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**Foul Weather Friends: Big Business and Health Care Reform  
In the 1990s in Historical Perspective**

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## ABSTRACT

Existing accounts of the Clinton health reform efforts of the early 1990s, which were intended in part to check unprecedented health cost inflation, neglect to examine the possibility that a steep drop in big business reform interests during the short period between 1992 and 1994 might, to a considerable degree, account for the stalling of comprehensive compulsory health insurance legislation in Congress. This paper explores evidence for the idea that big employers lost interest in national reform because in those two crucial years they managed on their own, through private actions, to bring their health cost inflation down without government help. At the same time, economic recovery out of the recession of the early 1990s rendered further cost control less imperative. The paper puts the argument in historical perspective, discussing how hard times during the Great Depression also made big employers into “foul weather friends” of compulsory social insurance. Unlike in the present case, however, foul weather did not clear and the social insurance reform of the New Deal succeeded. The article speculates, therefore, that had there not been a brightening of economic circumstances, continuing and even growing big business support may have neutralized small business opposition. Thus in light of the Clinton administration’s willingness to compromise on details of its plan, some kind of major reform might have passed.

In March 1990, Bethlehem Steel, Chrysler, Dayton Hudson, Southern California Edison, Georgia-Pacific, International Paper, Lockheed, Northern Telecom, Pacific Gas and Electric, Safeway Stores, Time Warner, Westinghouse, and Xerox joined forces with various labor unions and other corporations to promote an outrageously un-American idea: corporatist or tri-partite regulation of compulsory national health insurance (Swoboda 1990b; Pear 1991; Martin 1993).<sup>1</sup> Their National Leadership Coalition for Health Care Reform (NLCHCR) was no isolated phenomenon. Around the same time a survey of Fortune 500 executives found that 53% supported the idea that government should force all employers to pay for their workers' health care (Cantor et al. 1991:99-101). No fewer than 185 Fortune 500 companies participated in the Washington Business Group on Health, an association led by a progressive health activist dedicated to comprehensive reform (Bergthold 1990; Burke 1990:32).

Not since the New Deal had efforts to forge a major piece of social insurance received as much direct encouragement from big employers as the Clinton administration's efforts on behalf of national health insurance.<sup>2</sup> Therefore voter opinion was probably not the only reason the issue caught fire, first of all in the special Senate election in Pennsylvania in 1991. Harris Wofford, once the state's Secretary of Industry and Labor, landed the Senate post after promoting comprehensive reform. In his earlier job, Wofford would have to have been blind and deaf not to have noticed the potential for a broad-based alliance with major business interests in reform. One

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<sup>1</sup>In 1991 it proposed a universal health care plan tied to a European-style tripartite rate-setting board composed of representatives from business, labor, and the government. The board, a corporatist conception that seemed more typically European than American, would have the power to set health care billing rates with the force of law and set a cap on overall expenditures (Pear 1991). AT&T, Du Pont, Arco, Eastman Kodak, 3M, and Burger King dropped out, finding the proposal too radical, but set up another group, the Corporate Health Care Forum, to look for other solutions (Martin 1993:379-80).

<sup>2</sup> Drafters of the Social Security Act were in close contact with a significant number of big businessmen expressing keen interest in compulsory social insurance. There is of course much controversy over the numbers and significance of business supporters (Swenson 1997 and forthcoming).

of the corporations most insistent on change was Bethlehem Steel, located in the state, and a member of the NLCHCR.

Inspired by the Wofford phenomenon, Clinton ran for the presidency with health as a central plank of his campaign. James Carville, a campaign consultant, had also worked for Wofford, having encouraged him to focus on health care. After winning, Clinton brought in Ira Magaziner to craft legislation, a man to whom corporations paid millions for telling them what changes they needed to make to cope with intensifying global competition. At the time he was recruited, Magaziner was busy analyzing health care cost problems for the state of Rhode Island. Once in the Clinton administration, and after coming into contact with Boston and Cambridge economic and business advisers, Magaziner became a full convert to some form of “managed competition.” Finally Clinton, no enemy of big business (as his NAFTA efforts indicate), fell under the sway of the idea (Johnson and Broder:15, 78, 104).

Among employers, large manufacturers in sectors like steel and autos, with high wages and health-related labor costs and competing in the international marketplace looked most favorably upon reform. The idea of shifting some health costs off their backs and onto other employers currently not providing insurance appealed to them. So did the efficiency benefits of the forced introduction of “managed competition.” Assumption of costs for early retirees attracted a number of big unionized firms trying to cope with an expensive aging workforce.

