Case 10 *(continued)*

too risky by this point because they could serve as stealth vehicles for comprehensive reforms, expanding at the last minute into some kind of universal coverage legislation. In late September, congressional leaders delivered a demand to President Clinton—if the president expected action on the General Tariffs and Trade Treaty, there could be no more discussion of health care legislation. On September 26, a year after Clinton said he would fix a broken system, Senate Majority Leader George Mitchell took health care reform off life support. The "corpse" was now officially dead.

Discussion Questions

1. Theda Skocpol (1996) described two approaches that critics argue Bill Clinton should have used to develop his proposal: (1) ask a small group to develop broad outlines for reform and then ask Congress to work out the details and (2) establish a prestigious blue-ribbon commission that might have achieved buy-in from business groups, congressional leaders and other policy makers, and stakeholders. What might be some of the pros and cons of the three different approaches? (The third was the Clinton approach.)
2. What would a map of Bill Clinton's authorizing environment for health care reform look like?
3. Discuss how the three streams of policy making identified by John Kingdon—policies, politics, and problems—opened a window of opportunity for health care reform in 1993 and what had changed in those streams by the time that window had closed in 1994.
4. What would a force field analysis of the Health Security plan look like?
5. Where would the Health Security proposal fall on Oliver's framework for analysis of policy design and political feasibility? What were some of the concentrated costs and benefits and to whom did they accrue? Now answer the same question of diffuse costs and benefits.
6. Who would you have surveyed if you were using the Delphi technique to analyze the political feasibility of the Clinton proposal at the time?

Chapter 11

The Policy Analysis Process: Evaluation of Economic Viability

Policy analysis involves the allocation of scarce resources. This chapter focuses on economic and financial aspects of the allocation process. Both affect the economic viability of a proposed policy alternative, which likely turns on the following questions:

- How much will it cost?
- What value will we be getting for the money?
- How does that value compare with other alternatives under consideration?
- If it is something we want to do, how will we pay for it?

To address these questions, the analysis team needs to undertake the tasks outlined in **Figure 11-1**. The team also needs to consider the points of view or interests of whoever commissioned the study. However, a fine line exists between pleasing the "customer" and maintaining a group's professional integrity. One way to address this is by "changing hats." The analysts can say, "When we put on Hat A, we get X, but when we put on Hat B, we get Y." All of us wear many hats in health care, including patient, payer, parent, spouse, professional, and citizen.

Case 10 *(continued)*

down in jurisdictional disputes. Congress was becoming increasingly polarized and partisan, making it difficult to move any kind of major initiative. Breaking this gridlock would have required a coordinated, unified approach from the party leadership, but many Democrats were still drawn to the simplicity of a single payer. Many Republicans, meanwhile, were drawn to a strategy advanced most strongly by the Project for a Republican Future—refuse any temptation to compromise and defeat any Clinton proposal outright, at any cost. Democrats did not seem to have a clear strategy for moving the bill through the various committees without Republican cooperation.

As the Health Security proposal took a tedious, contentious, and messy path through committee hearings and markups, external stakeholder support, which had seemed so solid at the start, began to crumble. The plan's greatest nemeses proved to be the Health Insurance Association of America (HIAA) and the National Federation of Independent Business (NFIB), which vehemently opposed any employer mandate. In addition to lobbying policy makers, NFIB engaged in what Michael Weisskopf, a *Washington Post* reporter, labeled "cross lobbying"—targeting other stakeholder groups to change their positions. One of the first targets of cross lobbying was the AMA. The AMA had expressed several reservations about the Clinton plan, but had reversed its decades-long opposition to any employer mandate and was on record as supporting health system reform. At the urging of NFIB, the AMA House of Delegates voted December 7, 1993, to rescind its support for an employer mandate.

Big business also broke ranks. Medical inflation seemed to be slowing in late 1993, and President Clinton had failed to deliver on his promise to reduce domestic spending. In February 1994, the Business Roundtable endorsed a competing plan, and the National Association of Manufacturers and the U.S. Chamber of Commerce followed quickly by repudiating the Clinton proposal.

That same month, the Congressional Budget Office announced that it could not support many of the budget assumptions the Clinton working groups had used to argue that the plan would help reduce the deficit. It would not even agree the plan was budget neutral. Instead, it argued the plan would add $74 billion to the deficit.

The White House, meanwhile, was losing ground in the court of public opinion. Polling immediately after the proposal went public was strongly favorable. A Harris Poll conducted in March 1993 found strong support for short-term price controls (76%), caps on premium increases (78%), an employer mandate (82%), and regional purchasing cooperatives (86%), but early polling also disclosed that people did not understand these concepts. Early response to the Clinton proposal released later that year was also favorable according to the polls, but some of the same surveys demonstrated that the public did not really understand what was being proposed in the highly complex 1,342-page draft legislation. The public also had some major concerns.

An ABC News/*Washington Post* poll conducted in early October 1993 found that 51% supported the Clinton plan and 59% thought that it was better than the current system; however, 57% opposed new taxes to pay for it. More people thought health care would get worse under the plan (34%) than thought health care would improve (19%). Many were worried about having less choice in providers (72%), increasing costs (70%), a loss of access to expensive services (69%), and a host of other issues.

These concerns gave the plan's opponents very effective points of leverage. In particular, HIAA focused in on them with its Harry and Louise campaign, which featured a worried couple discussing concerns about the plan. These campaigns made good use of polling information. The first advertisement focused on worries that health insurance plans would be less comprehensive and there would be fewer types of plans from which to choose. The couple concluded its conversation with the exchange, "They choose. We lose."

Congress struggled with the proposal through the first half of 1994, trying different solutions and searching for some kind of compromise that had a chance of success on the floor; however, none of the proposals appeared to have enough support to survive a filibuster. At one point, Republican Senator Phil Gramm announced that Congress needed to "stop carrying around this corpse, changing its clothes, and putting more powder on its face."

When Congress returned from summer recess, it was prepared to consider less-ambitious reforms. By this time, 57% of the public favored more incremental steps according to a *New York Times* poll published September 13, although 50% said the president should veto anything that did not cover everyone. Even modest reform bills were considered

Case 10 (*continued*)

sometimes days-long vetting process called "tollgates." The task force also held hearings to solicit input from stakeholder groups.

The task force's initial meetings were not open to the public or the press—a fact that prompted a *Washington Post* story saying that the private meetings violated the Federal Advisory Committee Act. The act is meant to prohibit committee members who are not part of the government from having undue and undisclosed influence over government policy making. It technically applied because Hillary Rodham Clinton did not draw a paycheck and was not a "government employee." On March 10, a judge ordered that all task force meetings be public. Critics of health care reform exploited the brouhaha. "It was a deft political move," Hillary Clinton wrote in her autobiography, "designed to disrupt our work on health care and to foster an impression with the public and the news media that we were conducting 'secret' meetings" (2003, p. 154).

In May, the task force handed a thick set of recommendations to the White House and disbanded. Work continued as small White House teams began the next phase, which included tasks such as converting the task force output into legislative language, working up budget projections, and developing political and communication strategies. Most of this work was done behind the scenes while the president focused his efforts, and the public's attention, on the budget. Very few decisions were put on paper, and high-level meetings were avoided from the end of May through August.

It wasn't until September 7 that copies of a "Working Group Draft" went to key members of Congress and from there leaked to the public. Full bill language was not available until October—after Clinton's September 22 televised address to Congress.

THE HEALTH SECURITY PROPOSAL

Clinton's Health Security proposal owed a lot to the Jackson Hole Group, but also borrowed from existing proposals on both sides of the aisle. It relied on the employer-based system by mandating employer coverage. To help small businesses and those with low-wage employees, the government would offer subsidies. It would also provide payments

to help the poor cover the costs of premiums and out-of-pocket expenses. The self-employed would be able to deduct their premium costs fully. Annual premium increases would be capped, but as a cost-control measure, this was a backup to the core of the Clintons' plan—the creation of regional "health alliances," much like the Jackson Hole Group's HIPCs. Under the oversight of a national health board, they would pool individual and business premiums and collectively bargain with insurance companies.

The proposal had to be revenue neutral, and thus there had to be a way to offset the estimated $331 billion cost. Some of that money, according to the administration, could come from a cigarette tax and a 1% tax on corporations with more than 5,000 employees that did not participate in the regional alliances. Because health care costs would presumably go down, tax revenues would increase. Nearly $200 billion could be trimmed from Medicare and Medicaid budgets because of cost savings and decreasing caseload. Critics scoffed at the savings potential, pointing out that cutting Medicare and Medicaid would be politically difficult and arguing that increased coverage would lead to greater utilization of health care services, driving costs up, not down.

THE BEGINNING OF THE END

On October 27, the Clintons handed off their brainchild to the U.S. Congress. It suddenly had to compete for attention with more than 20 cousins. These included a single-payer bill supported by more than 200 liberal House Democrats, another version of managed competition supported by centrist Democrats that stopped short of an employer mandate and would not have limited premium increases, a Republican proposal that would have required individuals to purchase insurance and used resulting Medicaid savings to help low-income individuals and families pay their premiums, and another Republican proposal to introduce insurance industry reforms that would help chronically ill people obtain and retain health insurance and allow for the creation of health savings accounts (called medisave accounts).

Not only were there competing proposals, but there were competing fiefs. Health care as an issue did not belong exclusively to any one committee in either house. Arguably, five different committees had jurisdiction. Each committee and its chair had its own personality and its own perspective on the issue. The Clintons' plan quickly bogged

Case 10 (*continued*)

percentage (they initially proposed 80%) of the cost of a plan that provided a basic set of standardized benefits. If employers or individuals wanted to purchase more comprehensive coverage, it would come out of their pockets. Tax reform would ensure that this additional money was not tax exempt.

Enthoven and Kronick believed health care inflation was driven mostly by the fee-for-service system, which provided no incentive for providers to provide better health outcomes at lower costs. They were also concerned about the effects of risk selection on health insurance affordability. They believed their plan would encourage people to purchase basic, lower cost plans appropriate to their level of actuarial risk and priced accordingly. They also believed it would drive people toward managed care plans.

Enthoven and Paul Ellwood invited health policy experts, government officials, and reform-minded executives from health care organizations and large health insurance companies to a meeting in Jackson Hole, Wyoming, in February 1990. The group anticipated that government would play a greater role in regulating health care unless someone put forward a successful market-oriented proposal. They sought to reform the system while minimizing government regulation and using managed competition as a starting point.

