affordable health care. The policy implication of this kind of comment by a representative of Oregon's business community is that the business attitude toward health care reform is not a leap-year phenomenon. It reflects a perennial question the business community has been searching for answers to here in Oregon and across the nation.

Nationally, the business community is well aware of the acute crisis facing the health care system. For that reason, they actively follow developments surrounding the issue. For instance, at the national level, the business community gets involved in helping to fashion legislation that influences the nation's health care system. For example, Maher (2003: 92) reminds us that "employers were the major cause of the failure of President Clinton's Health Security Bill." In this regard, the role that three business groups played in the nation's health care debate is instructive. The three groups: US Chamber of Commerce, the Business Roundtable, and the National Association of Manufacturers (NAM) had gotten together prior to Clinton's health care reform proposal to discuss the impacts of the nation's skyrocketing health care cost, especially on employers. This was in the late 1980s. According to Maher (2003:92), "all 3 groups debated reform alternatives in an atmosphere largely devoid of political considerations." They seemed to recognize that there were limits to what they could do alone to counter act this cost trend. They also were well aware that the best managed care plans that various segments of the business community had remained exposed to government cost shifting and to cost shifting from employers not offering health coverage to their workers. What followed was that even though all three recognized the dilemma that the business community faced, each of them had their own on specific agenda on how the problem ought to be solved. For example, NAM did a survey in 1992 of its members and found that the majority of its members approved an employer mandate so long as it was part of a comprehensive reform plan. The business Roundtable did not embrace employer mandate and, quite predictably,

the NFIB - a major voice for small business was unalterably opposed to an employer mandate claiming that the mandate was costly and that it would lead to job loss. But the mandate was Clinton's key financing mechanism for his health care reform package. When the Clinton plan surfaced in the mid-1990s, the Chamber of Commerce flip-flopped. According to (Maher 2003:93), the Chamber of Commerce, after a lengthy process had developed a policy in support of an employer mandate and was prepared to advance this position before the House Ways and Means Committee, but in 1994 "suddenly reversed course and totally rejected the Clinton plan." What this whole process reveals is that the business community at the national level tries to initiate policy debate regarding health care issues but it is incapable of agreeing on the right kind of policy mix on those issues.

Berghthold (1993) asked the question: Why does business care about health care reform? The short answer, according to Bergthold (1993: 803), is that "business pays for a large proportion of health care and insurance in the United States." Bergthold's conclusion is consistent with the views that have been expressed by some business leaders around the country. This researcher noted in chapter 1 the comments attributed to former Chrysler Chairman Lee Iacocca that in effect attested to the affirmative response to this intriguing question. In Oregon this attitude was prevalent in the business community especially in the period prior to the evolution of the Oregon Health Plan (OHP). Although the answer to this policy question did generate this affirmative response, there are some who might disagree with that assessment. To those who might disagree, business does not pay for the greater proportion of the

health care in the United States. As an example, theses critics point to the costs of Medicare which the federal government funds alone, and the Medicaid programs that both state governments and the federal government jointly fund. At the state level, funding for Medicaid is extremely costly and when this is combined with the federal matching dollars according to some formula set by Congress, it consumes a great proportion of the national health care expenditure. With the addition of Medicare costs, one can argue reasonably that the proportion of expenditure devoted to these programs dwarfs anything the business community is doing in terms of health care expenditure. The broad policy implication of this situation is that the business community is in the business of health reform not because it is interested in fixing the problem but, to reiterate, to protect its own interest. On the other hand, governments get involved in the health care reform movement to protect the publics' interest. In terms of public policy implications for this situation, a fundamental reform that is aimed at reducing the costs of health care expenditure, whether nationally or at the state level, should be a partnership between business and government. It should also include other stakeholders, such as labor and social advocacy groups. In short, this means that all consumers of health care, whether low-income or high income, should participate in that partnership. That, it seems, was the direction Oregon was heading with its experiment with health care reform.

From a purely economic perspective, business provides its own ethical framework that is built around a business objective. Certainly, charity cases or subsidization of the "public's" business is not one of those objectives. Therefore,

Oregon's Medicaid expansion in the context of the Oregon Health Plan was the public's business and should be regarded as such.