But support among the bigger employers was anything but consistent and unchanging. In fact, big business support rose and fell. It grew in the period leading up to Clinton’s election and his administration’s early efforts to draft a bill. According to one analyst, 1992 was “the high-water mark of business support for the Clinton approach” (Pauly 1997:29; Greenhouse 1992). It was shrinking rapidly when the legislation shattered against the rocks of Congressional politics in 1994 (Uchitelle 1994). Evidence about this arc of rising and declining business support in the suspenseful drama of health care reform poses a fascinating though ultimately, perhaps, unanswerable question: Might national health insurance have passed in some form or other, if not exactly in the shape of the “Clinton Plan,” had business support had not flagged in the course

of the debate?

### *The Argument*

In lieu of a completely confident answer indicating that it would have, this article offers a modest proposition: that no account of the reform process can be complete without analysis of these changing interests. We argue that during the late 1980s and very early 1990s many big employers regarded reform with open minds, if not outright favorably. They liked the promise of controlled medical cost inflation with legislation that reserved for them considerable control over employees' benefits as a managerial instrument. They liked the idea of restraining costs far better than the idea of cutting their workers' pay and benefits. Because of this friendly climate, politicians threw themselves into an unusually frenetic level of reform promotion in electoral and legislative politics, now sensing an unusual chance of success based on a broad based coalition founded on business as well as labor support.

By no means did employers regard legislation as the only solution, however. As professional managers and only amateur political activists, they simultaneously pursued, with great energy, all manner of private solutions to controlling costs. Probably most important among them, of course, was "managed care," very often in the form of Health Maintenance Organizations (HMO's), into which they eagerly herded their workers. Often they were assisted in this by unions, who after all had been, even more than employers, early proponents of the idea for the leverage it gave in distributional conflict with providers (Garbarino 1960:157-66; Muntz 59-66, 74-77). Thus the legislative solution enjoyed no advantage in terms of cross-class support.

For various reasons managed care, among other efforts, delivered cost containment for employers and their workers more quickly than the political process. Indeed, inflation in employer health costs took a steep dive exactly in the two-year period leading up to the political shipwreck of the Clinton Plan in 1994. Not only that, the U.S. had begun to swing up out of recession and many employers' competitiveness problems dissipated. Big business, in short, lost interest in national health care. We can reformulate our question therefore in the following way: Had they not solved their cost problem on their own as the urgency to do so became less acute,

would they have let political efforts on behalf of comprehensive national health care die such a quick death? Would they have stood so idly and indifferently by without promoting efforts at resuscitation?

*How Business Figures in Other Accounts*

The role of big business's declining interest has not been a focus of attention in most important accounts of the failure of the Clinton plan (See for example Weissert and Weissert 1996: 138-40; Skocpol 1997:158-160; Rushefsky and Patel 1998: 152-57 and the special issue of *Journal of Health Politics, Policy and Law* 1995). Instead, researchers tally up numerous other factors: the intensive lobbying by various groups of providers and insurers; the ferocious attack on employer mandates and universal coverage by small business; the scorched earth, take-no-prisoners, with-us-or-against-us tactics of Republican Party opponents of the plan; strategic errors of the Clinton administration; and sagging public support.

These analyses, all of them sensible, attach little importance however to changing business interests.<sup>3</sup> Organizational policy is another matter. Some accounts do take note of a damaging shift in position taken by business organizations like the U.S. Chamber of Commerce. In these, however, forces external to the organizations acted upon them to change the internal balance of power between advocates and opponents. There are for example the "reverse lobbying" and "cross lobbying" arguments (Schick 1995:241-44; Judis 1995; and Martin 1997:418-19 and 2000). "Cross lobbying," for example by the National Federation of Independent Business (NFIB), or pressure on other business organizations, probably helps account for the change in position of the United States Chamber of Commerce. It had been initially favorable. But the NFIB could credibly threaten to cause a defection of large numbers of its small business members if it failed to join the opposition (Schick 1995:252).

The "reverse lobbying" argument also attributes the policy shifts to external forces

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<sup>3</sup> Other relevant analyses tend, on the whole, to regard positive business interests, in the United States at least, as either too ambivalent or disorganized to make a decisive difference in favor of reform (e.g. Brown 1994; Martin 1993 and 2000).

affecting the dynamics of conflict and compromise within organizations. For example by 1994 the Republican Party's leadership successfully bullied business organizations into withdrawing their support for the Clinton plan, even threatening retaliation in other policy areas. Again the Chamber of Commerce figures prominently in this argument. Most dramatically, when its president was scheduled to testify before Congress in support of a plan including an employer mandate, managed competition, and a standardized minimum benefits package, conservative congressional Republicans "read them the riot act." Also, Republicans directed threats of legislative punishment at individual companies like Ameritech, Caterpillar and others (Schick: 1995, 243; Martin 1997:418). Thus it may well be that external pressures like these also caused the Business Roundtable and National Association of Manufacturers (NAM) to drop their initially supportive or at least neutral positions. They may have shifted the balance in the favor of determined opponents among small employers, insurance companies, and even big employers like Pepsico whose fast food franchises depended on cheap labor without extra payroll costs.