The group met throughout 1990 and 1991 to refine ideas and seek consensus. Ellwood and health policy consultant Lynn Etheridge drafted four papers that collectively articulated the Jackson Hole proposal. Much of the Enthoven–Kronick framework remained. An independent health board would certify health insurance plans and establish the basic services those plans would cover. Employers would be required to provide coverage to their full-time employees. They would also pay a business tax to fund coverage for part-time employees. The public-sponsor notion evolved into something called health insurance purchasing cooperatives (HIPCs)—regional organizations that would contract with certified insurance plans to purchase coverage for the employees of businesses with fewer than 100 employees and for people not covered through work or federal entitlement programs. HIPCs would subsidize coverage up to the cost of the least expensive plan. People who chose more expensive plans (or businesses that provided

employees with additional coverage) would make up the difference. Only the cost of the least expensive plan would be tax deductible.

Initially, the Jackson Hole Group considered the proposal to be an academic exercise, but then Michael Weinstein at the *New York Times* picked up on the plan. The paper ran dozens of articles that mentioned "managed competition" and endorsed the Jackson Hole Group's framework on its editorial page. Thus, when Wofford won his election in November, the idea had public legitimacy and was known to members of Congress and congressional staffers as a policy to champion. In particular, the idea attracted considerable interest from the conservative wing of the Democratic Party, although the Conservative Democratic Forum rejected the idea of an employer mandate.

During the 1992 presidential primary campaigns, many health care reform proposals emerged, including one by Paul Tsongas that emphasized managed competition. Clinton, a centrist with ties to the conservative wing of his party, promoted a play-or-pay strategy, but after winning the nomination began moving toward a plan that combined managed competition with regulatory reforms designed to drive down costs. He formally unveiled this plan at a September 24 speech delivered at the headquarters of Merck & Co., a major pharmaceutical company.

DEVELOPING THE CLINTON PROPOSAL

Clinton took office in January 1993, and for about the first 8 months his administration focused primarily on developing a budget that might grow the economy and reduce the deficit; however, he did try to deliver early on his promise to reform health care. Within days of his taking office, Ira Magaziner, an old family friend and business consultant, completed a work plan for an interagency health care task force that would oversee working groups charged with conducting analyses related to topics such as financing, economic impacts, controlling costs, and delivering preventive care. Acting on Magaziner's framework, Clinton established the President's Task Force on Health Care Reform, made up mostly of cabinet members. Magaziner would coordinate the effort, but the chair would be the First Lady, Hillary Rodham Clinton.

A ballooning number of working groups set about defining their respective pieces of the elephant. Participants, mostly executive agency employees, numbered more than 500. As they identified preferred policy options, they then took them to the task force leaders for a protracted,

Case 10 (*continued*)

On September 22, 1993, before Congress and a national TV audience, he outlined his plan to "fix a health care system that is badly broken." A little more than a year later, however, another unexpected death occurred. The deceased was President Clinton's plan for "Health Security." The plan's collapse doomed any hopes advocates had of passing significant health care reforms in the 1990s and was credited by some with inducing the electoral tsunami that gave Republicans control of both houses of Congress in the 1994 elections.

BUILDING TOWARD REFORM

A confluence of events put health reform on the top of the agenda in the early 1990s, not just the bellwether Senate race. The Clinton-era reform effort was not a unique event but rather part of a chain of efforts that spanned much of the century. What seemed to set the 1990s apart, however, was the variety of stakeholders prepared to support some kind of reform. Most came to the table because of the spiraling cost of health insurance and the growing number of uninsured:

- Businesses that covered their workers were spending as much as 25% of their earnings on health insurance.
- Organized labor was seeing business shift more and more of the costs of health care onto workers.
- Providers were frustrated by insurance companies managing their professional decisions and monetary losses when patients did not pay up.
- Hospitals were concerned about the increases in uncompensated care.
- State governments had watched the share of their budgets going to health care climb from 9% to 14% in the 1990s.
- Large insurers were concerned about small insurers siphoning off younger and healthier customers, leaving them to cover more high-risk populations.

Less certain going into the 1991 election was where the electorate, particularly the middle class, stood. As the sign at Clinton's campaign headquarters noted, "It's the economy, stupid." The United States was in the grips of a recession, and the middle class was worried—about unemployment, about medical bankruptcy, about jobs that offered no health insurance, or about insurance that required high out-of-pocket expenses or covered only catastrophic events. Wofford's and Clinton's elections had seemed to settle the issue—it seemed the electorate was prepared to support a major overhaul of the health care system.

THE MENU OF OPTIONS

Even before the 1991 and 1992 elections, several health care proposals were in the hopper. There were basically three concepts under consideration:

- Many congressional Democrats were pushing play-or-pay. Businesses that did not provide employee insurance would pay more in taxes, and government would use that money to provide health care to uncovered employees. Some were concerned that this strategy would lead businesses to decide to pay, not play, effectively creating a government health care system.
- Progressive Democrats were pushing for a single-payer system modeled on Canada's. Government would replace insurance companies, but would not run the health care delivery system itself. Under a variant, which Hacker (1997) referred to as "the liberal synthesis," the government would purchase universal capitated coverage from a mix of competing public and private insurance plans.
- Many congressional Republicans and President H. W. Bush supported various packages of market-oriented reforms that would regulate insurance company practices, provide tax credits or subsidies for people unable to afford insurance, offer tax incentives for business to cover employees, establish industry-wide insurance purchasing pools, reform malpractice litigation, and support expansion of managed care.

In the late 1980s, Alain Enthoven and Richard Kronick began developing their "managed competition" approach. Their first proposal included a pay-or-play system. People who could not obtain employer coverage could acquire coverage through a "public sponsor." Plans would have to offer standardized types of coverage and set premiums based on risk. Employers and the public sponsor would only pay a fixed

That was in 1992, however. By the time Congress was seriously considering the Clinton Health Security Plan in late 1993 and early 1994, the economy had greatly improved, and the public was less inclined to see health insurance as an immediate crisis.

It should be noted that frameworks like stakeholder analysis can lead to an almost exclusive focus on the actors, which may contribute to inadequate analysis of inputs such as economic changes. To effectively analyze political feasibility, it is important not to be satisfied solely with identifying and consulting with stakeholders. It may also be important to consult with experts on various inputs—economists, historians, futurists, political pollsters, organizational psychologists, and other experts.

Something akin to the Heisenberg uncertainty principle of quantum physics also operates in the realm of feasibility prediction. Efforts to measure something can influence the thing being measured and change the measured result. Feasibility analyses can actively influence the outcome of a political debate—they can be merely self-fulfilling or conflicting analyses can cancel each other out. Oberlander (2003) stated that "feasibility analysis does not merely play a passive role in the political process as an objective judge of what will or can happen. Rather, policy analysis itself can influence the course of events and is often deployed as a political weapon" (p. W3-393). As an example, he pointed to the number of policy analysts that opponents of the Clinton health plan brought forward to explain why the plan was irredeemably flawed.

Dror (1969) cautioned that "care must be taken to avoid a mistake widespread in practice and sometimes supported by theory, that 'feasibility' becomes a dominant criterion of a preferable alternative, in the sense of 'the more feasible the better'" (p. 2). He suggested that political feasibility analyses should be seen as challenges, not constraints. He noted that:

> . . . every political feasibility prediction tends to ignore the capacities of human devotion and human efforts to overcome apparently insurmountable barriers and to achieve not only the improbable but the apparently impossible. A good policy may be worth fighting for, even if its political feasibility seems to be nill [sic], as devotion and skillful efforts may well overcome political barriers and snatch victory out of the mouth of political infeasibility. (pp. 18–19)

CONCLUSION

Policy analysts may tend to avoid political feasibility assessments because they are highly qualitative in nature and subject to a great deal of uncertainty. We have discussed how medicine has become increasingly industrialized, but politics will likely remain more of an art than an industry. To address political feasibility at all, an analyst must understand the authorizing environment, the key political actors, the various inputs into the political process, and how they are likely to interact. Techniques such as force field analysis, independent looks at the three streams of policy that can create windows of opportunity, and assessments of whether the benefits or costs of a policy are concentrated or diffuse can be useful. Systematic approaches to assessing political feasibility typically rely on surveys of stakeholders but can also include surveys of experts who are not direct stakeholders. The Delphi technique provides one structure for such inquires. It is important, however, to select informants with care. This includes reaching out to a broad, diverse range of stakeholders, or in the case of academic or technical experts, being aware of the experts' biases and limitations. Finally, political feasibility analyses can become self-fulfilling prophecies if not used wisely. Analysts should be wary of abandoning good policy ideas because they seem unfeasible or settling on a poor idea because it would be an easy sell.

Case 10 The Politics of the Clinton Health Plan

BACKGROUND

A premature death helped set in motion the events that ultimately pushed health care reform to the fore of the U.S. political agenda in 1993, but it was not the early demise of a child whose insurance company refused life-saving treatment or the death of a heart attack victim turned away from the closest emergency room because of lack of insurance. The precipitating event was the April 4, 1991, plane crash that killed Henry John Heinz III, a Republican Senator from Pennsylvania. On November 5, Harris Wofford, the Democrat appointed to replace Heinz, won a special election to complete the term by upsetting frontrunner Richard Thornburgh with a campaign built almost entirely around health care reform. Politicians and pundits of all stripes quickly agreed: Major health care reform was just a matter of time.

Bill Clinton's election to the White House a year later reinforced that belief. Clinton recruited many of the campaign consultants who had advised Wofford, and he pledged during the campaign to reform health care. He set about delivering on his pledge within days of taking office.

Table 10-6 Stakeholder Analysis (Stakeholder Matrix) (*continued*)

Box A

These are stakeholders appearing to have a high degree of influence on the project, who are also of high importance for its success. This implies that the implementing organization will need to construct good working relationships with these stakeholders, to ensure an effective coalition of support for the project. Examples might be the senior officials and politicians or trade unions.

Box B

These are stakeholders of high importance to the success of the project, but with low influence. This implies that they will require special initiatives if their interests are to be protected. An example may be traditionally marginalized groups (e.g., indigenous people, youth, seniors), who might be beneficiaries of a new service, but who have little 'voice' in its development.