It has been noted in this study that the American business community is not a monolithic community. The same conclusion can be reached about the Oregon business community. From interviewing various individuals for this study and combing through various public records, it was clear that the business community had erroneously assumed that the OHP would be an opportunity to reduce cost shifting in the state's medical delivery system, including uncompensated care, and that the OHP would assist in the control of costs in that area. As an incentive to support the program, the business community wanted benefits reduced for the program's recipients. This idea was embraced by then Senate President John Kitzhaber when it came down to negotiating how to control some of the spiraling costs of the program. For instance, the employer mandate as had originally been conceived contained provisions that would have made all employers provide some kind of insurance to their employees. Instead of accepting the provisions as written, the business community pushed for a basic benefit package (especially something more affordable for smaller employers of Oregon). This request was granted. However, since the Oregon business community was not a monolithic community, differences still existed within the community despite these concessions and incentives granted to it by the state in the legislation. The policy implication here is that when it comes to public programs, the economic concept of the business community dictates that self-interest and not a humanitarian motive is the guiding principle.

This researcher has previously noted that although there are several coalitions in this country, the most notable and most important coalition that deals with health care issues is the Washington Business Group on Health (WBGH). To reiterate, the WBGH is a business lobby that is a spin-off of the Business Roundtable. WBGH has as its main mission to lobby for major American corporations on health care issues. This researcher previously made the point that WBGH did not exit in Oregon but in a sense has a clone in the Associated Oregon Industries (AOI). Again, these two organizations are different in many respects but their behavior seems to be similar. For instance, AOI does not have health care as its main agenda but it nevertheless lobbies on behalf of the Oregon business community on health care related matters because of its membership composition and its divergent interests. In this context, AOI is a major business organization that has the ability to influence a major public policy in the state of Oregon. Thus, the medical-industrial complex of Oregon had what looked like a health care coalition even though the coalition did not exist independently.

It is important to reiterate that in this pseudo-health care coalition, the state's small businesses are represented. One instance where this pseudo-coalition exerted its influence was when the issue of Senate Bill 935 came up for legislative hearing. This coalition was instrumental in getting the Oregon business community what it wanted (i.e., delaying the implementation date of the employer mandate several times and forcing several changes in the small business reform package). This success of the coalition is consistent with Johnson (1993), who argues that the business community forms coalitions to force change. The policy implication of this kind of coalition

activity is that business activism can be fostered by self-interest of businesses, especially if those interests are overlapping. The overlapping scenario leads to business collective action. Time and again, this characteristic of business behavior was evident in the Oregon business community's role in the formulation and implementation of the Oregon Health Plan.

Finally, it can be argued that what happened in Oregon could not have happened were it not for the unusual alliance between various stakeholders who participated in formulating and implementing the health plan. These stakeholders included social activists, ordinary health care consumers, the faith community, some medical professionals, social workers and labor unions. Although the business community and the state of Oregon were integral parts of this stakeholder community, these other groups equally played significant roles. This observation was authenticated by the response given by one social activist who was interviewed for this study. When asked "Was there one particular individual in your group who was considered responsible for the success of the Campaign for the OHP?" This respondent replied this way:

> I don't think any one individual can be attributed. When the legislators saw a list of organizations regardless of who was delivering that message, I think that's what carried the weight of the group. It wasn't any one individual. It was really the power of coalition.

In summary, Oregon's experience in initiating and implementing the Oregon Health Plan succeeded in part because the business community in Oregon was actively

behind the reform. However, it is worth noting that the business community's support for the health plan could not have been as successful as it was if there had not been a parallel support given by these other stakeholders such as the social activists and the labor unions. Therefore the analysis provided by this case study gives us a good understanding and insight into what happened in Oregon, how it happened and the specific role the Oregon business community played in the process of formulating and implementing the health plan.