As important as the cross and reverse lobbying phenomena may have been, they are unlikely to explain the change in views of powerful corporate executives registered in the *New York Times* survey in May 1994, which found that big business executives were now as opposed as their small-business counterparts despite earlier efforts, at the expense of labor support, to appease them (Uchitelle 1994; Pear 1993a). After all, such people had minds of their own, and therefore an ability to assess company-specific interests that can change over time with changes in their market environment. As "price makers," they may even have had the power to change that environment. Thus if their interests were moving independently in the same direction as their putative opponents, then external intervention in their relations with other employers can hardly be the entire story. A changed alignment of interests over time may account for the result, not a changed balance of power.

To be sure, at least two authors identify a plausible economic reason for individual companies to lose the will to defend reform within their organizations and testify in its favor in public and Congressional arenas. Over time, apparently, as small business in particular began to

mobilize so effectively against the Clinton Plan, the administration's strategists responded defensively in a "mad political scramble" to appease small employers at the expense of growing costs and rigidities for larger ones. Thus they "drew criticism from big companies that had been among the most vigorous champions of reform" (Schick 1995:244; Martin 1997: 410). The cost shifting advantages of compulsory reform were now being watered down, even as benefit mandates were being added to appease liberal opposition. Overall cost control would be increasingly dependent on highly intrusive government regulation in the form of rigid global budget caps. These strategic moves fed latent ideological suspicions about big invasive government among bigger firms willing to accept the risks of government intervention when the payoffs were bigger and clearer. At the end of the game, many big employers saw no sure benefits to compensate for increasingly certain "government interference with the internal operations of private business" (Silow-Carroll et al. 1995, 62).

Once again, however, the origin of the change over time in this account is the power struggle within the business community, not the halt in employer health cost inflation, improving macroeconomic performance, and dissipating international competitiveness problems. The power struggle led to a change in the design of legislative plans at big employers' expense. "In the end, the mistargeting of incentives lost some big business support without winning anything from small business lobbies" (Schick 1995: 244). Thus the possibility needs to be entertained that the power struggle may have played itself out quite differently if big employers had not had economic reasons independent of political maneuvering for losing interest.

By far the best and most exhaustive journalistic investigation of the Clinton Plan's failure supports our suspicion that employers' independent efforts to bring costs under control, and therefore flagging interests, were a powerful and potentially decisive factor in the failure of reform efforts. According to Haynes Johnson and David Broder, the chairman of the House Energy and Commerce Committee John Dingell saw the loss of big business support early in 1994, especially from the Business Roundtable, as "a defining event" leading to "a big shift in sentiment inside my committee." For pro-reform Republican Senator David Durenberger on the

Finance's Health subcommittee, it was "the moment of truth."

Johnson and Broder inquired among "executives involved in the debate" why they pulled away. The answer was that Clinton was too late. Their firms had developed strategies of their own that were just now "beginning to pay off." Among these were "a transfer of costs to employees or retirees; tougher bargaining with insurers and providers; a shift to managed care programs with more predictable costs; an emphasis on exercise regimens, anti-smoking drives, and other 'wellness' programs." At that point, "Durenberger and others like him . . . knew they were swimming against the tide" (Johnson and Broder, 1997: 323-26, 381-82; see also Pauly, 1997:29, 158,172).

*From Welfare Capitalism to Welfare Statism:*

*A Historical Precedent*

The history of employer-provided social benefits in America lend plausibility to our speculation that big business support and its decline are an important and underappreciated factors behind the trajectory of the Clinton health reform effort. History suggests, in other words, that the political climate for compulsory social insurance, is strongly affected by the economic climate faced by employers torn between commitments to workers and the need to meet the imperatives of market competition. When the economic climate is good, employers have been indifferent at best to social reform. When the weather turns foul, friendship with reformers can evolve.

The early 1990s was not the first time in American history that capitalists who saw their role as social providers as proper and (mostly) sufficient to meet the needs of American society became supporters of major welfare state developments. The same thing happened before the big bang in welfare state development in the 1930s, when the economic climate turned had turned foul. Up to that time, from early in the century, employers had been building a system of labor market segmentation in which only some workers enjoyed good benefits, usually alongside good wages. By introducing company benefits they intended in part to secure a loyal workforce and

thereby ward off unionization. But they were also seeking the benefits of extra productivity identified by economists' "efficiency wage" theory. According to this theory, paying premium wages, and by the same token, better benefits, helps firms attract a larger and better pool of applicants from which to select workers. Once in the firm, workers stay longer (turnover costs decline) and work harder (Useful introductions are Akerlof and Yellen 1986 and Weiss 1990).