Box C

These are stakeholders with high influence, who can therefore affect the project outcomes, but whose interests are not necessarily aligned with the overall goals of the project. They might be financial administrators, who can exercise considerable discretion over funding disbursements. This conclusion implies that these stakeholders may be a source of significant risk, and they will need careful monitoring and management.

Box D

The stakeholders in this box, with low influence on, or importance to the project objectives, may require limited monitoring or evaluation, but are of low priority.

Method

1. Make a list of all stakeholders.
2. Write the name of each stakeholder on a sticky note or index card.
3. Rank the stakeholders on a scale of one to five, according to one of the criteria on the matrix, such as 'interest in the project outcomes' or 'interest in the subject.'
4. Keeping this ranking for one of the criteria, plot the stakeholders against the other criteria of the matrix. This is where using sticky notes or removable cards are useful.
5. Ask the following questions:
   - Are there any surprises?
   - Which stakeholders do we have the most/least contact with?
   - Which stakeholders might we have to make special efforts to ensure engagement?

Source: Reproduced from: State of Victoria. (2013). Effective Engagement: Stakeholder Analysis (Stakeholder Matrix). Victoria, Australia: State of Victoria. Last updated on April 26, 2013. Retrieved from www.dse.vic.gov.au/effective-engagement/toolkit/tool-stakeholder-analysis-stakeholder-matrix. Courtesy of Department of Environment and Primary Industries, State Government of Victoria.

producing a "force field analysis map" that was similar to the one depicted earlier in this chapter, but it included more categories for measuring both the political power and the degree of support of each stakeholder (Gilson et al., 2012, p. 1174). This is comparable to determining whether the arrows in a force field diagram should be represented as strong, weak, or moderate.

The third step, gathering information from stakeholders, can take several forms, including use of a Delphi technique or key informant interviews. For the Vermont study, researchers interviewed 120 people representing at least 60 organizations (Hsiao et al., 2011). They then determined the key interests and concerns of different sectors and identified policy options that would not be politically feasible because of strong opposition from highly interested and engaged groups with significant economic and political power; for example, "stakeholder analysis shows that hospitals would mobilize all their political strength and support to oppose any reduction in the total amount paid to hospitals" (p. 7).

CRITIQUES OF POLITICAL FEASIBILITY ANALYSIS

The highly qualitative nature of such techniques makes their results subject to human error. Dror (1988) cautioned that "experts may easily be emotionally biased when hot political issues are touched upon and may be overconservative in underestimating possibilities of changes and jumps in political situations" (p. 273). Oberlander (2003) pointed out that the headlines about health reform in 2003 were reminiscent of those that appeared in 1993 and 1973. The disturbing statistics and the comprehensive reform proposals designed to address them were eerily similar. The problem, he argued, is not a lack of good ideas but a consistent failure to realistically assess political feasibility. People confuse feasibility with desirability and tend to argue that their favorite solution is the most feasible, he stated, or they can be predisposed to accept a flawed feasibility analysis that supports their position. He added that a "beltway mentality" leads people to assume that whatever appears in the *Washington Post* or has caught the imagination of Washington insiders is most politically feasible.

Both Dror and Oberlander raised concerns about the use of political feasibility predictions. Dror pointed out that such predictions assume that no unexpected occurrences would take place—and they often do. Bill Clinton ran for president on a campaign built around a central premise: "It's the economy, stupid." The economic downturn that hit at the end of George H. W. Bush's term not only doomed his reelection bid, but it also produced a great deal of public anxiety about people losing their health insurance.

Table 10-5 Scheme 2: Political Feasibility Conditions

Policy Alternatives	Is politically feasible during next X years?	If not, what changes in conditions are required to make it politically feasible?
Alternative 1		
Alternative 2		
....		
Alternative N		

Depending on interest and on capacities of the predictor, the scheme can deal with various time spans, different feasibility probabilities and probability changes, and various combinations of conditions and assumptions.

Source: Reproduced from: Dror. (1969). The prediction of political feasibility. Santa Monica, CA: The Rand Corporation.

universe of policy options, estimate the impact and consequences of those options, and assess their acceptability.

In the past couple of decades, stakeholder analysis has emerged as the most common methodology for analyzing political feasibility. It has been employed across many disciplines, including political philosophy (Gilabert & Lawford-Smith, 2012), public health (AusAID et al., 2004), business management, development, environmental and natural resource management, and health care finance (Brugha & Varvasovszky, 2000). Spreadsheets, manuals, software systems, and consulting services can be purchased online to help people conduct such analyses, and several governments have published guides.

There are many ways to structure stakeholder analysis, but the process generally involves three steps: (1) stakeholder identification; (2) stakeholder mapping or prioritization; and (3) gathering information from stakeholders. Each of these we have already discussed, just not within the context of stakeholder analysis. Though anyone conducting a stakeholder analysis will want to start with stakeholder identification, these steps are iterative and not necessarily sequential. Key informant interviews, say, might identify stakeholders that researchers would not have included otherwise, or they might cast new light on the relative power of organizations or interest groups.

Stakeholder identification is basically the same process as developing a map of an authorizing environment. This can be the product of brainstorming, or asking experts and readily identified stakeholders to identify

the players. When Vermont was researching policy options for a statewide health care system after the implementation of the ACA, researchers conducted a "political landscape analysis" that included conducting a literature review to gather information of the history of health policy in the state and the organizations involved in shaping health policy (Hsiao, Kappel, & Gruber, 2011).

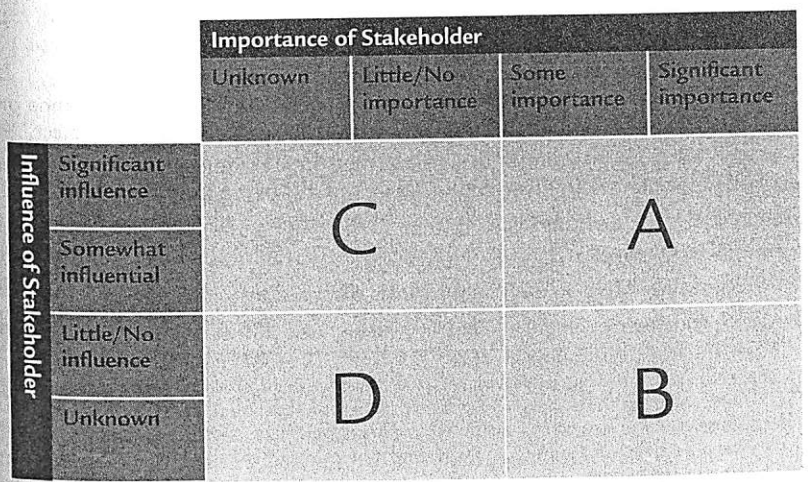
Stakeholder mapping or stakeholder prioritization typically involves placing the identified stakeholders on a grid, such as the one developed for expert interviews by Oliver (2006), or the "stakeholder matrix" proposed by the Victoria state government in Australia (see **Table 10-6**) to identify how influential they will be and how much effort should be put into encouraging their support.

A stakeholder analysis for a project to improve universal health care coverage in South America and Tanzania expanded on this concept by

Table 10-6 Stakeholder Analysis (Stakeholder Matrix)

Description

Stakeholder analysis is an essential part of developing a useful Engagement Plan. A common method of stakeholder analysis is a Stakeholder Matrix. This is where stakeholders are plotted against two variables. These variables might be plotting the level of 'stake' in the outcomes of the project against 'resources' of the stakeholder. Another is the 'importance' of the stakeholder against the 'influence' of the stakeholder. The concept is the same, though the emphasis is slightly different.



Boxes A, B, and C are the key stakeholders of the project. The implications of each box is summarized on the next page:

(*continues*)

After you have identified the forces bearing on the policy, you can assign them a score from 1 (weak) to 5 (strong) and tally to create a combined score for the forces for and against.

In their analysis of the political feasibility of mandated health insurance benefits, Oliver and Singer (2006) used a framework that examines whether the costs and the benefits are concentrated among a few or diffused among many (see **Figure 10-3**).

The most politically feasible solutions are those involving "client politics" where there are strong advocates who would reap the concentrated benefits but little opposition because the costs are minor or are spread broadly among many interests or individuals. The least politically feasible are those involving "entrepreneurial politics" where the benefits are shared so broadly that there are no impassioned, self-interested advocates and yet there is great opposition from interests that would bear the concentrated costs. Incrementalism, according to Oliver (2006), is a natural byproduct of "interest group politics" that occurs when both benefits and costs are concentrated. "With clear winners and losers, the level of conflict is high and the outcome of any single proposal is highly unpredictable" (p. 211).

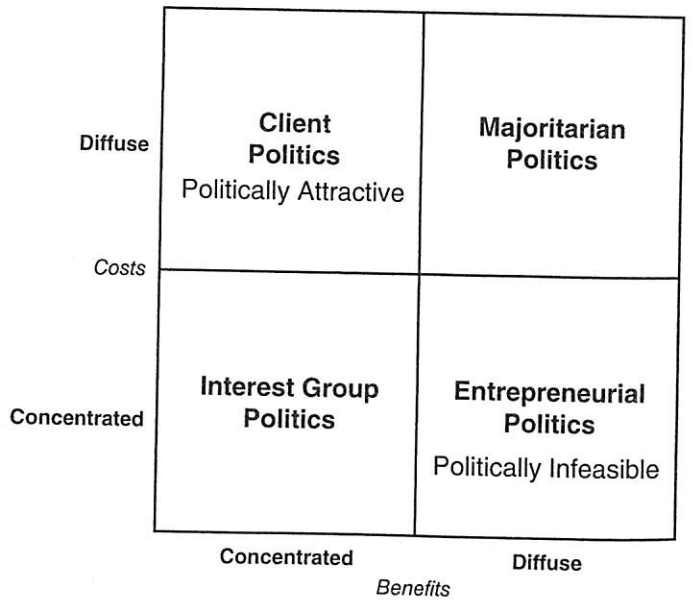


Figure 10-3 Framework for analysis of policy design and political feasibility.

Source: Reproduced from: Oliver, T. R. (2006). The politics of public health policy. Annual Review of Public Health, 27: 195–233. Reproduced with permission of ANNUAL REVIEWS in the format Republish in a book via Copyright Clearance Center.