Lessons learned from this research

In conclusion, it is the view of the researcher that it is easy to suggest that a health care reform like the Oregon Health Plan offers a definitive solution or a final policy destination for the people of Oregon and its government. In politics, there is no such thing and this researcher cannot make that claim. In a field as complex as health care reform, all reform programs produce winners and losers; they solve some problems and exacerbate others. Every political innovation leads to a new policy debate. Today, both the debate and the innovation are carried forward through the institutions, interests, and ideas described in the pages of this study. As one business executive interviewed during this research noted:

> From the business sector to the private sector, it is extremely difficult to understand with any comprehension what public health policy is about. And public health officials have not done a good job of explaining public health policy to the private sector. In the private sector, we have co-pays, we have deductibles, we have premium shares, we have a number of vehicles that help put incentives in place to use – just the right amount of care, not too much.

The implication of this statement is that despite enormous research focusing on the health care reform issues at the state-level in the United States, scholars and public policy practitioners have not yet developed a template for explaining public health policy to the business community. It is conceivable that this situation is part of the reason there has been an uneasy relationship between state governments and the business community in matters of public health policy innovation. How to manage this tension offers the greatest challenge to future generations of scholars and policymakers who will be interested in developing new policy initiatives for state level health policy innovation.

Chapter 8

Limitations of the study and Directions for future research

This academic research study is a qualitative research as well as a single case study. As such, the research must be understood in the context of several limitations. First, is in the nature of a qualitative research that is not generalizable. There was no hypothesis testing or probability sampling in the research design. Instead, the method of sampling was a "snowball" method. Second, the research is a single case study. For that matter, any conclusions reached by it are suggestive at best and limited to this particular study. Feldstein (2001:15) reminds us that while case studies can make a valuable contribution to understanding a particular piece of legislation, they do not enable us to generalize across different types of legislation.

Another important limitation in this research study is the question of validation. Individuals interviewed by the researcher during the data-gathering phase of this study did not review the draft before the report was presented to the academic committee. Therefore no additional comments were elicited as to corroborate the essential facts and evidence presented in the research. The benefits of reviewing the draft with the individuals or informants is that often times the opportunity to review the draft may yield further evidence, as the informants and participants in the study may remember new materials that they had forgotten during the initial data collection

period. As Yin (1984:138) indicate: "A major way of improving the quality of case studies and assuring their construct validity is to have the draft reviewed by those who have been subjects of the study."

Although the researcher has indicated that the business community played a very important role in the formulation and implementation of the Oregon Health Plan (OHP) especially during the debates of Senate Bill (SB 935) – the "employer mandate," and Senate Bill (SB 27), that does not confirm that the findings would apply to all the business communities in the fifty states of the United States. Again, the findings are at best suggestive. However it is important to note that during the data gathering process, effort was made by the researcher to pursue different data gathering techniques instead of employing a single one. This technique allowed for the data gathered to be sufficiently rich, complex and contextual. The technique also allowed the researcher to address the questions and support the analysis from multiple perspectives.

It is important to reiterate that key points of the findings are based on interviews conducted by this researcher and the records the researcher was able to retrieve from the state's archival records and other sources. Therefore the quality of the data must be understood in terms of the credibility of the respondents/informants and the quality of the data retrieved from the archives. If certain relevant documents were missing from the archives that may affect the quality of the work this researcher has done, then there would be a case of missing elements from the sampling frame.

The situation would lead to poor quality data and potentially the quality of findings as well.

Because the researcher is an outsider, there may have been particular kinds of information people did not share with him. For example, some bureaucratic elites still in government may not have been as candid as their counterparts who are out of state government. And some individuals from the business community may have said what they thought would "impress" the researcher, and not what is really crucial to the study's main purpose—that is to really understand what happened in those years when the health plan was being formulated and to really provide some depth and context in understanding what happened in the intervening years as opposed to what is happening today with the program.

There are limitations imposed as well by who was interviewed and who was not –the sample pool. The possibility of this can be real and presents a problem of a missing case or elements. For example, this research study used a snowball method of sampling or purposeful sampling technique as it is sometimes called. If it happened that the researcher did not include appropriate individuals or included the wrong people in the snowball sample pool that alone can distort the findings and conclusions reached by this research.

A pitfall of qualitative research particularly if it involves historical analysis is the issue of mortality. Some people who have a good knowledge about the subject matter may have died or moved on to other things or places and therefore cannot be located. Many former legislators and business people who were around during the

formulation of OHP could not be reached during the period this researcher was contacting people who were to participate in the interviewing process.