Early on during the Great Depression, a considerable number of "corporate liberals" from large "welfare capitalist" firms, most notably Gerard Swope of G.E, Walter Teagle of Standard Oil of New Jersey, and Marion Folsom of Eastman Kodak, gave clear signals that various aspects of the New Deal, especially elements of the Social Security Act (SSA), would help stabilize competition for better employers being undercut in the depression economy by low-wage, low-benefit producers. Kodak's Folsom, which weathered the blows of the depression better than most corporations, according to Sanford Jacoby, was no liberal ideologue. Instead, he was "a pragmatic businessman eager to level the playing field" for Kodak as well as other progressive firms, and through social security, even "profit from the situation" (Jacoby 1996: 67; 1993:549; 1997:206-7).

In other words these capitalists preferred not to follow their product market competitors down the low road of wage and benefits reductions. By going down that road, they could of course reduce costs without closing their pay and benefit differentials (because other employers in their labor markets were going down too, actually widening the differentials). But that would come at the risk of reducing morale and inciting labor unrest and unionization associated with reductions (Bewley 1999:430-43; Jacoby 1997). Furthermore, their downward moves might simply be one more step in a deflationary spiral, reducing wages and purchasing power, only inciting competitors to reduce their pay and benefits more (O'Brien 1989).

Better, then, to avoid being bruised by ruinous competition and intense class conflict by imposing new social insurance costs on product market competitors. Government intervention with the welfare state being now proposed would help check the cut-throat competition and displace the distributional conflict onto outsiders. As the editor of *National Petroleum News* put

it bluntly, "most if not all of bigger oil companies now have, and some have had for many years, various forms of pensions" and other social benefits, while 20 to 25 thousand "legitimate" oil producing and market companies lacked them, as did "some 200,000 and more price-cutting retail dealers, cooperative oil companies, and straight price cutters who have no protective features for their employees." Come to think of it, he ventured when asked about the industry's position on social security, "if these last were forced to contribute to such protection as bigger companies are now doing, it might help to lessen some of their price cutting by bringing up their costs." (U.S. Senate, Committee on Finance 1935: 796).

In this stormy weather of intense cut-throat competition and resulting class conflict, prominent welfare capitalists looked favorably on the welfare state as a way of providing market security for capitalists as well as social security for workers. The New Dealers expected that many other businessmen would accept their reforms and not mobilize to undermine their legislative efforts, and they were proven correct ("What Business Thinks" 1939). Later, however, while the sun shone over the post-war years, big employers ceased playing a progressive role. Instead they reapplied the brakes, supporting broad but only "basic" or minimal social insurance. This set up would reserve for them the role of providing grateful workers with generous company retirement and unemployment benefits to supplement meager public ones. For example while Marion Folsom remained a stolid champion of the basic welfare state after the depression, he was also most adamant that social security could not be allowed to displace welfare capitalism (Jacoby 1997:207. On auto industry executives' similar views and strategies see Wilson 1958:1001; Drucker 1978:275; Sloan 1990:405).

### *The Fate of the Clinton Plan in Historical Context*

Employment-based health insurance dovetailed with the long tradition of welfare capitalism described above, though its development was somewhat arrested relative to other employment-based benefits. Some firms experimented with health care benefits early in the century (Jacoby 1997:11-34), but these were mostly limited to treatment of job-related injuries

and illnesses, as organized physicians insisted. Their ferocious resistance from the medical profession probably inhibited its development before the New Deal (Starr 1982:203). Physicians had fairly successfully fought, tooth and nail, all forms of “contract practice,” “corporate medicine,” or “pre-paid group practice,” i.e., early precursors of managed care that employers could arrange for their workers in the presence of insurance market failure, i.e., the absence of a health insurance industry. Thus the Roosevelt administration shied away from antagonizing organized medicine and dropped the idea of including compulsory health insurance in the SSA. They worried that big medicine’s opposition would endanger passage of the entire bill. By contrast when Roosevelt’s cabinet-level Committee on Economic Security contemplated dropping old-age security, their big business advisors intervened kept the ball rolling (Brown 1972:21-2).

The surge in private employer-provided health insurance had to wait, therefore, until World War Two. By then the American Medical Association and many state medical societies were ready, having been rattled by the initial moves to include national health insurance in the SSA, and for example efforts to pass compulsory legislation at the state level—e.g., Governor Earl Warren’s repeated efforts in California in the 1940s. Also a Supreme Court ruling against the AMA in the 1930s had put an end to state and county medical societies’ worst strong arm tactics against physicians willing to participate in early employer-based managed care. So organized medicine now collaborated in the spread of new forms of insurance (e.g., Blue Cross and Blue Shield) for low-income working Americans (Cunningham and Cunningham 1997). Company-based insurance started taking off around 1943, when employers seized upon health benefits, allowed by the National War Labor Board, as a way to attract and retain employees when wartime wage controls prohibited wage increases in extremely tight labor markets (Seidman 1953:127-130; Stevens 1986).

