Abstract  This article addresses the potential role of business leadership in diverse efforts to reform health care financing: exploring managers efforts to alter health care markets in their role as large purchasers of health insurance, their potential contributions to future national policy proposals, and their involvement with community-level activities to control local health costs and quality. I argue that managers’ leadership in market restructuring and community health initiatives will be difficult to reproduce in the realm of major national health policy initiatives due to constraints related to ideas, interests, and organization.

Business and Health Care Financing in the Twenty-First Century

At times it seems easy to forget what decade we are in, because in some rather odd ways the early twenty-first century resembles the early years of the 1990s. Once again we are veering toward war with an Islamic country—once and again the overheated stock market has faltered. The president is named George Bush, and ten years after Bill Clinton ran for president promising national health reform, doomsayers are predicting calamity for the health system. As the incomparable Yogi Berra so succinctly put it, “It’s like deja vu all over again.” At other times these easy comparisons with the past decade seem sanguine, as many conditions in our post–11 September world are far worse. Ten years ago airline pas-
sengers from Boston to Los Angeles would not have wondered about their chances for survival. Ten years ago a comprehensive overhaul of the health system seemed irrefutable to those naïve enthusiasts (mea culpa) who so desperately desired rationalization of a system veering out of control. Yet few are now making such rash predictions.

Central to the optimism about the inevitability of national health reform in the nineties was the anticipated support, if not leadership, of at least some employers. Business managers would recognize the economic benefit of health reform, persuade moderate Republicans and Southern Democrats of its efficacy, and shift the political balance of power in favor of the reform coalition. Thus I wrote (Martin 1993: 360), “In a remarkable reversal of fortune, national health reform has become associated with keeping costs down rather than driving them up. As a result . . . some businessmen are at the forefront of the latest national reform effort” (see also Peterson 1993).

The unenviable task now before us (in an older, sadder-but-wiser world) is to consider possible avenues for reforming the health financing system through market, national policy interventions, and community coalitions to restructure local markets. This article addresses the potential role of business leadership in these diverse efforts to tame the tar baby that is the health care system. I explore how managers are changing health care markets in their role as large purchasers of health insurance. I consider what employers’ might contribute to future national policy proposals, questioning whether managers are likely to participate in a movement for comprehensive health reform, or whether as in the nineties employers will ultimately stop short of engagement with comprehensive health system overhaul. Finally, I consider the community-level activities of business leaders in trying to control local health costs and quality.

I argue that managers today are very involved with market restructuring and community health initiatives, albeit with somewhat different consequences. Companies’ struggles to contain costs have driven significant market restructuring in the form of loose managed care arrangements that often are neither well managed nor particularly caring. As James C. Robinson argues in his article in this issue, managers’ short-term incentives to save money may in fact have contributed to a longer-term escalation of costs and fragmentation of risks. Employers’ involvement with community coalitions to bring about local quality, cost control, and access in health care have often had more sanguine results; yet the success of regional coalitions has varied widely.

Yet expecting employers to lead in major national health policy initia-
tives may be unrealistic. In particular, three major constraints work against business leadership in a national comprehensive overhaul of the health system: problems related to ideas, interests, and organization. First, are problems related to the ideas of health financing reform and, in particular, the issue of achieving consensus on a specific solution. Ten years ago managed competition appeared to be the silver bullet that would fire health reform forward. Broad support for the idea ultimately broke down at the detail level; indeed, this was a large part of health reform's ultimate demise. But in the early days of health reform, the power of the idea gave the project political momentum.

Today, in wondering whether employers will lead, we must ask, “lead to what end?” This question is far from settled at the moment. As I demonstrate later in the article, the health policy universe is not even aligned on the primary goal of reform: government policy makers have been largely taken up with the regulation of managed care and with expanding access to the neglect of cost controls. Managers have been largely concerned with quality and firm-level cost controls and have been less involved in thinking about access.

Another issue in the realm of ideas has to do with employers’ attitudes toward government intervention. Business managers tend to be less than enthusiastic about state intervention under the best of circumstances, but there was a certain ideological openness to government intervention in the early Clinton years. Yet the Clinton failure left legacies for policy entrepreneurs and business managers alike (Hacker and Skocpol 1997: 317). When national health reform was rejected by Congress, many large employers who had initially supported the initiative felt that they got burned and are now reluctant to endorse nonincremental change again (Martin 2000).