Dror (1969) proposed a framework for political feasibility analysis that relies on the Delphi method. He recommended that prediction panels consist of senior executives, politicians, and political observers:

> While politicians are the ideal panel members for political feasibility prediction studies, this itself may be politically and personally non-feasible, especially if such studies become widespread. Therefore, main reliance may have to be put on politics-observing persons, such as political aides, political correspondents, political science scholars, senior civil servants, etc. (pp. 12–13)

Dror suggested that panelists be asked to complete three different types of questionnaires. One form would ask the panelists to rate the probability that specific policy alternatives might be adopted across different time frames. Another would ask whether various alternatives were feasible within a specific time frame and solicit information about barriers to adoption and what conditions would have to change to make adoption possible. These two forms are displayed in **Tables 10-4** and **10-5**. The third one would solicit opinions about the various actors—how much leverage they have, what their intentions are, and what actions they are likely to take alone or in combination with other actors. He also recommended that the informants be divided into three panels that get the surveys at different times. This would allow the coordinator to test for consistency. A number of researchers and analysts over the years have proposed or employed numerous variations on both the Delphi technique in general and the framework proposed by Dror. Turoff (1970), for example, has proposed a variant technique called the Policy Delphi that can be used to identify the

Table 10-4 Scheme 1: Direct Political Feasibility Estimation

	Political Feasibility Estimate			
Policy Alternatives	Next X Years	Next Y Years	....	Next N Years
Alternative 1				
Alternative 2				
....				
Alternative N				

Each cell to be filled out with a probability, or probability distribution, or alternative probabilities with explicit assumptions—depending on the capacities of the predictor.

Source: Reproduced from: Dror. (1969). The prediction of political feasibility. Santa Monica, CA: The Rand Corporation.

university centers with narrowly defined missions, and a variety of other sources whose work may reflect an ideological or financial bias.

The push toward evidence-based medicine has heightened the focus on making policy based on data, as government policy makers have realized that it is becoming increasingly common for state governments to fund research centers that evaluate the comparative evidence basis for certain drugs and other medical technologies. Oliver and Singer (2006) found that research conducted by the California Health Benefits Review Program, which relies on university-based researchers to analyze the evidence basis for requiring that health insurance plans cover certain types of care, played a significant role in shaping legislative decision making around mandated benefits in that state.

METHODS FOR ANALYZING POLITICAL FEASIBILITY

Dror (1988) confessed that he had become skeptical about formal modeling. Almost by default, political feasibility prediction tends to rely on seeking out expert informants and asking them how key players are likely to respond to the policy or policy alternatives.

Identifying the actors by mapping the authorizing environment, as we did in the example earlier in this chapter, is often a key early step. A subsequent step would likely involve determining the amount of support or opposition that each actor is likely to generate, either by soliciting information from the actors themselves or from some other set of experts. One could also solicit the experts' opinion on how much influence each actor is likely to have over the outcome. It also is important to identify other inputs likely to influence the outcome of a specific policy debate. This would involve addressing a variety of questions, such as the following:

- Is the economy expanding or contracting? What is that likely to mean for government revenues? How expensive is the policy alternative?
- What other focusing events are likely to demand the attention of the public and decision makers?

It may be useful to tease apart the different factors that contribute to political feasibility. Kingdon (1984) suggested that there are three streams to the policy process. He argued that change will be incremental unless these three streams converge favorably, typically as a result of a crisis that redefines a problem or a change in who controls the government that creates a window of opportunity. The three streams are:

- The problem stream: People need to agree there is a problem, their understanding needs to be supported by basic science, and they need to share a common definition of what the problem is.
- The policy stream: Credible scientific, technological, and/or policy solutions must be available.
- The political stream: The problem needs to be on the agenda, and there needs to be political will to address it.

Another useful concept for thinking about political feasibility is force field analysis, a decision-making tool developed by psychologist Kurt Lewin that provides a way of examining the forces working for or against a particular decision. Lewin (1951) argued that issues were held in balance by driving forces (those promoting change) and restraining forces (those favoring the status quo). These included both strong and weak forces, as represented in **Figure 10-2**. As a decision-making tool, force field analysis is often represented with a chart. In a box in the middle is the decision, or in our case, the policy. On the left side is a set of arrows representing the forces for change, and on the right side is a set of arrows representing forces against change. In political feasibility analysis, those arrows would represent actors and inputs.

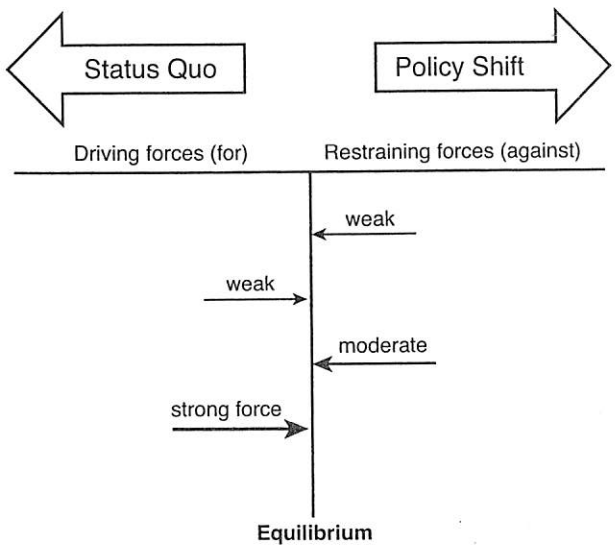


Figure 10-2 Force field analysis diagram.

Source: Modified from: Lewin, K. (1951). Field theory in social science. New York: Harper and Row.

ability to ensure a bill's passage is the 1993 Health Security Act proposed by Bill Clinton, which is the subject of the case at the end of the chapter.

The federal government passes a new budget for each fiscal year. The president initiates the budget process, but the budget that emerges from Congress may be significantly different. In 2006, for example, George W. Bush proposed a fiscal year 2007 budget that would have eliminated the Urban Indian Health Program. Legislative committees marking up the Department of the Interior, Environment, and Related Agencies Appropriation Bill restored the funding and even proposed an increase in the program's budget.

A president's ability to push a measure through Congress depends in large part on his or her *political capital*. For presidents, political capital primarily comes down to two things—popularity and their party's strength in Congress. For a recently elected president, popularity can be judged by the electoral margin of victory. For a president well into her or his term, popularity can be assessed by opinion polls.

The 1965 passage of Medicaid and Medicare has been attributed to Lyndon Johnson's phenomenal political capital. He clearly had a mandate, as he was elected with more than 61% of the popular vote, a feat unsurpassed since. The first Gallup poll of his term showed an 80% approval rating. He was a Democrat, and his party had a two-thirds majority in both houses. This gave him authority to push the agenda that had gotten him elected and a Congress unified enough, despite a North–South split in the Democratic Party, to tackle even the most divisive issues.

In a sense, the president is a stand-in for the body politic, the most visible official in the country. Presidential words can carry considerable moral authority. Presidential messages reach the public through numerous vehicles—the State of the Union address, press conferences, speeches, fireside chats, photo opportunities, public appearances, and more. This gives the president unequalled ability to elevate issues onto the national agenda, propose strategies, and bring public pressure to bear. The president's leadership role involves working to build coalitions, broker negotiations, and develop compromises. When Congress balks at a presidential proposal, the president can engage in education, persuasion, and horse trading. Extreme arm-twisting by a president, however, is rare.

Presidents do have authorities they can use to leverage policy. One is veto power. The president has 10 days after enactment to sign or veto legislation. Congress can override a veto by a two-thirds vote in both houses.

Another policy tool at the president's disposal is the ability to issue executive memoranda, which provide direction to agencies. If they are published in the *Federal Register* and not challenged by Congress, they become

executive orders, which have the force of law. Because they can address almost any policy area provided that they are supported by some constitutional administrative authority or congressional directive, they can be legislative in nature. A 1999 executive memorandum required the Federal Employee Health Benefits Board to provide mental health parity (coverage for mental illnesses equivalent to that for physical ailments) by 2001.

In theory, most bureaucracies are line agencies under the control of the executive, but the truth, as usual, is more complicated. For one thing, the president's reach is limited. Although a president fills some 2,400 positions, appointees occupy only the top layers of a bureaucracy's management ranks. It is not unusual for career bureaucrats further down in the organization to try to subvert a president's agenda. How much attention a given president pays to the management of executive agencies varies.

Bureaucracies serve two masters. Senior appointments may require congressional confirmation. Congress establishes the agencies' budgets, authorizes their programs, and enacts the laws under which they must act. Congressional committees and subcommittees oversee agencies under their purview.

Bureaucracies and bureaucrats can draft legislation, and their expertise may be called on to craft amendments at various stages of policy deliberations. Weisert and Weisert (2002) described the role Wilbur Cohen, then assistant secretary of Health, Education, and Welfare and the leading expert on Social Security, played in the 1965 passage of Medicare and Medicaid:

> Cohen helped draft the administration bill on Medicare, consulted with members on proposed bills, and was asked to summarize various proposals to the key committees. When Wilbur Mills decided to combine several proposals into a "three-layer cake" (the layers were later known as Medicare Parts A and B and Medicaid), he asked Cohen to draw up legislative language to pull the pieces together, along with an analysis of the costs, within 12 hours. (p. 154)

Many bureaucracies generate data, information, and research as part of their regular activities, and these work products can inform the policy development process. Examples in health care include the research produced by the 25 centers and institutions that make up the National Institutes of Health and the data on the cost and quality of personal health services generated by the Agency for Healthcare Research and Quality.

Bureaucracies have their own networks and constituencies. They can mobilize outside groups to support or oppose legislations and work with them to convince them of the merits of a particular proposal or to at least

public hospitals, as well as associations of other types of facilities that provide care, such as long-term care facilities and adult family homes. Then there are the insurance companies and their associations and the manufacturers of pharmaceuticals, other health care technologies, and durable medical equipment. Associations of businesses and labor unions also lobby on health care. There are also several interest groups organized to represent consumers, specific subsets of consumers, and the uninsured. These include groups formed to combat a certain disease or class of diseases and to represent the interests of those afflicted. One of the most powerful consumer groups in the country, the AARP, represents people older than 50 years of age and is a major player in discussions related to Medicare, retiree health benefits, and other health policy issues. Oliver (2006) stated that the proliferation of groups "has led scholars to conclude that political influence is more generally dispersed across loosely organized 'issue networks' or 'policy communities'" (p. 209).