After the war, unions kept up the pressure on businesses to grant collectively bargained measures. They also put pressure on the government to provide a supportive climate for private benefits, having been discouraged by the political obstacles to national health care (Lichtenstein

1989:148-54; Derickson 1994:1353-56; Gordon 1997: 277-79). Employers did not put up any genuine resistance, for by and large benefits come out of wages, not profits, and a dollar of benefits often had more recruitment and managerial value than an extra dollar of wages. One reason was that the law made benefits deductible from taxable corporate income, and employees paid no income taxes on their benefits (Stevens 1988; Pauly 1997). The result: while in 1940 less than 10 percent of the population had job-linked health insurance, by 1966 over 80 percent did (Reed 1967:9,12-13). By 1999, as one estimate has it, without the tax subsidy twenty million adults would lose their employment-based health insurance (Custer et al. 1999:118).<sup>1</sup>

In more recent years big employers were rewarded for putting money into benefits rather than wages by two further developments. First, experience rating or the differentiation of insurance premiums gave big firms with healthier-than-average workers a double advantage in competition over the best labor with more marginal firms: they could pay lower premiums for the same coverage (Cutler 1995:35). A cross-class alliance of forces promoted the practice, shattering the more egalitarian “community rating” principle followed by the Blue Cross-Blue Shield movement. In other words unions as well as employers sought better deals for their members and workers (Gottschalk 2000). Second, the 1974 Employee Retirement Income Security Act (ERISA) insulated big self-insuring companies from expensive state-level regulation and malpractice litigation (Weissert and Weissert 1996:182ff; Battistella and Burchfield 2000). ERISA-induced self-insurance therefore also reduced big firms health care costs relative to others (See also Fox and Schaffer 1989; Jacobson 1999; Grogan 1995). Employment-based health insurance was still a bargain.

*Foul Weather Again: Government Mobilizes for a Rescue Operation.* Until the enormous medical cost inflation of the 1980s it was mostly smooth sailing for the employment-based system. But now employers had steered themselves into stormy seas. There was intense

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<sup>1</sup> The tax code continues to support health benefits. An extra dollar of pretax income for an employee might turn into approximately forty cents of aftertax income. An extra dollar of health care remains untaxed, and remains an extra dollar of health care.

international competition, high interest rates, and a strong dollar. The recession of 1990-91 made things worse, putting even heavier pressure on big employers to hold back growth in the cost of health benefits along with other labor costs, or even reduce them. By 1988 Chrysler was spending more per car on health care than on steel (Himmelstein and Woolhandler 1994:40). In 1990 health care costs for businesses generally exceeded profits, and recent increases in the cost of health care exceeded the percentage increase in all other labor expenditures combined (Himmelstein and Woolhandler 1994:41; Starr 1994:11). Ford complained in 1992 that the company's cars were at a \$500 per car competitive disadvantage compared to Japanese cars due to health care costs (Greenhouse 1992; Pauly 1997).

If not always open mutiny among the crew, there were morale problems. Worker morale and relations with unions suffered when employers tried to pay for health cost increases out of current or future wages. Workers naturally wanted to increase or at least maintain their sagging wages and at least preserve existing health benefits. Even though wages ultimately pay for rising costs, as Alcoa CEO Paul O'Neill admitted, companies do not come away unscathed for they "exert pressure on company/union negotiations" (Igelhart 1991:80-81). Thus Harris Wofford had discovered in Pennsylvania that "increasingly, every labor dispute, every strike, turned in whole or in part on the issue of health care" (Johnson and Broder 1997:59). Indeed, efforts to hold the line or cut back on health benefits were the cause of 78% of all strikes involving over 1,000 workers in 1989 (Victor 1990: 704-06).

Reducing nominal wages, apparently, is the last thing employers want to do in a recession, including in the early 1990s, largely for morale reasons (Bewley 1999). So in the course of the 1980s many employers cut back or restructured benefits in ways that allowed them to keep nominal cash wages stable or even increase them to sweeten the deal (Bergthold 1990: 34). These changes ensured that a higher proportion of future increases in health costs would come out of workers' cash wages (especially for payment of deductibles, for example). Continuing along this route had its limits, as the high proportion of strikes caused by pressure for continued benefit cutbacks indicated.

Under these circumstances it made sense to displace and reconstitute the distributional conflict between big employers and their workers at the workplace into one between a cross-class alliance of both against others in the political arena. Political entrepreneurs like Clinton, like New Dealers before him, saw the chance to broker just such a cross-class coalition. The Clinton Plan promised to dig into the pockets of health care providers like physicians and hospitals by setting up large purchasing cooperatives consisting of most, but not the biggest, employers. The “employer mandate” element also promised to dig into the pockets of other free-riding employers and their workers where company-based health benefits were lacking. For a long time the employers of the uninsured had their hands in the bigger employers pockets: their workers often enjoyed dependent coverage through spouses at better workplaces. Also, some companies already providing benefits would have been happy to see extra costs imposed on product market competitors not currently paying for employee health. Subsidization of benefits for early retirees would shift costs onto a much wider population.