Second is the problem of fractured interests among employers. Before the Clinton legislative cycle it seemed possible to resolve employers’ conflicting interests in health care financing. Yet the Clinton effort exposed the stark divisions among firms: those with large retiree commitments had very different interests from those without. A mandate was not a problem for those firms already paying for health benefits but was bitterly opposed by those that did not fund their workers’ health care.

Third are problems with the organization of the large employers, who have traditionally shown an interest in reforming the health system. As I argue elsewhere (Martin 2000), large employers are more poorly politically organized in this area than the small business and provider interests that have opposed reform efforts. The Clinton effort made painfully appar-
ent the weaknesses of the organizations that purported to organize large employers in the health care area.

In addition, during the Clinton campaign the much better organized small business community became politicized over the health issue. For example, the National Federation of Independent Business (NFIB) and other powerful small business groups allied themselves with for-profit providers and insurers in opposing a comprehensive reform measure. This group has stayed active in health reform battles, most recently opposing the patients’ rights legislation.

**The Current State of Health Care**

A prerequisite for evaluating potential business leadership is understanding why employers might be worried about the health financing system. For a brief period in the 1990s employers experienced guarded optimism that managed care would do what no private sector interventions had been able to accomplish before—restrain health costs. Yet this optimism dissipated as public dissatisfaction grew with the managed care option and as health spending began to inch up again. Health spending had come to claim 13.2 percent of the GDP by 2000, with the private sector responsible for about 55 percent of the total (Levit et al. 2002: 172). Employers certainly felt the pinch of rising health costs: premiums increased by 11 percent in 2001, 12.7 percent in 2002, and are expected to go up by 15 percent in 2003 (Abelson 2002). Hit especially hard, small employers saw their costs increase almost 20 percent between 1998 and 2000 (Fronstein 2002: 188). The backlash against managed care became newsworthy when it was discovered that public opinion came to rank these companies beneath oil firms (Morone 1999; Blendon et al. 1998). By 1998, four-fifths of Americans viewed managed care reform as a top-priority issue (Jacobs and Shapiro 1999: 1023.)

Corporate purchasers are a major part of health care delivery and a key stakeholder: consumers of health look to them for guidance, and it is natural that we might expect this group to provide leadership (Bergthold et al. 2000; Hacker forthcoming). Yet the steep increases in health costs may force many firms to stop providing benefits. Ray Werntz (2001) worries that if enough companies stop providing benefits, the entire employer-based system may collapse. The uninsured already predominantly come from the ranks of workers—only 15 percent are unemployed. If business managers hope to influence the policy solutions, they need to participate
in the discussions. Brian Klepper of the Center for Practical Health Reform (Klepper 2002) adds:

Cost increases are going so hard and fast that employers are up against the wall. . . . All employers should expect a 5–8 percent hit above premium hits in October due to stress-related conditions linked to September 11. Employees are doing a lot of preemptive things because they fear the loss of their health benefits in the future. . . . The health care system is going to go into free fall.

Many managers are also concerned about the growing ranks of the uninsured. For a period in the past decade, the booming economy and tight labor markets gave one the sense that access to health care was slowly expanding. The uninsured percentage of the population fell in both 1998 and 1999 (Fronstein 2002: 188). Yet more recent indicators have been less sanguine: the recession and jobless recovery of the past year seem to be expanding the ranks of the uninsured again. The group CoveringTheUninsured.org (2002) estimated that two million Americans lost their health coverage in 2001 alone, representing the largest increase in a decade and bringing the figure up to nearly forty-one million without insurance. The State Children’s Health Insurance Program (SCHIP) has been a bright spot in this picture by helping states to fund low-income kids; for example, many states have made these children eligible for Medicaid. Yet there has been a low participation rate in the program in many low-income communities. Ideally there should be very few uninsured children left in America, but in reality a large share continue to go without coverage (Cunningham 2001).