Interest groups have multiple tools at their disposal for influencing policy, including the following:

- Political action committees: Fund-raising committees that can make contributions to candidates, parties, or issue campaigns.
- Direct democracy: Sponsoring voter initiatives and referendums, hiring signature gatherers, and funding campaigns.
- Grassroots lobbying: Organizing the general public (or voters) to appeal directly to lawmakers or to make their positions known at the ballot box.
- Cross lobbying: Convincing other groups to support a particular policy or change an existing position that runs counter to that policy.
- Coalition building: Increasing political leverage by forming coalitions to work on a specific issue or policy, often for a limited time.
- Research: Conducting studies, compiling data, and producing reports that influence policy choices, often focusing on the evidence basis and economic and technological feasibility of policy options.
- Framing: Using public opinion research, message development, and other communications techniques to "tell the story" about a policy in a way that changes the public discourse.

The Media

The news media play a critical role in shaping policy debates and outcomes in this country. Media outlets exert their influence in three principle ways:

- Setting the frame: The news media tell stories to interest their readers and viewers, and the way those stories are organized helps establish the frames that people use to interpret both the coverage and the underlying social issue. Media provide the context people use to help form opinions on an issue, and even a set of often subtle cues to guide them to their decision.
- Sorting and delivering data and information: Decision makers rely on data and information; however, their time is limited, and we live in an era of information overload. They are not able to sort and process all of the relevant information that emerges in a constant stream of studies, reports, and journal articles, and thus they tend to rely on media to sort information and identify what is relevant. Opinion makers tend to rely on facts to shape their opinions or buttress them—facts they often gather as news media consumers.
- Setting the agenda: The role of the *New York Times* in promoting the Jackson Hole Group's managed competition model, described in the case at the end of the chapter, provides a clear example of how the media can set the political agenda.

Here is how Goddard (1998) explained the role the media plays in U.S. public opinion formation and agenda setting:

> The media communicates with opinion leaders . . . about an issue. "Hey! Here's something that's important" . . . What's really critical is that the opinions that "informed" Americans form after exposure to them are then communicated to policy makers. And all of a sudden the policy makers say, "Wait a minute! All these people out there who I count on for support are concerned about this issue." (p. 1)

Scientists and Other Experts

The notion of rationality in decision making presupposes that there is sufficient information and resources to understand fully the implications of each policy alternative. Although this rarely occurs in practice, most policy makers try to understand what the research tells them about the value of various policy proposals. This gives researchers who generate data and informed analysis considerable influence over political feasibility.

Research and data can come from a variety of sources. Generally, the most credible sources are academic researchers who publish their findings in peer-reviewed journals. Policy makers also turn to raw data from primary sources (especially from government agencies) and to reports and studies from think tanks, advocacy groups, pharmaceutical firms,

The Senate and the House of Representatives have different makeups and personalities. Each plays by its own rules. Senators are elected by a statewide vote—two from each state—which means that the least populous states have the same representation as the most populous. House members represent congressional districts that are roughly equal in population and are redrawn after every census.

Committees are where the bulk of the work in Congress gets done. When legislation is introduced, it is referred to one or more policy committees. They may hold hearings, mark up a bill, and refer it to the floor for action. Committees have subcommittees with policy expertise in certain areas. Major policy subcommittees for health care issues are the Subcommittee on Public Health of the Senate Committee on Health, Education, Labor, and Pensions and the Subcommittee on Health of the House Energy and Commerce Committee. If the policy has budgetary implications, it will also have to go through one or more of the six powerful fiscal committees—Appropriations and Budget committees in both houses, House Ways and Means, and Senate Finance. The latter two have tended to be bottlenecks for major health care legislation. In the House, another powerful committee, the Rules Committee, directs the progress of legislation and establishes the rules of debate.

If related but different legislation passes both houses, one house may ask the other to reconsider, or leadership from both houses may appoint a joint conference committee that will develop compromise legislation and send the new iteration back to both houses for adoption. Legislation can perish from neglect in a conference committee. Committee members can also add major policy changes with little fanfare. Just 10 days before the 1974 passage of the Employment Retirement and Income Security Act (ERISA), conferees slipped in language that restricted states from regulating the health benefit plans of self-insured companies. This "ERISA exemption" severely limited the ability of states to enact significant health care reforms such as play-or-pay laws.

Congress will sometimes authorize a new program but not provide an appropriation. In 1998, for example, Congress passed the Ricky Ray Hemophilia Relief Fund Act, which authorized payments of up to $100,000 to hemophiliacs and their partners (or their survivors) infected with the human immunodeficiency virus. Congress, however, did not appropriate money for the payments until 2001.

Another part of the budget process that can undermine policy committees is the reconciliation bill. Congress can adopt a budget, and then committees can go back and recommend changes to existing laws to conform to the budget instructions. These recommendations are compiled into a reconciliation bill that requires no hearing and often passes with little scrutiny. Anything vaguely related to the budget can be thrown in. Most major health legislation during the 1980s took this route (Starr, 2011).

The two houses passed different versions of the ACA. Resolving the differences typically would have meant sending the bill to a conference committee, then having both houses vote on a compromise version. But after Democratic Senator Ted Kennedy of Massachusetts died in office, Republican Scott Brown won his seat in a special election. Senate Democrats no longer had the 60 votes needed to survive a filibuster if the ACA came back to the Senate (it was doubtful they had the votes even before Brown's victory because the House insisted on changes that were unpalatable to some Democratic senators). In an unprecedented move, the House passed the Senate version despite reservations, then included negotiated changes in a reconciliation bill. On the Senate side, the reconciliation bill was not subject to a filibuster, so proponents needed only 50 votes (the vice president would have been the tiebreaker).

Before major legislation can take effect, then, it may have to wind its way through a maze of committees and subcommittees, be scheduled for a floor vote, receive a majority vote in both houses (and perhaps 60 votes in the Senate), survive a conference committee, have a budget appropriation, and be signed by the president or have enough votes for a veto override. It is hardly surprising that major reform initiatives are easy to derail. Oberlander (2003) identified the fragmented structure of Congress as a significant barrier to health care reform.

The President: The Chief Executive Officer

The U.S. president is often referred to as "the leader of the free world." The phrase perhaps overstates the importance of the office, given the relative strength of Congress. The day after the 2006 midterm elections, Representative John P. Murtha told National Public Radio, "The president has no power. The president has perception of power." That phrase is very apt in some ways because while a president has limited authority to *make* policy, he or she has tremendous ability to *influence* policy. A president is more likely to become a policy maker because of leadership than any direct authority.

The president can and does craft major legislative initiatives—the annual State of the Union address is often full of new policy initiatives—but only Congress can introduce them. The president must find a sponsor to introduce legislation, and after a bill is in the hands of Congress there is no guarantee it will pass or if it does pass that it will resemble the original proposal. In health care, perhaps the greatest example of the limits on a president's

even though people seemed confused about exactly how the plan would work or what it would do. That supportive trend began to reverse itself in late 1993, about the same time that the Health Insurance Association of America began running its famous Harry and Louise advertising campaign (Goldsteen et al., 2001). These ads were targeted at informed members of the public who could serve as opinion leaders (Goddard, 1998). By April 1994, only 43% of the country supported the proposal (Blendon, Brodie, & Benson, 1995).

One useful construct for understanding the vulnerability of public support for health reform is the notion of frames. The FrameWorks Institute defines a *frame* as, "The way a story is told—its selective use of particular values, symbols, metaphors, and messengers—which, in turn, triggers the shared and durable cultural models that people use to make sense of their world" (Gilliam, 2005). Essentially, people use predictable story elements to help them sort information; they respond to metaphors, plots, and values and other familiar aspects of the story. When communication is inadequate, says Gilliam, people rely on the pictures and stories already in their heads, but effective communication can allow them to see things from new and different perspectives. Health care reform efforts, if not understood, are subject to attack by arguing within certain frames and appealing to certain closely held values. For example, many Americans are skeptical about government and opposed to too much direct government involvement in their lives. Designers of the Harry and Louise ads conducted research that told them the public did not want a massive government program and tailored their campaign accordingly (Goddard, 1998). In other words, they told a story within a "big government" frame.

According to Gilliam (2005), frames, or value-based messages, that move people toward supporting health care reform (i.e., increase political feasibility) include interdependence, the need for practical management, and the importance of prevention. They suggest that advocates of health reform promote the need for a health coverage infrastructure akin to a utility or transportation infrastructure. **Table 10-3** provides an example of the kind of language that might have framed the issue effectively.

Interest Groups

When individuals and corporations with common social and political goals form alliances and influence policy in support of those goals, they comprise an interest group. Weissert and Weissert (2002) argued, "Next to Congress, interest groups may well be the most important actors in health policy" (p. 117). The use of the term *the third house* to refer collectively to the

Table 10-3 Sample Frame for Promoting a Health Coverage Infrastructure

In the last 50 years, the United States has built a series of modern networks that are essential to our economy and our quality of life—our power grid, phone systems, water systems, interstate highways, and the Internet; however, with health coverage we are stuck in the 1940s because we never built a modern health coverage infrastructure. Instead, we still have job-based insurance, which has become an increasingly hit-or-miss, inefficient, and unreliable approach. What we have is the equivalent of scattered wells, individual generators, and county roads but no health coverage infrastructure we can rely on, no system for making sure that people have health coverage.

Source: Modified from: Gilliam, F. D. (2005, December 6). Framing health care reform for public understanding and support. Presentation delivered at Health Legislative Conference, Seattle, WA. © 2006 Frameworks Institute; and Making the Public Case for Improving Health Care: A FrameWorks MessageMemo. 2009. Washington, DC: FrameWorks Institute.

lobbyists that represent interest groups before the legislative branch is no misnomer.

Interests groups do more than just attempt to sway votes in their favor; they can be critical partners with government actors in policy development from inception to implementation. They generate proposals, provide expertise that can improve others' proposals, offer channels for testing the feasibility of proposals with their members, broker deals, and help mobilize public opinion. After a policy is adopted, their support, apathy, or opposition can determine whether it succeeds or fails. Much of the legislation introduced by lawmakers is initially drafted by interest groups.