The biggest employers were to retain considerable control over health benefits, tailoring them to their particular managerial and labor market recruitment needs, by exempting them from participation in the purchasing cooperatives or alliances. All they had to do was meet minimum national standards, though the nature of those was not easily predictable in the shifting winds of politics, and therefore still the cause for some anxiety regarding overall cost control. That the plan allowed the largest firms to retain control over health benefits is unsurprising; the Chamber of Commerce helped to develop the mandate provisions (Center for Public Integrity 1994:57-61). At least in broad outlines and general principles, the plan was to harmonize with many big employers’ long-range need for a relatively restrained system of national standards applying to all employers, reserving room—as Kodak’s Marion Folsom would have recommended—for the upward differentiation.

In short, unfavorable exogenous macroeconomic and price shocks turned big employers into foul weather friends of a major expansion of the welfare state. The same dynamic of employer-friendly politics proceeded at the state level. In seven states, ranging from traditionally

progressive Minnesota to conservative Tennessee, businessmen played catalytic roles in initiating efforts to engineer health reform in alliance with governors and other political actors, demonstrating the depth of business interest in health care reform (Paul-Shaheen 1998:328ff). Politicians at this level were in part motivated by the desire to increase coverage, but they were especially moved by the budgetary blows medical cost inflation was delivering them through Medicaid, which a former Oregon governor called “the monster that ate the states” (Fox 1994:143). All these efforts combined prospective cost control with universalism and were based on a mixture of employer mandates, competitive managed care, and state regulation of benefits standards (Weissert and Weissert 1996:211-220; Brown 1994: 32,38; Leichter 1994:97,121).

*Doing Something about the Weather.* As mentioned above, a central feature of the Clinton Plan was some form of “managed competition,” a scheme marrying government regulation with market forces, forcing purchasers into an alliance against final providers, and creating powerful incentives for employers and workers to choose managed care arrangements like HMO’s. There was nothing really new and necessarily “governmental” about purchaser alliances and managed care however. Around the country employers had already begun experimenting with purchasing alliances without waiting for government compulsion (Bergthold 1990; Hilzenrath 1994; Pauly 1997). The move *en masse* by big employers to HMO’s, after a slow start in the 1970s and early 1980s, started more or less with Allied Signal Corporation in 1988 (Brown 1983; Swoboda 1990a; Anders 1996: 16-19). Many more followed in the following few years, though the effect on cost inflation was not to be felt right away. Some of the initial positive attitudes about government compulsion may have been a consequence of this early lack of results, perhaps giving rise to a view that the solution might have to be imposed across the board. In the meantime, companies persisted with other private strategies—shifting costs to workers and retirees, promoting “employee wellness,” and the like.(Crenshaw 1992; Freudenheim 1992; Pear 1993b; American Business Publishing 1994).

By 1991, although health care costs were still rising, the rate of inflation had begun declining. Private strategies were probably starting to work, though not yet to a degree that

recommended optimism. Meanwhile, in 1991 the economy had begun slowly building steam before Clinton even took office. The first economic indicators and manufacturers' sales improved, and firms were beginning to sell and produce more by the end of 1991 (OECD 1999:23). In the quarter after the formal introduction of the Clinton Plan in November 1993, manufacturing capacity utilization, which had hovered around 79 percent since early 1988, began to increase significantly. It rose above 84 percent by the summer of 1994, by which time the reform momentum was spent (OECD 1994:29). The job market had finally showed real improvement in the course of 1993 while the legislation was being drafted (Census Bureau 1998:403). Some of the improvement can be attributed to the decline of the dollar against Western European currencies and most of all the Japanese yen, reducing the pressure on firms that faced international competition (Bureau of Economic Analysis 1999: table 2A; OECD 1994:38). Finally, the passage of NAFTA gave American businessmen all the more reason to see fair weather ahead, and to the extent it did, Clinton's free trade agenda may have undermined progress on the health care front.

With the American economy returning to health in 1992, things turned even brighter in 1993, a turning point for health care costs. Of enormous political significance was the fact that growth in employers' share of all health costs actually went below zero in 1993 (Freudenheim 1995). At the beginning of the year the *Wall Street Journal* reported an unusually small increase in premiums for California state employees newly enrolled in managed care. Rep. Jim Cooper (D-TN), inspired by the fact that the California system "worked remarkably well within today's structure to deliver cost savings," would soon sponsor an alternative that many big employers were to find more attractive (Anders and Stout 1993).