Managers’ concerns about the continuing viability of medical coverage are also linked to their interest in human capital investment. Human capital investment in the training, health, and work/family areas are said to improve productivity, turnover, attendance, and job performance. Wellness programs and other benefits that improve the physical and mental functioning of workers affect job performance and absenteeism (Bertera 1990; Shephard 1986). Cost-benefit analyses of workplace health promotion programs demonstrate positive returns on investment and benefits in areas such as productivity and absenteeism (Golaszewski 1992; Warner et al. 1996). Because health benefits are important to workers, they affect job satisfaction, which in turn influences organizational commitment and turnover (Davis and Ward 1995; Tett and Meyer 1993; Barber, Dunham, and Formisano 1992). Health benefits have implications for economic
growth in a more systematic way: the high costs of U.S. health provision add to the price of U.S. goods, thus hurting companies’ market positions (McNerney 1990; Altman, Goldberger, and Crane 1990). At least some believe that the high costs of health benefits reduce available resources for other company needs such as training and investment in research and development (Brailer and Van Horn 1993: 128).

Employer Efforts to Restructure Health Financing Markets

As major purchasers of health insurance, large corporations have in the past driven profound changes in health care markets and are likely to continue to play this role. Company efforts to contain costs fall into three categories: managed care, cost shifting, and defined contribution plans.

In the past decade firms have exerted leadership in restructuring the private health insurance market through the use of managed care plans, the intervention of choice for companies throughout the 1990s. For example, Sears launched a huge campaign, resulting in 87 percent of its employees being covered by managed care plans by the end of the decade (Ioma’s Report 2001). Yet many critics feel that this industry-led market restructuring has failed to achieve its promise. The managed competition concept developed by Alain Enthoven and others rested on the assumptions that consumers would make wise decisions about their health plans if they were given choices and adequate information about these choices, and if the firm limited its contributions toward these varying choices. Under this approach the company sponsor establishes a level playing field to allow consumers to make informed decisions. But as James Maxwell and Peter Temin (2002) point out, firms stopped short of endorsing this managed competition approach, preferring instead to use industrial purchasing of health care as with other inputs into the production process. Under the industrial purchasing model, companies use their economies of scale to negotiate highly favorable rates with a couple of managed care plans and encourage their employees to join these company-selected plans. Thus, firms rather than consumers maintain control: firm negotiations are responsible for reducing the costs of health care for employees. Choice of health plans is kept limited, as firms hope to gain economies of scale in health; in addition, firms do not want to leave health choices up to the consumer-driven health insurance because they link health to productivity concerns. Somewhat ironically, where the managed competition approach promised to increase consumer choice, managed care has served to limit consumer
choices over providers and insurers. At the same time, firms have abandoned the traditional HMO model with its prospective capitation payment, focus on prevention, and comprehensive benefits. Instead, most employers have endorsed PPO and other soft managed care plans with retrospective, fee-for-service payment and thin benefits with large deductibles (see Robinson, this issue).

Although managed care seemed to be the key to stopping the rising costs of health care, the market became saturated by the end of the past century, and firms ceased to see significant savings in their managed care plans. One study found that 92 percent of people in job-based plans were in a managed care plan (Prince 2001). Given this high level of market penetration, managed care plans began changing their strategies by offering less-restrictive plans with more choice, negotiating less-adversarial relations with providers, and shifting the focus from expanding market share to increasing profitability. Although in 1996–1997 there was intense price competition among HMOs, 2000–2001 saw premium increases of 11 percent on average for HMO products (Draper et al. 2002). In part this may reflect the consolidation movement that has transformed the group health insurance industry in recent years. Now with only a few insurance companies to choose from, employers have lost much of their leverage power to negotiate lower rates (Dutton 2001).

With the erosion of savings in managed care, employers have more recently moved to cost shifting. The high costs of health care seem due in part to the irrationality of the medical financing system. Unlike other markets, where price is arrived at by the interplay of supply and demand, the health market is distorted by the presence of a third party, the insurer. This market failure releases the consumer’s demand from the constraints of price. Thus, employers have sought market changes to make their workers more sensitive to health choices through cost shifting. Yet a Health Affairs Community Tracking Study found that few employers have increased premiums to their employees, in part due to the competition for labor in the tight labor market. Indeed, the employees’ share of single-coverage premiums dropped from 21 percent to 14 percent from 1996 to 2000. Firms are, however, engaging in more subtle forms of cost shifting: by increasing co-pays and deductibles and decreasing pharmacy benefits, such as implementing a three-tiered pharmacy benefit in which generic prescription drugs are cheapest (see Trude et al. 2002).