Another pitfall of qualitative research as this researcher has found is that some "business elites" and "bureaucratic elites" were willing to talk to the researcher but they were also constrained by their "business schedule" and therefore unable to participate in the interview process.

Although not intentionally designed, it seems that most of the business community's respondents represented the views of AOI and less the point of view of small businesses in Oregon. Under the circumstance, there may be some bias in the kind of answers this researcher received from those respondents that may not have represented the views of the business community at large. Due to the constraints of time, money and other resources, this researcher was not able to remedy the situation. This research would be richer and more robust if the study had included these other people in the interview process.

The most frustrating limitation to the researcher was funding. Lack of funding resources prevented the researcher from embarking on an elaborate design of a multi-case study. Perhaps other researchers fortunate enough to get financial assistance can apply that method if they are interested in pursuing and replicating this academic study in the future.

Finally, a major contribution of this study is that it provides a valuable insight into state level health policy innovation that is focused on a specific state's business

community. The fact that the study chronicled their activities and participation in their health reform process is a major contribution to the literature of health politics.

Future directions

In the course of completing this study, particular avenues for further research present themselves. These avenues require engagement with some literature that has much a richer theoretical basis that is not included in this study. They would require further data collection and analysis especially in a multi-case study.

Three avenues of interest are: (1) What will likely be required to sustain business support for the (OHP)? (2) Based on the current findings of this report, and the existing literature, state level business intervention in the health care policy process is not universally applicable at the present time. For example, we know that the business community is a beneficiary of government, but we don't know if the business community is also a benefactor of government. (3) Impact of coalition building at the state level on health care reform needs further exploration. Most of the existing literature documented business coalition activities at the national level but hardly discusses them at the state level. All of these aspects of future potential research are beyond the scope of this study but are tantalizing as promising new areas to be pursued and examined.

Finally, it is instructive to refer to Locke (2001), who notes that once completed it is sometimes the case that a piece of qualitative work makes a much more

powerful contribution to a theory base other than the one the researcher had originally selected. This is because the findings are field-generated, not theory generated. If this research dissertation has accomplished this expectation, the time and effort that went into doing it will have been worth it.

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Appendix A: Definition of Groups and Terms

The Oregon Business Community: This refers to all the business organizations and their surrogates involved in the planning process and implementation of the Oregon Health plan (OHP). Thus the business community includes: large and small Oregon companies, hospitals, insurance firms (both medical and non-medical), the provider community, and doctor groups in the state of Oregon.

Social Advocacy Group.

This refers to a coalition of different organizations with special interest agenda devoted to health care issues. The coalition includes labor, senior citizen groups, low-income advocacy groups, faith-based groups and some provider group.

Political Executives: This refers to senior executives who serve in government on an appointment basis. Usually they are not long career people in government. They are in and out government.

Bureaucratic Elite: This refers to career government employees in management position who are considered very knowledgeable in the inner workings of government. They are very influential in their departments and are they the must-go-to individuals when outsiders want to gain a thorough knowledge about particular issues in that department.

Employee Retirement Income Security Act (ERISA): This refers to a federal law enacted in 1974 that was designed to preempt states rights with regard to worker's

pension benefits and employee benefits. ERISA does not affect the benefits the benefits and rights of employees whose employer is self-insured.

Capitation: A fixed amount of money paid to a provider on a periodic basis to provide medical services. It is generally paid to the provider for each member to them on a per member, per month basis.

Guaranteed Issue: With guaranteed issue, Carriers must make coverage available to any group that applies regardless of the employees.

Guaranteed Renewal: Once a company is covered an insurer must renew its coverage and may not cancel coverage or introduce new policy exclusions at the time of renewal based on claims or changes in health status.

High Risk Pool: A fund set up to offer health insurance to small groups and individuals who have been denied coverage or whose medical history makes rates too high.

Appendix B: Informed Consent Form

You agree to take part in this research project on *Oregon's approach to health care reform: An analysis of the role of the business community in the evolution of the Oregon health plan* conducted by Peter C. Olemgbe, a Ph.D Candidate at Portland State University.