Optimism about private efforts in 1993 was fully validated by a steady decline in costs in 1994. The yearly growth in overall premiums (charged to both employers and workers) for HMO-insured firms had fallen fairly steadily--from 7.8% in 1991, 6.8% in 1992, 5.3% in 1993, and then down to a modest 2.7% in 1994, the year that the Clinton Plan died (General Accounting Office 1997b:28). The picture looked even better for employers than workers, who

continued to see actual reductions in their share of those costs. San Francisco businesses reported in June 1994 that they were negotiating 5 to 10 percent discounts on health care with their new HMOs. The emerging managed care market in Houston made national headlines with projected savings of 25 percent and no government involvement (Hilzenrath 1994).

In short, the Clinton administration and congressional reformers were proposing remedies for a problem that was already solved, at least for the time being. As John Welch Jr. chair of General Electric put it to the media in May of 1994, “The system is now getting under better control” (Rogers 1994).<sup>2</sup> With deflationary trends in employer costs so strong that they would continue into 1995 (Freudenheim 1995; General Accounting Office 1997b:28) big employers had every reason to think that government efforts would bring no benefits and only risks. For them it was smooth sailing; for demoralized reformers like Senator Durenburg, it was “swimming against the tide.”

*Death by Disinterest.* While public support for Clinton’s efforts softened throughout 1993 and 1994, there was never a strong rejection of reform in principle (Rushefsky and Patel 1998:234-242; Blendon et al., 1993; Blendon et. al., 1994). Therefore it makes sense to puzzle, as does Theodore Marmor, about “why all the health care reform plans died in 1994 when the Clinton Plan disappeared from American politics” (Marmor 1999:458). If big business interest played an important part in propelling the issue onto the national agenda, and if the loss of interest helps explain the collapse of the Clinton plan, then Marmor’s puzzle is largely solved. Had big business remained interested, perhaps it would have helped finance a counteroffensive in the battle over public opinion, which opponents so ruthlessly dominated.

While businessmen were key activists in contemplating legislative initiatives (the NLCHCR, for example), there were no big new corporate initiatives after 1994. Activist firms retreated from the debates, and even Bethlehem Steel, which remained a supporter of the Clinton

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<sup>2</sup> A few business figures, in unionized, internationally competitive industries with the most aging workers and extremely large health care bills, remained; Bethlehem Steel held a press conference that day with labor and other executives supporting reform (Roberts 1999).

plan until the end, never bothered to contact politicians on the issue, all the while lobbying them on other issues like shipbuilding or steel imports (Pearlstein 1994).

Promising health reform efforts at the state level, in which businessmen played an important role, faltered at the same time as the Clinton plan did. Massachusetts and Oregon both passed legislation with employer mandates, but delayed their implementation until 1995, and ultimately abandoned them before that year (Paul-Shaheen 1998; McDonough 1992:61-2). Enthusiasm for the private solution took over completely. Large firms continued moving large numbers of employees out of traditional insurance into managed care in the aftermath of the national legislative struggle (Marquis and Long 1999:81). Exuberance for the private remedy even upset existing regulatory structures that had previously enjoyed business support. For example, deregulation occupied the 1996 legislative agendas in Massachusetts and New York, pioneers in regulatory control favored by big business groups. Legislatively imposed rates, payment or funding caps, or other intrusive regulation were abolished or severely weakened (Hackey 1998:90,133).

Of course as many analysts predicted, managed care was not likely to do much more than introduce a one-time reduction in costs, and perhaps at best counteract strong underlying causes of inflation. Indeed, the eerie calm that settled over employer health costs between 1994 and 1997 has been rudely disrupted. Recently health cost inflation has galloped ahead, by a factor of three, of general inflation (Mercer 1999b). One reason, perhaps not noticed by employers, is that managed care companies insurers competed voraciously over their business in the 1990s with unsustainably low prices. Recently their chickens have come home to roost as subnormal profits and declining stock prices are forcing charges to employers and workers back up.

Also, the surge into managed care has subsided, having reached a saturation point. Enrollment is actually now dropping. To the consternation of big employers, the political attack on managed care in the form of “patient rights” bills in Congress and state legislatures has pressured the health care industry to relax some of its more stringent practices for holding costs down. Organized labor, in a major historical turnaround, has shifted sides from being an

advocate of managed care to an ally of physicians against it. Meanwhile, aside from political efforts to defend managed care, employers have nothing much more left in the way of private solutions to hold the line on costs. Passing more costs on to workers is for the time being difficult, given labor shortages. The best they can do is expansion and improvement of employee “health and well-being” programs, although even there the saturation point is being reached. Today a huge 90% of all worksites in the U.S. are now sponsoring at least one health-promoting activity, with virtual all senior managers citing health care costs as the reason (Mercer 1999a; 2000).