Finally, a few (but very few to date) firms have developed defined contribution plans and other consumer-directed forms of financing health care. A 2001 Hewitt Associates survey found that although only 22 per-
cent surveyed were considering a defined contribution plan, half were interested in offering plans that gave employees greater control over options. The employers were motivated in this regard by concerns about cost control (85 percent), a desire to empower employees (70 percent), and a desire to limit liability (30 percent) (Hewitt Associates 2001).

With defined contribution plans, a firm specifies how much it will pay toward premium coverage and allows workers to choose from a variety of high- and low-cost offerings that are usually described in detail on the Internet. Typically part of the firm’s contribution to the worker’s health care is placed into a medical spending account, from which the employee could draw to fund health needs beyond the major medical insurance that the employer provides (Christianson, Parente, and Taylor 2001). Technology has made this increased focus on individual responsibility possible, as the Web offers a wealth of easily accessible data in as much detail as the consumer can tolerate. In seeking to move beyond a flex-plan strategy, the defined contribution approach allows workers to choose either one of the official company-sponsored plans or another option altogether. The philosophy underlying this approach is that asking employers to pay for part of their premium out of pocket makes them more cost conscious and motivated to choose the plan that best fits their individual needs. From the employee’s perspective, what one loses in terms of coverage, one gains in terms of choice. Yet the most troubling aspect of the approach is its transference of liability from the employer to the employee. In a fully developed defined contribution plan, the firm loses all incentives to restrain the growth of premium costs as well as the responsibility for ensuring that its employees are insured (Sullivan 2001). The employee may not be able to grasp fully the nuances of the plan and loses an important health care advocate (in the form of the company benefits manager). Indeed, part of the reason why these plans have not yet been picked up is that with the tight labor market, firms do not want to alienate workers and workers do not want these plans (Dutton 2001). In addition, defined contribution plans threaten to fragment the risk pool even more than ever (Stone 1999).

Large corporations to date have been constrained in cost shifting and insurance restructuring by tight labor markets and a desire to retain productive workers. Yet workers’ share in deductibles rose by more than 30 percent in 2002, and fights over health benefits are at the center of current collective bargaining rounds (Uchitelle 2002: 18). If economic malaise continues to strangle the American economy, we may see firms opting out of health care benefits altogether and greater cost shifting by employers.
Employers and National Policy Solutions

Shifting the health burden back onto workers has costs for firms; therefore, companies might also try to alter the health financing system through national policy change. Indeed, one wonders (given the reputed power of corporate America in public policy) why the major corporate purchasers of health insurance have not demanded that government bring the health financing system under control.

The first factor working against policy demands from employers has to do with uncertainty about policy solutions. There is simply no consensus about the best solution to health financing problems or the appropriate direction for public sector leadership in this area. As Joseph White points out in this issue, many problems have no technical solution, and this deficit of ideas is a major roadblock to current health reform. In the early 1990s there was a happy confluence between private sector efforts to restrain health costs in the form of managed care and the managed competition policy proposal. Thus, national health reform proposals attempted to build on what was already occurring in the marketplace; the consolidation of consumers into health alliances seemed compatible with the consolidation of patients into managed care.

Yet today efforts to improve the health care system and its financing are all over the map, and private firm activities tend to be quite separate from the legislative efforts of the national government. As Table 1 illustrates, employers play a greater or lesser role in the variety of types of reforms. The dimensions of health reform cut along two lines. First is the question of venue: public versus private initiatives. Are activists trying to change private plans, or are they trying to implement changes through public sector legislation? In the public sector these changes can be located at either the federal or state level. The second dimension is one of the reform’s intended goal. Reforms may be targeted toward lowering health costs, increasing access to health benefits, or improving the plans themselves.