You understand that the study involves an interview about the subject matter that will take 1 hour to 1 1/2 hours of your time at your office or a location that is convenient to you. Peter Olemgbe has told you that the purpose of the study is to explore and analyze the role the Oregon business community played in the evolution and implementation of the Oregon health plan. You can decline to answer any particular questions or stop the interview at any point.

You may not receive any direct benefit from taking part in this study, but the study may help to increase knowledge that may help others in the future.

Peter Olemgbe at (503) 639-5253 has offered to answer any questions you have about the study and what you are expected to do. He has promised that all information you give will be kept confidential and that the names of all people in the study will be kept confidential as well unless approval has been given to associate their names with a quote. Participants who elect to do this will have the right to review the quote before they are published.

You understand that you do not have to take part in this study and that this will not affect your relationship with Portland State University or my own agency.

You have read and understand the above information and agree to take part in this study.

Date: _____ Signature: _____

If you have concerns or problems about your participation, please contact the Human Subjects Research Review Committee, Office of Research and Sponsored Projects, 111 Cramer Hall, Portland State University, (503) 725-4288 or if you have questions about the study, please call Peter Olemgbe, the researcher at (503) 639-5253.

Appendix C: Interview Questions for the Business Community:

1. Associated Oregon Industries [AOI] was involved in the early stages of the evolution of the OHP.
   1a. Did you think that the business community got involved in the early stages so as to effect legislation?
   1b. What were the main issues or concerns regarding the OHP for the business community?

2. Businesses often have diverse interests.
   2a. For the business community, what were the main factors for supporting the OHP? 2b. Who were the key individuals in the business community responsible for "rallying" such support for the OHP?

3. In Oregon, it is known that AOI lobbies for the interests of "big business." 3a. What mutual interests did you have with Oregon's small businesses in reference to the OHP. 3b. Prior to the implementation of the OHP, did AOI "join forces" with small businesses in other legislation or campaigns? If so, what were they and when?

4. Was the relationship between the AOI and the small businesses "favorable" from the beginning in this particular campaign? 4a. If yes, what was the "common ground" for this favorable relationship? 4b. If not, then describe the conflicts or concerns between the two and how were these resolved in order to campaign under the same "umbrella" for the implementation of the OHP?

5. Often the business community and the government are at opposite ends of the spectrum on various programs and policies. 4a. Can you describe the typical relationship between the business community and the state of Oregon? 4b. Describe the relationship between the business community and the State of Oregon in reference to the evolution of the OHP? What was the most important factor that fostered this unique relationship?

6. Did the business community form other strategic alliances? If so, who were these alliances?

7. A lot of debate surrounded SB 935 which addressed "employer mandate." What were your group's specific objections to that legislation?

8. The OHP has been in operation for more than eight years now. 8a. Has the businesses community's current perception of the OHP changed from its original expectation for the plan? 8b. What is the business community's current opinion about the OHP? 8c. If the OHP continues as a sate program, would your group lobby for any changes in the plan?
9. Would you like to add any additional comments regarding the current OHP and its future for survival?

Appendix D: Interview Questions: Bureaucratic Elite.

1. What role do you think Oregon businesses played in the formulation of the Oregon health plan [OHP]?

2. What factors influenced Oregon business leaders to support the Oregon health plan?

3. How did specific business leaders promote the interests of their own companies?

4. I am aware that in response to the business community's concern about more tax burden, the legislation did not include a payroll tax on employers or single-payer plan and in response to the business community's concern about cost-shifting, the legislation included the employer mandate but also allowed smaller employers to voluntarily comply with the mandate by 1995. Are there any other specific incentives granted to Oregon business in the legislation that I have not mentioned? If so what are they and could you tell me more about them?

5. In your opinion, why was there never a unified health care coalition in Oregon in the period prior to and immediately following the evolution of the Oregon health plan?

6. In other states like Massachusetts, Florida and Hawaii business activism was critical in passing their healthcare reform legislation which addressed among others things, escalating healthcare costs to businesses and the healthcare needs of the states' uninsured. In your opinion, why did the business community in Oregon not take an activist role as in these other states during the formulation of the Oregon health plan?