The recent resumption of health cost inflation for employers raises the following question: Can a new coalition with big employers be forged? One would have to answer pessimistically, at least about a coalition around something like the Clinton plan. It had assumed a basic bargain: competitive mechanisms and cost shifting would hold down costs enough to pay for universalism. This bargain entailed three assumptions. First, it assumed that competitive mechanisms for cost control had to be imposed by government. Second, it assumed that a compulsory system was necessary to save big employers money by shifting costs that were traditionally shifted onto them onto other payers. These included costs for care received by the indigent uninsured, early retirees, and dependents—and costs for the medical education system, which combines care with instruction, making the care more expensive than otherwise. Third, it assumed that competitive forces imposed by government, once harnessed, would keep medical cost inflation down to low levels.

By the end of the 1990s, however, none of these three assumptions appear to hold. A truly revolutionary transformation of the system, incorporating far-ranging and ruthlessly competitive processes, had been carried out without government compulsion. A great deal of cost shifting has been accomplished through private competitive mechanisms. Now costs are rising again. The prospect of government imposing an even more rigorous system of competitive mechanisms is remote. Indeed, it is politics—a broad-based alliance of political forces for patients’ rights—that is undermining some of the private market controls.

Thus the chances of a cross-class coalition brokered by liberal and centrist reformers in favor of universal health care on the Clinton model are effectively nil. Without a convincing model for cost-containment that requires government and universalism, firms will continue to favor private health care mechanisms, especially in tight labor markets making recruitment and retention difficult. Single-payer systems, of course, face powerful political opposition from the business community. Businessmen regard democratically elected politicians as too weak and unreliable to withstand political pressure for benefits and protections that will increase costs. By delaying passage and therefore ensuring the death of the Clinton plan, opponents of reform closed a window on an unusual opportunity to establish a universal health care system in the United States. It also closed the window on that model of business-government cooperation in health care.

*Conclusion* A highly influential school of thought about the repeated failure of national health insurance in the U.S., implicitly comparative in nature, focuses on the nature of American political institutions (Steinmo and Watts 1995; Skocpol 1997). In this view, echoing the conclusions of British observer James Bryce in 1893, movements for progressive and egalitarian reform in America lose energy and cohesiveness as they scrape and fracture on the rough terrain (the “veto points”) spread out across this vast country’s political system. “There is an excessive friction in the American system, a waste of force in the strife off various bodies and persons created to check and balance one another.” In short, “Power is so much subdivided that it is hard at a given moment to concentrate it for prompt and effective action” (Bryce 1893:1:302). There is much to be said for this argument, and research on other countries is highly persuasive in showing how constraints on political executives has slowed health reform (Immergut 1992). If it had been entirely up to American presidents like Roosevelt, Truman, and even Nixon--and governors like Alfred E. Smith, Earl Warren, and Michael Dukakis--this country’s health care system would look a lot different than it does today..

Institutional conditions no doubt gave enormous and fatal stalling power to health care’s

opponents in the 1990s. However, it must be remembered that other major welfare reforms have passed in this country despite the same institutional obstacles. Social Security in the 1930s and Medicare and Medicaid in the 1960s are the most important cases in point. Circumstances surrounding those reforms give rise to the suspicion that the favorable interests of big business may be what is necessary to overcome those obstacles. The evidence touched on here about the New Deal support that suspicion. In the case of Medicare, the fact that big employers did not rise up in effective opposition may mean more than that they were intimidated by the magnitude of public and congressional opinion. At the time, they faced the looming problem of an aging workforce whose medical coverage would disappear upon retirement. Distributional conflict between employers and unions on the issue of retiree coverage, and indeed within the unions themselves between young and old workers was inevitable. By displacing the distributional conflict into the political sphere, unions gave big unionized employers reason to breathe a sigh of relief, for it shifted large looming costs onto broader shoulders. A tacit cross-class coalition therefore, we hypothesize, may have helped passage of Medicare.

Looking at the events of the 1990s in historical perspective as we have done therefore makes it all the more plausible to believe that reform could have passed with big business support, despite institutional obstacles. The analysis suggests that the opportunity will not arise again except under unusual economic and political conditions. History suggests that might involve severe economic crisis, further reductions in coverage hitting large parts of the politically efficacious population, and highly skillful political entrepreneurship. It would not hurt if the American Medical Association and other physicians' associations finally spent some money and energy on public promotion of reform, now that they have left their historical opposition to compulsory measures behind them. Executive and congressional leadership will need to be highly innovative in designing reform that somehow helps employers cope with the crisis while also expanding coverage to the uninsured. It will need therefore the "cautious reformer" too, like Edwin Witte, whom FDR brought in to direct legislative drafting efforts for the SSA. Witte's advice would be to take extra care and keep an eye on the interests of big business (Witte 1935:8;

Schlabach 1969: 123; Swenson 1997).

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