Interest groups also lobby the executive branch and may resort to lawsuits to assert their policies. Some narrowly focused industry or consumer groups work almost exclusively with regulatory agencies. Others, such as the Sierra Club Legal Defense Fund in the environmental policy arena, work almost exclusively through the courts.

Hundreds of interest groups are involved in health care issues. A majority of them represent either occupations or health-related companies. Major, longstanding examples of these, respectively, would include the American Medical Association (AMA) representing physicians and the American Hospital Association (AHA) representing health care facilities. The last few decades have witnessed a splintering and proliferation of these groups. Each medical specialty, for example, is likely to have its own professional association that engages in some form of political lobbying. Nurses, midlevel professionals, home health aides, and providers of alternative and complementary medicines also have their own groups. In addition to the AHA, there are associations representing smaller, more specific groupings of health care facilities, such as specialty hospitals, rural hospitals, and

At the federal level, the U.S. Environmental Protection Agency regulates drinking water, although a standard for lead in school drinking water has been invalidated by the courts. It also runs a voluntary program to help schools ensure a healthy environment. The Centers for Disease Control and Prevention administers the coordinated school health program.

In Seattle and other communities, parents are active and organized. They have concerns about other drinking water contaminants, indoor air quality, and mold. These issues have been the subject of extensive media coverage. The Washington State PTA is an influential political player in the state.

Often aligned with parents are teachers and their Washington Education Association (WEA). School employees attribute many ailments to school environmental conditions. The WEA is a major actor in state politics.

The State Board of Health is committed to basing decisions on science, but the science is incomplete, inconclusive, and evolving.

The state, the schools, and the WEA all consulted with lawyers during rule making, and school districts have frequently challenged state policies in court.

On this one rule alone, the board's authorizing environment included schools, school boards, local government, local public health jurisdictions, the governor, the legislature, several state agencies, two federal agencies, parents, students, teachers, researchers, the courts, labor, the media, contractors that provided service to schools (such as architects), and the general public (see **Figure 10-1**).

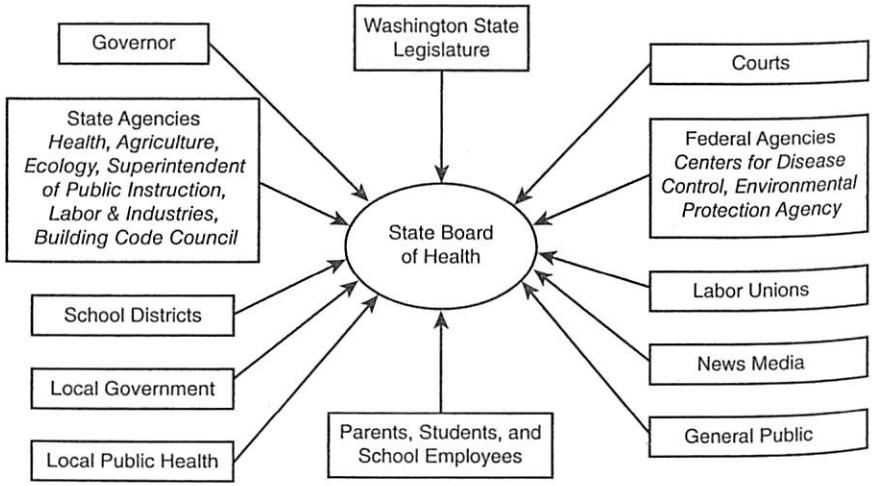


Figure 10-1 Washington State Board of Health authorizing environment for school health and safety rules.

Nearly all health policy making operates in similarly complicated authorizing environments. Each actor has its own agenda, its own constituencies, its own set of inputs to consider, and its own idiosyncrasies. That complexity is one of the main reasons that political feasibility is so difficult to predict.

KEY GOVERNMENT ACTORS

Many important governmental actors are active at the federal level, and in this section we consider factors that determine how they behave within their niches. This will be followed by a discussion of key actors at the state and local level and some of the ways they may differ from their federal counterparts.

Federal Government Actors

The drafters of the U.S. Constitution were wary of a government that put unrestrained power in the hands of one individual or institution. The Constitution that took effect in 1789 created a stronger national government, but it established three branches—legislative, executive, and judicial—and a system of checks and balances to ensure that no one branch would dominate. This basic framework also exists down through lower levels of government. At the federal level, the strengths of these branches relative to one another have waxed and waned over the years, but the separation of powers has survived intact.

Congress: The Legislative Body

Assessments of the relative power of the three branches of government in the modern era tend to conclude that Congress is the most powerful. This is largely because only Congress has the power to make laws and create budgets, whereas bureaucracies implement them and courts interpret them. The relative power of Congress has grown over the past few decades as its members have expanded their capacity to act as policy entrepreneurs. In this they are supported by personal and committee staffs that grew after World War II and expanded dramatically in the 1960s and 1970s. The larger staffs have freed Congress from reliance on the executive branch to generate major policy proposals. According to Oberlander (2003), "Congress, measured in terms of its political independence, administrative capacity, and ability to pursue policies that diverge from the executive, may be the most powerful legislature in the world" (p. W3-394).

ends, thwarting its passage. Sometimes a bill passes both houses quickly; however, the money to implement it may not be appropriated before the session ends, and it effectively dies, although the legislators can claim credit for having voted for it.

Personal Issues

In the fields of public administration and public policy, rational decision making is held out as the ideal. Decision makers are expected to weigh the costs and benefits of various policy options and make reasoned choices that maximize the gains to themselves, their constituents, or society as a whole, but personal preferences, relationships, irrational behaviors, and unanticipated events often influence political feasibility. In the case of the thimerosal legislation, for example, the chair of the senate committee who sponsored the bill was the grandmother of a child with autism, and family members believed that the autism was linked to an immunization the mother received when pregnant. Few analysts trying to assess the political feasibility of the environmental mercury legislation would have anticipated that its fate might be tied to a personal tragedy. In the case of the tobacco sampling bill, sympathy for the bill's sponsor, who was terminally ill and wheelchair bound, may have contributed to the bill's eventual passage.

Sometimes a bill does not move because one party does not want the other to get the credit, because one house does not want the other house to have credit, or because one member does not want another member to have credit. Committee chairs have been known to bottle up legislation in response to a sponsor's behavior before their committee.

Unexpected Events

An unanticipated event that many believe influenced the outcome of health legislation occurred in Washington State during the 2004 legislative session. Senator Rosa Franklin, an African American Democrat, sponsored a bill to establish the Joint Select Committee on Health Disparities. Many observers doubted the resolution would pass because of a lack of enthusiasm among Republicans who held a majority in the state senate. As part of an unrelated discussion of health policy, however, the chair of the senate health committee called the minority leader of the house health committee a "nigger in the woodpile." Both men were white Republicans. Franklin defended the senate committee chair (although not his choice of words) and tearfully accepted his apology on the floor of the state senate. There was never any public discussion of a deal, but few political observers were surprised when Franklin's resolution passed unanimously.

NONGOVERNMENTAL ACTORS

The Public

Politicians are constantly attempting to read the prevailing winds of public sentiment as they chart their policy courses. This is commendable up to a point. In a representative democracy such as the Unites States, elected officials presumably have some autonomy to pursue the policies and advance the values that got them elected without polling the electorate before every vote, but there is also an expectation that their actions will reflect the views of the majority of their constituents. At a baser level, focusing on public opinion can be about winning the next election, and subservience to public opinion polls can work against elected officials providing leadership, consistently pursuing long-term strategies, or taking risks. Politicians often focus on determining and responding to the opinions of likely voters more than those of their entire constituency. This is relevant in the context of health care reform, where a significant number of the uninsured are socially disenfranchised and generally not a powerful voting bloc. Additionally, older people are more likely to vote and are less likely to support significant changes to the health care system (Starr, 2011).

Individuals can make a difference. Politicians can be very sensitive to a small number of contacts from constituents expressing an opinion on an issue (they are less influenced by individuals they do not represent). The type of contact also matters. Elected officials are more likely to be influenced by a unique, personalized visit, telephone call, letter, or email than by something obviously generated by an organized letter-writing or email campaign. Furthermore, efforts to sway public opinion often are targeted to sets of individuals who are well informed and engaged in public issues. These are people who have a "big picture" view of the world and help form other peoples' opinions and can bring issues to the attention of the media and policy makers (Goddard, 1998).

Public opinion polls consistently show that at most points in time a majority of people in the United State have favored health care reform. Historically, however, public support for major reforms has been "soft." The public can easily be talked out of supporting a reform through the use of carefully crafted messages. In 1993 and 1994, polls repeatedly showed that Americans supported universal access to health care. Public support continued, and even seemed to be growing as the Clinton plan moved forward,

OVERVIEW

To assess political feasibility, one needs to turn to the fields of political science, public administration, economics, and business management. The first part of this chapter focuses on the *authorizing environments* in which policy is made. By mapping an authorizing environment (a process also referred to as *stakeholder mapping*), we identify the major actors that populate the political stage. These are all policy makers to some extent, even if they are not elected officials, bureaucrats, or judges, because they all can influence political feasibility. Next we discuss the players' roles and briefly describe some inputs they typically take into account, some factors that influence what gets onto their agendas, some formal and informal rules they operate under, and some ways they push a policy toward adoption. The oft-repeated word in the preceding sentence is *some*, because there is no room in this work for more than a very cursory overview of U.S. political science.

The second part of this chapter focuses on methods for analyzing political feasibility. These include various techniques, some dating back to the 1950s, as well as the most widely used contemporary methodology, stakeholder analysis, which is a framework that incorporates many of the older techniques.

Finally, we examine some of the ways political feasibility analysis can be used, for good or ill, to drive political decisions and policy adoption.

Although this chapter focuses primarily on government policy making—the adoption and implementation of policies through legislation, budgets, executive orders, rules, or court decisions—many other channels for implementing policy exist. Organized community-based activities that are designed to change attitudes, beliefs, and individual norms also can be considered policies (Lamson & Colman, 2005). Individual private nonprofit and for-profit organizations are also political environments in which policy alternatives have to be evaluated for political feasibility (Hansmann, 1996).

AUTHORIZING ENVIRONMENTS

The term *authorizing environment* comes from the field of public administration and refers to a list of the actors from whom a public manager must receive authorization in order to survive and be effective. It applies equally well to an institution, and, in a pluralistic society, it is relevant to the development, adoption, and successful implementation of a policy.