Appendix E: Interview Questions for Labor

1. Did labor play an active role in the formulation of the OHP?
2. If not, did at what stage did labor get involved in the OHP policy-making and implementation process?
3. What role did labor play in the implementation of OHP?
4. From the labor perspective, what were the main issue and concerns regarding the OHP? In what ways did these issues and concerns differ from those expressed by the business community? How did business and labor treat each other's issues and concerns?
5. Did labor form any alliances with other groups or organizations in reference to OHP? If so, who were those allies?
6. What is labor's current perception of the OHP now that it has been in operation for several years? Has this perception changed over time? If so, in what ways?
7. Do you think that OHP is meeting its program objectives? Has OHP deviated from its mission during implementation? Please explain.
8. Does labor have suggestions for improving OHP? If so, how important are these changes to labor given its other priorities?

Appendix F: Interview Questions: Political Executives.

1. What role do you think Oregon businesses played in the formulation of the Oregon health plan [OHP]?

2. What factors influenced Oregon business leaders to support the Oregon health plan?

3. How did specific business leaders promote the interests of their own companies?

4. I am aware that in response to the business community's concern about more tax burden, the legislation did not include a payroll tax on employers or single-payer plan and in response to the business community's concern about cost-shifting, the legislation included the employer mandate but also allowed smaller employers to voluntarily comply with the mandate by 1995. Are there any other specific incentives granted to Oregon business in the legislation that I have not mentioned? If so what are they and could you tell me more about them?

5. In your opinion, why was there never a unified health care coalition in Oregon in the period prior to and immediately following the evolution of the Oregon health plan?

6. In other states like Massachusetts, Florida and Hawaii business activism was critical in passing their healthcare reform legislation which addressed among others things, escalating healthcare costs to businesses and the healthcare needs of the states' uninsured. In your opinion, why did the business community in Oregon not take an activist role as in these other states during the formulation of the Oregon health plan?

7. Often the business community and the government are at opposite ends of the spectrum on various programs and policies: 7 (a) Can you describe the typical relationship between the business community and the State of Oregon? (7b) Describe the relationship between the business community and the State of Oregon in reference to the evolution of the OHP. What was the most important factor that fostered this unique relationship?

8. Did the business community form other strategic alliances? If so, who were these alliances?

9. During the evolution of the Oregon health plan the Oregon medical community seemed supportive of the program. Can you tell me what was important in their willingness to support the program?

Appendix G: Interview Questions for Social Advocacy Groups:

1. During the legislative hearings leading up to the creation of the Oregon health plan, you were one of the individuals who testified before the Oregon Senate subcommittee on health and Bio-Ethics in support of SB 27. What was it that galvanized your group to lobby and campaign for the creation of the Oregon health plan?
2. How was your group formed?
3. Was the OHP campaign the first issue that brought your group together? Was your group involved in other campaigns or issues other than the Oregon health plan [OHP]? If so, what were they and was your group successful in lobbying for those issues too?
4. Tell me about the relationship between your group and the Oregon business community in reference to Oregon health plan [OHP]? How did your group first perceive the Oregon business community in this particular campaign and how did they initially view your group? Did any of these perceptions or views change over time? What was the business community's reaction to your groups and vice-versa? What do you think contributed to this particular relationship between your group and the Oregon business community?

5. What was the single most important factor, in your opinion, germane to your group's campaign for the OHP? Was there one particular individual in your group who was considered responsible for the success of the campaign?
6. What obstacles, if any, did your group encounter and then overcome in terms of lobbying for the OHP? Whom did your group perceive to be the greatest concern or threat to the implementation of the OHP? What is your group's current perception of the OHP? Do you currently view the OHP as being responsive to the targeted population? Does the current mission of the OHP meet your group's expectations? In your opinion, is the current OHP effective in achieving its overall goals?
7. What factors continue to inspire your group's support for the OHP? Do you think that the OHP needs to make any major changes in its current delivery or policies? If so, what would these changes entail?