As becomes quite clear when looking at Table 1, there has been limited overlap in reform efforts between the private and the public sectors in recent years. Whereas during the early 1990s both sectors shared the goal of containing health costs, and to some extent of increasing access as well, today public and private actors are pursuing fairly different ambitions. This is a problem: leaders need followers, and the first step is agreeing on the goals.

The irony is that while private firms and coalitions have largely focused
on cost controls and quality concerns, the national legislative process has focused almost exclusively on quality and access with little attention to costs. According to some critics, the primary congressional vehicle for improving quality, the patients' rights legislation, has so over-regulated managed care that these insurance products can only fail (see Robinson, this issue). The initiative does little to expand access, as employers may be forced to reduce or to discontinue their benefits, and the bill does little to expand coverage for the uninsured (Wechsler 2001: 11). In Deborah Stone’s (1999: 1214) elegant words, “While all the political energy swirls about these reforms, the politics of universal insurance has been buried in the dust.”

Consequently, the patients' rights legislation has virtually no corporate supporters, accomplishing something that other health policy proposals have failed to achieve by unifying nearly everyone in the business community—albeit against it. A red flag for employers in this legislation is that it allows consumers to sue health plans and, at least in some versions, to sue firms as well. Employers fear that the legislation will greatly extend their liability by permitting these lawsuits and object to other provisions such as proposed regulations demanding parity between physical and mental health benefits. In one Hewitt Associates (2001) survey, 70 percent of those queried felt that this type of legislation would drive up costs. Robinson (this issue) sees culpability on both sides: while the public sector has engaged in microregulation, private employers have continuously searched for new ways to isolate their employees from the sick and uninsured.

Comparing business opinion polls about national health reform and

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Table 1 Goals of and Venues for Health Reform
patients’ rights gives one a sense of how deeply ingrained corporate opposition is to the legislative health efforts of the past few years. A 1991 Harris poll found two-thirds of its corporate sample at least somewhat accepting of a mandated standard benefits plan (“Leaders Look at Health Care,” 1991). A National Association of Manufacturers (NAM)-commissioned study showed 55 percent of NAM members favoring a play-or-pay approach (complete with employer mandates) as part of overall system reform (Foster Higgins/NAM 1992). In comparison, the Health Benefits Coalition (1999c) claims that in surveys about the potential passage of legislation allowing workers to sue their employers, NAM found that 38 percent of its members would cease to provide health benefits, and the Chamber of Commerce found 65 percent of their members threatening to do the same.

The other government legislation has been focused on expanding access. Most significant in this area has been SCHIP, legislated to expand access for low-income children. States can choose to cover kids through their own program or through Medicaid—a $2.8 billion program in 2000 (Levit et al. 2002). The Republicans have proposed expanding access with a tax credit scheme for uninsured workers. These proposed numbers are sizable; for example, the recent Bush proposal would total $89 billion over the coming decade (Goldstein 2002). Yet this approach does not include obvious cost control mechanisms.

A second constraint working against an easy solution to the problems of the health financing system is that business interests vary significantly across and even within sectors. The Clinton reform cycle demonstrated the difficulty of reconciling complicated interests and this continues to be the case. Firms that derive profit from the health care industry have a different perspective on cost control than do those in other sectors. Firms offering extensive benefits resent additional imposed surtaxes to pay for the uninsured; however, companies without benefits programs (and with a substantial share of uninsured workers) have limited financial incentive to seek changes in these taxes. Many large manufacturing companies that provide benefits want to end cost shifting and to protect the Employee Retirement Income Security Act (ERISA) preemption for their own private plans. Yet this group contains marked differences in interests between those firms with extensive commitments in retiree benefits and those without (Martin 2000; Judis 1995). Employers as a group may want cost containment, but as individuals they each want to preserve their market power. Reforms that alter the distribution of health costs created new winners and losers.

Since the rise and fall of national health reform, interests have become, if anything, even more complicated. For a brief period during the latter part of the past decade, it seemed as if the zero-sum conflicts in health
reform might be reconciled. Starr 2000 argues that the new economy, rapid economic growth, and budget surpluses—combined with the transitory successes of managed care—enabled policy makers to decouple proposals for expanding access from measures for cost containment. Thus in 2000 Bradley, Gore, and Bush all had proposals to expand coverage unconnected to cost containment. This perspective also explains the aforementioned phenomenon: why business and government actors are working on such different tracks. Yet times have changed since September 11. Budgetary constraints are back with a vengeance, and it seems likely that any efforts to expand access will require cost controls as well.