Consider the authorizing environment experienced by one of the authors while employed by the Washington State Board of Health. The board's authorities include the ability to make rules for the environmental health and safety of schools. When the board decided to update its school environmental health rules, it had to operate in a crowded and contentious authorizing environment.

The primary authority for schools rests with local school districts, and school board members are accountable to voters. Washington laws grant local jurisdictions considerable authority. The state, however, pays 69% of public schools' operating costs and most construction costs. The legislature imposes numerous mandates on the districts.

School health and safety inspection programs, where they exist, reside with local public health jurisdictions governed by local boards of health comprised wholly or in part of county commissioners. They work closely with the state Department of Health. Local governments and local boards of health can enact their own ordinances, as long as they are not less stringent than state statutes and rules. They have limited authority over school districts; however, they can adopt and enforce building codes.

The governor appoints 9 of the state Board of Health's 10 members to 3-year terms and is the supervisor of the 10th member, the secretary of health.

The legislature granted the board its regulatory powers and could repeal them or cut the board's budget. It also could overrule board action through preemptive legislation, and a special committee can investigate whether any agency's rules exceed its authority.

Other state agencies have authorities and programs related to health and safety.

- The Office of the Superintendent of Public Instruction operates a "coordinated school health" program and has sustainability standards for school construction.
- The Department of Health is a partner on the coordinated school health project, provides technical assistance to schools and local public health agencies, regulates drinking water systems, and administers money for schools to test for lead.
- The Department of Labor and Industries protects employees' workplace safety.
- The Department of Ecology addresses contaminated soils on school grounds.
- The Department of Agriculture regulates pesticide use on and near school grounds.
- The Building Code Council establishes the statewide building code.

Campaign Fund-Raising

The second major concern for politicians looking to be reelected is campaign fund-raising. Like constituent relations, fund-raising can vary in scope depending on the office. The bigger the constituency, the more it costs to campaign. The need to raise money continually influences the behavior of elected officials in many ways. When one of the authors covered politics as a reporter in California during the 1980s, legislators jockeyed aggressively for appointments to so-called juice committees—those that regulated industries and professions where a lot of money was involved, such as horse racing. These regulated entities could be counted on to make generous campaign contributions to ensure access to committee members. Discussions of the role of money in U.S. politics tend to focus on campaign fund-raising and often include the axiom that money buys access, not votes. That can be said of various gifts and junkets, as well as cash campaign contributions. Jesse "Big Daddy" Unruh, the powerful speaker of the California Assembly in the 1960s, once said of lobbyists, "If you can't take their money, drink their booze, eat their food, screw their women, and still look them in the eye and vote against them, you don't belong here." There are, however, numerous examples, some recent, of contributions and gifts, as well as outright bribes, influencing government decisions, or at least creating the appearance of a conflict of interest. North Carolina's Speaker of the House, Jim Black, helped push through a bill in 2005 requiring comprehensive eye exams for children during the first 6 months of kindergarten. These exams would earn optometrists $75–100 per exam. Black was an optometrist and accepted $59,750 in campaign money from his professional peers that year.

Party Agendas

Candidates' ability to bring their own money to the table or to raise funds independent of the political party they represent has weakened party control in U.S. politics. Oberlander (2003) argued that the weakness of political parties in the United States is one of the political obstacles to health reform in this country. Of late, though, party politics has become more polarized and policy positions have more closely followed ideological lines. Moderate Republicans who have broken ranks to work with Democrats on health care and other issues have been defeated in their primaries by more conservative candidates. Historically, members have crossed the aisle to form bipartisan coalitions in support of health legislation, but the votes on the ACA followed strict party lines.

The Economy and the Budget

The state of the economy and the revenues flowing into government coffers can determine a politician's willingness to create new programs or retain or expand existing ones. When Washington's Governor Gregoire took office in 2005, one of her first acts was to roll back health care–related changes instituted under her predecessor that had reduced the number of children enrolled in government health insurance programs. After the September 11, 2001, attacks and the economic downturn that followed, the previous administration and the legislature had needed to cut $1–2 billion a year from the state budget for a few years running. By 2005, the state economy had begun to rebound, which left Gregoire with a projected surplus and allowed her to allocate an additional $140 million to provide coverage to an estimated 70,000 more children.

Political Trading

Lawmakers will not infrequently leverage their votes, pledging to vote a certain way in return for obtaining something else they are interested in. Leadership and committee chairs can also hold a bill hostage until some kind of quid pro quo is negotiated. In Washington State, one Senate committee chair refused to release a bill to reduce commercial sources of environmental mercury, including methylmercury, which is found in fish, unless an agency withdrew its opposition to her bill banning vaccines for children and pregnant woman that have more than trace amounts of thimerosal, a preservative that contains ethylmercury. Methylmercury is a persistent toxin that accumulates in the environment and is extremely harmful to humans, whereas ethylmercury appears to be metabolized quickly and cleared by the body. Yet the committee chair saw the two mercury bills as linked. Public health advocates had to weigh their concerns that the thimerosal bill, which was largely symbolic, would reinforce unsubstantiated fears about vaccine safety against the very real threat to human health posed by environmental releases of elemental mercury.

Adjournment

In states whose legislatures do not meet year-round, the end game can become very important. Bills can languish and appear to be dead, when in fact they may be being saved for the wheeling and dealing that invariably happens as the end of session approaches. On the other hand, a bill may pass in one chamber and be kept bottled up in another until the session

last decade, but as Gilson et al. (2012) noted, "there remains surprisingly few published accounts of the use of stakeholder analysis in health policy development generally, and health financing specifically, and even fewer that draw lessons from experience about how to do *and* how to use such analysis" (p. 164).

Yet no policy analysis is complete if it avoids the issue of political feasibility, and there are some systematic techniques that can help predict political feasibility.

TERMINOLOGY

Brown (2006) described *political feasibility* as "the right fit between bright ideas and the values and interests that animate stakeholders with crucial pieces of power" (p. W163). Oberlander (2003) noted, "Feasibility analysis deals not with policy ideals but with what is more or less adoptable given policy constraints" (p. W3-392).

Dror (1969) identified three characterizations of political feasibility:

1. For a political actor, political feasibility is a measure of the actor's ability, within a given period of time, to influence various activities, specifically policy adoption and implementation. He used the term *political leverage* to describe the actor's influence and *political leverage domain* to describe the setting or range of activities within which an actor can exercise political leverage effectively.
2. For a specific policy alternative, political feasibility is a measure of the likelihood that an alternative will be adopted and implemented within a specific time period.
3. For an issue area, political feasibility is a measure of the range of policy alternatives that could potentially be adopted and implemented within a specific time period. Dror referred to the range of politically viable alternatives as the *political feasibility domain*.

Dror also described four sets of "variables" for thinking about political feasibility:

1. The main actors—who they are and what they intend.
2. Other inputs into the policy arena—the political climate, the state of the economy, public opinion, technological capabilities, and so forth.
3. The interplay of the first two—how actors come together and interact, taking the other inputs into account. Those interactions are governed by laws and informal "rules of the game." Some actors

perspectives of various stakeholders impact the feasibility of a policy Δ

may join to form a *required coalition* with enough combined political leverage to move a policy forward.

4. The threshold for adoption—in the House of Representatives, for example, the threshold for passage is a simple majority, but the threshold changes if Congress has to override a presidential veto, which requires a two-thirds majority. An actor or a coalition may have considerable aggregated policy leverage, but whether it has enough will depend on the threshold that has to be met.

In Dror's model, the actors, influenced and informed by various inputs, interact with other actors and seek to combine political leverage to achieve a mass of critical leverage.

Health care has traditionally been a *political feasibility domain* in which the range of political feasible policies is severely limited. Taking other *inputs* into account, the *actors* supporting change have not been able to create enough *aggregate political leverage* to meet the *threshold for adoption*. Therefore, it has been a domain marked by incrementalism, compromise, and failure. Starr (2011) has attributed this to a policy trap—the health care system is unwieldy and dysfunctional, yet enough people are satisfied by the current arrangement that they are unwilling to support disruptive changes. Even the Affordable Care Act (ACA), as sweeping as it may appear, is a product of this dynamic.

Another set of variables involves factors that induce actors to become concerned about a particular issue or attracted to a particular policy strategy or solution in the first place. If an issue is not on anybody's radar, there are no actors, and thus no actor interactions.

In the fields of political science and public affairs, the process by which political parties and government entities decide to address a particular problem or consider a particular policy approach is called *agenda setting*. A prerequisite, of course, is that a set of circumstances be identified as a problem whose time has come. A number of factors influence when a problem is identified, how it is defined, and whether politicians choose to address it. These include public opinion, the national political mood, media coverage, emerging social movements, interest group mobilization, voter attitudes, arising risks and threats (real or perceived), new research findings, critical evaluations of program performance, economic changes, the level of sympathy for the affected populations, and the availability of potential policy solutions (Hacker, 1997; Oliver, 2006). Action on an agenda item may be either *ceremonial* or *intentional*. Ceremonial action means going through the motions for public relations reasons or political leverage, but does not imply a strong will to address the underlying issues.

state statutes, and the charter for the political subdivision, officeholders may have different titles, and institutions may have different names. Municipalities typically use one of two basic structures:

- The council–manager system: A city council, board of alderman, city commission, or other legislative body handles policy. The mayor (who may be a member of the council) is largely ceremonial, and a city manager hired by the council performs most day-to-day administrative functions.
- The mayor–council system: A legislative body works with a separately elected mayor. How much executive authority the mayor has depends on whether the municipality has a "strong mayor" or "weak mayor" system.

County government is often structured like the council–manager system, and the legislative body is often called the board of commissioners. Counties are typically responsible for providing services such as fire, police, public health, criminal justice, garbage and recycling, and roads in unincorporated areas.

Just as states have despaired at looking to the federal government to address access-to-care issues and other problems linked to the nation's system of health care finance and delivery and have tried to find solutions on their own, so, too, have local governments and local communities. Some local community efforts have experienced significant government involvement, whereas others have relied on grassroots efforts. One example of an effort driven by local government began in the early 1990s in Hillsborough County, Florida. In response to the strain placed on the local budget due to the rising costs of providing services to the disadvantaged at the local public hospital, voters approved an increase to the county property tax to purchase health coverage for low-income residents ineligible for other public health insurance programs. Through a network of local hospitals, clinics, and providers, the Hillsborough County Health Care Plan would provide case-managed care to an initial 30,000 beneficiaries. Part of what made the plan politically feasible was a commitment that it would in time lead to a reduction in property tax levies.