Appendix H: Introductory letter to Potential Respondents

Dear _____

I am a Ph.D candidate at Portland state University currently working on my doctoral dissertation entitled "Oregon's Approach to Healthcare Reform: An Analysis of the Role of the Business Community in the Evolution of the Oregon Health Plan [OHP]". My research is an historical analysis of the program and focuses on the legislative process that led to the implementation of the OHP. It is a case study approach of the OHP and will be solely used for academic purposes. Interview information shall be reported anonymously unless participant permits researcher to quote responses.

I am kindly requesting your participation in my research [as well as other key individuals] to elicit expert knowledge and insight relating to the legislative history, process and implementation of the OHP. Your participation will involve granting me a face-to-face interview in which I shall ask you a few questions related to my research topic. I could meet you at your office or any locale of your choice. I would greatly appreciate your time, cooperation and consideration in granting me this interview, as it would be an important part of this dissertation research. If permissible, I will call you in the very near future to set an appointment for us to meet in reference to my research.

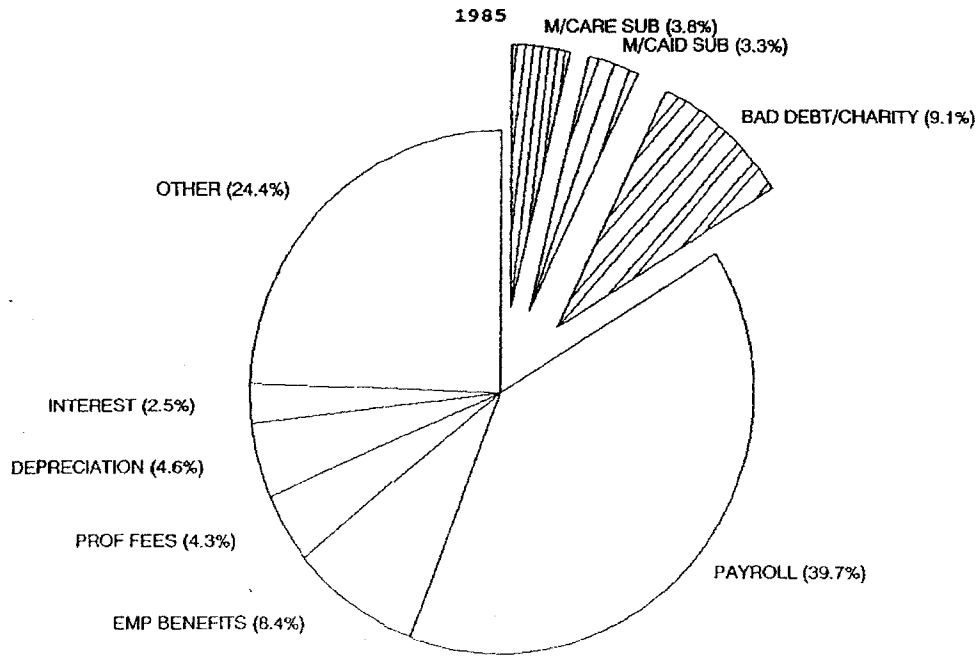
If you have any questions or concerns regarding this research, please contact me at home [503] 639-5253 or, you may contact the Human Subjects Review Committee, Office of Research and Sponsored projects, 111 Cramer Hall, Portland State University at [503] 725-8182.

Sincerely,

Peter C. Olemgbe

Appendix I: Exhibit Of Graphic Display of Expense Component of Non-Medicare / Medicaid Bill for 1985 of Oregon's Hospitals.

EXPENSE COMPONENTS OF A NON-MEDICARE/MEDICAID INPATIENT BILL

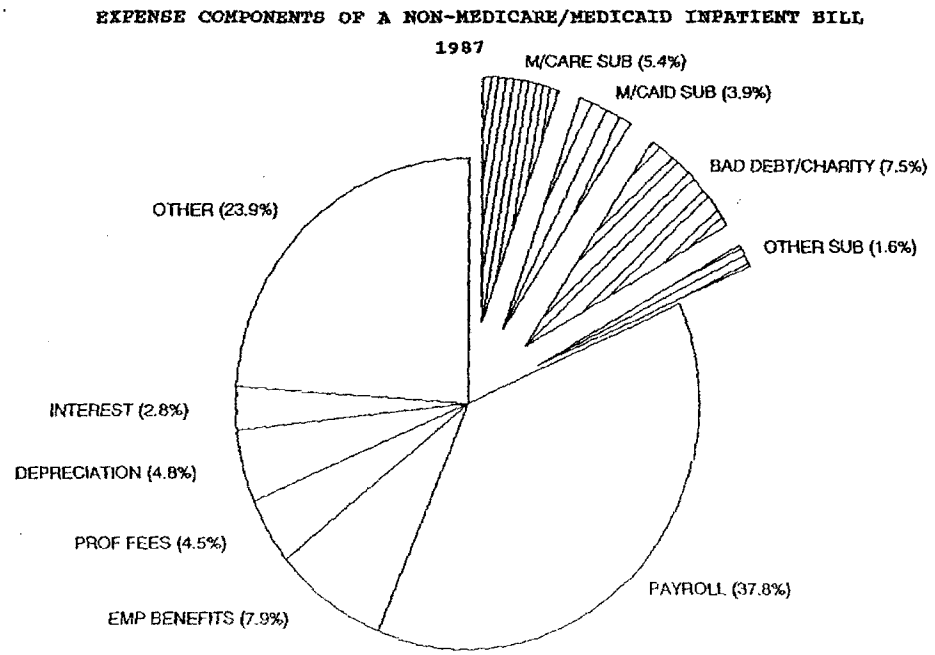


SOURCE: Oregon Association of Hospitals, October 1988

THE FOLLOWING CHART SHOWS WHAT THE BILL WENT TO COVER:

PAYROLL EXPENSES	$1,286.90	
EMPLOYEE BENEFITS	$272.23	
PROFESSIONAL FEES (MEDICAL, CONSULTING)	$140.16	
DEPRECIATION	$150.74	
INTEREST	$81.61	
ALL OTHER EXPENSES (PURCHASED GOODS AND SERVICES)	$791.05	
SUBTOTAL	$2,722.69	83.9%
MEDICARE SUBSIDY	$122.58	
MEDICAID SUBSIDY	$106.34	
BAD DEBT/CHARITY	$293.88	
OTHER	$0.00	
SUBSIDY SUBTOTAL	$522.80	16.1%
TOTAL	$3,245.49	

Appendix J: Exhibit of Graphic Display of Expense Component of Non-Medicare / Medicare/Medicaid Bill for 1987 for Oregon's Hospitals.



SOURCE: Oregon Association of Hospitals, October 1988

THE FOLLOWING CHART SHOWS WHAT THE BILL WENT TO COVER:

PAYROLL EXPENSES	$1,565.20	
EMPLOYEE BENEFITS	$327.36	
PROFESSIONAL FEES (MEDICAL, CONSULTING)	$184.53	
DEPRECIATION	$196.82	
INTEREST	$117.50	
ALL OTHER EXPENSES (PURCHASED GOODS AND SERVICES)	$990.06	
SUBTOTAL	$3,381.47	81.6%
MEDICARE SUBSIDY	$221.94	
MEDICAID SUBSIDY	$161.13	
BAD DEBT/CHARITY	$311.62	
OTHER	$65.36	
SUBSIDY SUBTOTAL	$760.06	18.4%
TOTAL	$4,141.53	

Appendix K: List of Respondents Interviewed for this study by Organization, Code and Date.

List of Respondents by Cluster

Cluster 1	Organization	Code #	Date of Interview
	Business Community	1	November 18, 2003
	Business Community	2	November 24, 2003
	Business community	3	January 9 2004
Cluster 2			
	Bureaucratic Elite	4	December 1, 2003
	Bureaucratic Elite	5	December 1 2003
	Bureaucratic Elite	6	January 9, 2003
	Bureaucratic Elite	7	December 5, 2003
Cluster 3			
	Labor	8	January 20, 2004
	Labor	9	January 9, 2004

Cluster 4	Social Advocate	10	December 4, 2003
	Social Advocate	11	January 29, 2004
	Social Advocate	12	December 5, 2003
Cluster 5	Political Executive	13	January 29, 2004
	Political Executive	14	December 18, 2003
	Political Executive	15,	February 5, 2004