POLITICAL INPUTS

Being able to identify the actors and describe their interactions is only part of the challenge of assessing political feasibility. It is also important to understand another set of variables—inputs that influence actor

interactions. There are many such inputs, but key ones include elections, constituent relations, campaign fund-raising, party agendas, the economy and its impact on government budgets, political trading, and idiosyncratic personal factors. This section discussed these types of inputs and provides examples of how these inputs have influenced public health and health care financing. Many of the examples are from Washington State because one of the authors spent several years as an agency executive for the state.

The Election Cycle

Elected officials, unless they are planning to retire or face term limits, must be concerned with reelection. The timing of elections can profoundly influence their willingness to take on controversial issues. If an issue is likely to interest the electorate favorably, it might rise to the top of a politician's or party's agenda preceding an election. Such instances often provide examples of ceremonial agenda setting. If an issue or policy is likely to alienate or confuse voters, politicians might put the issue off until after the election. Lawmakers are reluctant to raise taxes during an election year, for example. Presidents typically focus on reelection throughout most of their first term, but tend to demonstrate more independence during their second. When assessing political feasibility, it is important to consider the timing of the next election and the mood of the electorate.

Constituent Relations

For politicians concerned about reelection, one of their top two concerns is likely to be constituent relations. The nature of constituent relations activities will differ depending on the geographic area and population represented. Generally, the smaller the direct constituency, the greater the importance given to grassroots activities such as addressing service clubs.

One of the jobs of a politician is to bring home benefits, such as state and federal funding for capital improvement projects. A member's focus on these activities could make it difficult to get other issues onto his or her agenda, or a policy proposal that makes sense on a national level may conflict with the interests of folks back home. Efforts to ban tobacco sampling in Washington State were tied up for years by an influential state representative who said he opposed sampling bans because giving tobacco to kids was already illegal, and for adults, tobacco is a legal product; however, he also represented a district that is home to many small rodeos that are supported by tobacco companies and are major sites for tobacco giveaways (Callaghan, 2006).

Chapter 10

The Policy Analysis Process: Evaluation of Political Feasibility

Evaluating political feasibility can be one of the most challenging steps in the policy development process. Policy choices are proposed, considered, adopted, and implemented in sociopolitical contexts that are complex, subjective, and dynamic. They are difficult to quantify or to analyze within a structured, systematic, rational framework, especially because politics can be quite irrational when factors such as emotions, ambitions, egos, disputes, personalities, allegiances, relationships, and deeply held value systems come into play.

This makes reliable prediction of whether policies have a realistic chance of being adopted and successfully implemented virtually impossible (Dror, 1969). It also helps explain why explicit discussions about political feasibility are often absent from policy debates and why literature specific to political feasibility is sparse. Oberlander (2003) observed that "political calculations are often a footnote in health care reform proposals" (p. 392). There has been some increase in the use of structured political feasibility analysis, particularly using a framework called *stakeholder analysis*, in the

rulings of the district courts appear to be in conflict. The court ultimately decided the lawsuit filed by Republican attorneys general that argued the ACA was unconstitutional. The justices upheld the constitutionality of the law's individual mandate but ruled that a requirement that states expand Medicaid was unconstitutional because it was overly coercive.

State Governments

States play a leading-edge role in formulating health policy and are major purchasers of health insurance and health care. Health care is the most critical cost driver for state government. Medicaid spending alone accounts for 24% of spending across all states (National Association of State Budget Officers, 2012). States are major local employers and also manage and fund public health and mental health services, authorize public hospital districts, regulate health insurance, license and discipline health care providers, and oversee health care facilities. They also serve as test markets for reform efforts.

States are organized on the surface as smaller versions of the federal government. The governor plays a role akin to the president. All have legislative bodies that correspond to Congress, and all but Nebraska have a bicameral legislature. States apportion legislative seats in both houses on the basis of population—the result of a Supreme Court decision in the early 1960s affirming the "one man, one vote" doctrine. States also have their own courts system, including their own supreme courts.

One of the most profound policy changes in terms of health outcomes for this country came solely through the courts and started at the state level. Attorneys general from several states sued tobacco companies to recover the costs of caring for publicly insured individuals with smoking-related illnesses. In 1998, the 5 largest tobacco companies and 46 states, plus 6 commonwealths and protectorates, signed the Master Settlement Agreement (4 states settled previously). The agreement called for payments of $206 billion over 5 years. Several of the states used the money to fund anti tobacco programs that have contributed to lower smoking rates. Although the states filed the suits in state courts, the cases might have been consolidated in federal court if the parties had not settled.

To describe states as miniature replicas of the national government would not do them justice. Their different powers, authorities, and organizational structures need to be taken into account. For example, most states allow the governor to veto line items in the major budget bills or sections of legislation. The president does not have line-item veto authority. Fifteen states also have term limits. The only federal term limit is Article 22, ratified in 1951, which restricts presidential terms. State legislatures have their own rules and customs as well.

Bureaucracies are also organized differently from state to state. Some states have combined public health, social services, and health care purchasing into a single huge agency. Some have split off public health into a separate department so that it does not get overshadowed. Some states have health care–purchasing agencies that may or may not include federal entitlement programs. Something as simple as state boards of health provides an example of the high variability in organizational structure among states. The Washington State Board of Health (2003) identified entities fitting the definition of a state board of health in 30 of the 50 states. Eight were advisory only, whereas 22 made policy in addition to providing advice. Eight of the 22 policy-making boards had direct oversight of the state health agency.

Weissert and Weissert (2002) have identified three key differences between states and the federal government that directly affect health care policy making:

- Budget limitations: States are not able to run at a deficit (although technically, Vermont is not prohibited from doing so), and they are generally prohibited from borrowing to cover operating expenses.
- Direct democracy: Twenty-four states allow initiatives—voters can pass statutes directly by voting on them on the ballot or indirectly by submitting them to the legislature. Twenty-four states (mostly the same 24) allow referenda. A legislative referendum is when the legislature puts something to public vote. A popular referendum is when, as a result of a petition, voters can confirm or repeal a legislative action. Eighteen states allow voters to recall officials.
- Media coverage: State governments receive less news coverage. Fewer reporters cover the state houses, and legislators are less adept at generating media attention.

Local Government

Local government bodies can be even more diverse. Generally speaking, each state has two levels of local governments: counties (parishes in Louisiana and boroughs in Alaska) and municipalities (cities, town, villages, and boroughs). Typically, these exist side by side, but there are examples of combined cities and counties (San Francisco is one), and, in Virginia, some large cities operate outside of the county structure. Hawaii has four counties and no municipalities, except that Honolulu is a consolidated city-county.

Such entities typically have a chief executive, a legislative body, and a court system. Depending on the level of government, the state constitution,

minimize resistance, or pull together stakeholders early in the policy-making process to craft a policy alternative that has broad support. They can also use their outside contacts to try to assess political feasibility.

Finally, bureaucracies with regulatory authority are policy makers in their own right. Although legislatures make law, regulatory agencies make administrative law in the form of rules and regulations.

At the federal level, most agencies with health-related portfolios are part of the Department of Health and Human Services (DHHS). **Table 10-1** offers a list of DHHS agencies. **Table 10-2** lists some of the agencies that operate health-related programs but are not part of DHHS.

The Judiciary: The Federal Courts

The federal courts most often play a critical role when it comes to issues of federal preemption, constitutional protections, and interstate commerce. In the federal system, district courts oversee most civil and criminal trials, although there are separate court systems for bankruptcy, international trade and customs issues, and claims for monetary damages against the federal government.

Table 10-1 U.S. Department of Health and Human Services Program Divisions

Administration for Children and Families
Administration for Community Living
Agency for Healthcare Research and Quality
Agency for Toxic Substances and Disease Registry
Center for Faith-Based and Neighborhood Partnerships
Centers for Disease Control and Prevention
Centers for Medicare & Medicaid Services
Food and Drug Administration
Health Resources and Services Administration
Indian Health Service
National Institutes of Health
Office for Civil Rights
Office of Global Health Affairs
Office of Health Reform
Office of the National Coordinator for Health Information Technology
Substance Abuse and Mental Health Services Administration

Source: Data from: the U.S. Department of Health and Human Services. (n.d.). HHS organizational chart. Accessed on December 11, 2013, at www.hhs.gov/about/orgchart.html.

Table 10-2 Federal Agencies with Health-Related Duties (Excludes HHS Divisions)

Department of Agriculture
· Animal and Plant Health Inspection Service
· Cooperative State Research, Education, and Extension Service
Department of Defense
· TRICARE
· Army Medicine Department
· Navy Medicine
· Air Force Medical Service
Department of Homeland Security
Department of Labor
· Mine Safety and Health Administration
· Occupational Safety and Health Administration
· Employee Benefits Security Administration
· Benefits Review Board
Department of Veterans Affairs, Veterans Health Administration
Environmental Protection Agency
Federal Bureau of Prisons, Health Services Division
Federal Mine Safety and Health Review Commission
Nuclear Regulatory Commission
Occupational Safety and Health Review Commission
Uniformed Services University of the Health Sciences

Source: Data from: the Office of the Federal Register, National Archives and Records Administration, & U.S. Government Printing Office. (2013). United States Government Manual. Retrieved on December 11, 2013, from www.usgovernmentagency.gov.

When Maryland enacted a play-or-pay law requiring that any company with more than 10,000 employees spend at least 8% of its payroll on employee health care or pay into a state fund for covering the uninsured, the Retail Industry Leaders Association filed suit in federal court. U.S. District Court Judge Frederick Motz overturned the law on July 19, 2006, finding that ERISA preempted state authority.

All districts belong to one of 12 regional circuits, each of which has its own U.S. Court of Appeals. The federal appeals courts hear appeals to decisions reached by district courts, the Court of International Trade, the Court of Federal Claims, and federal agencies.

The U.S. Supreme Court picks from among the cases brought before it and chooses which it will hear. It seeks out cases involving important issues related to the Constitution or federal laws and hears cases where the

Chapter 10

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