A final factor working against business leadership in creating public policy changes to the health financing system is the fragmented organization of large employers and the superior political power of small business inside the beltway. As I argue elsewhere (Martin 2000), national business organization in the United States is extremely fragmented, and large firms especially lack an organizational forum to consider their collective interests. Many voices claim to speak for business: firms are increasingly speaking for themselves on policy issues, the umbrella organizations compete with one another to represent employers, and there is not an obvious leading business group to organize large firms in the health area.

The absence of a centralized organization to aggregate firm interests creates a least-common-denominator politics. The big umbrella associations such as the Chamber of Commerce, the National Association of Manufacturers, and the Business Roundtable are the most likely sources of centralized thinking and planning among business leaders. But these groups compete for members and are, consequently, risk-adverse and unwilling to alienate anyone with controversial stands. Lacking jurisdictional monopoly, these groups act more like sales organizations than like decision-making bodies, defer to vocal minorities and neglect the sentiments of the more silent majority. The art of offending no one leaves big business groups in a kind of political limbo, in which they voice short-term objections rather than endorse positive policy change. Thus, this weakness in the political organizations representing employers makes it difficult for American managers to generate collective positions and to take collective action for shared common goals (Martin 2000; Wilson 1986).1

1. These constraints typically do not affect action toward the narrowly targeted self-interests of companies. In areas where a few large firms or even sectors have very direct economic interests, producers tend to dominate the policy process. But where a wide spectrum of companies shares a broad collective goal, employers are hard-pressed to find common ground.
Included in the unique profile of American business representation is the political power of the small business trade associations that have managed to move beyond a least-common-denominator politics. Small business (and here I mean the primary small business trade associations that are referred to as the small business lobby in the popular press) is a political powerhouse in Washington today. The fragmentation of business organization in the United States has meant that large employers have never been able to force small business to acquiesce to modernizing economic and social changes (Freyer 1992). Small employers in America have always enjoyed a strong political voice that large firms have been unable to quiet, and with the rise of groups such as the NFIB, this voice has grown louder in recent years. To some extent, small employers have an easier task of wielding political power in Washington because it is easier to oppose than to promote. But small business groups also have unambiguous organizational advantages over large firms. Small business groups are better able to play to the media; for example, small firm proprietors were found credible by 71 percent of journalists in 1982 but only 50 percent believed CEOs of big corporations (Brown, Hamilton, and Medoff 1990: 73). The well-heeled corporate lobbyist who wields power behind closed doors lacks the television charisma of hundreds of restaurateurs storming Congress. Innovations in computer technologies have augmented the advantage of small business groups: grassroots computer mailings first made popular by public interest groups are perfectly suited to their large and varied membership (Martin 2000). As Mark Peterson (2001) points out, small business groups also benefit from having members in every state, adding up to an omnipresence in Congress.

Small business groups have also developed organizational decision rules to augment the natural advantages of a broad-based, numerous membership. The NFIB avoids the least-common-denominator politics of larger umbrella groups by grounding policy positions in regular membership polls (NFIB 1995). The largest small business groups have enhanced their power with single-issue coalitions. Large employers sometimes join these coalitions; for instance, PepsiCo was an important actor in the Health Equity Action League (HEAL) to defeat the Clinton health plan. But such groups as the National Federation of Independent Business, the National Association of Wholesaler-Distributors, the National Restaurant

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2. Although small firms are a varied lot, the primary trade associations in the small business lobby, such as NFIB, generally reflect the interests of low-wage, low-skilled enterprises rather than small high-technology companies.
Association, and the National Retail Association are typically at the core of these coalitions and are the leaders in organizational efforts. Coalitions evolve because employers feel dissatisfied with the limitations of the umbrella associations’ least-common-denominator politics and believe that a new forum dedicated to a single issue can make tougher decisions. They are usually organized to address a single issue and to influence a specific bill, although some outlast their precipitating legislative initiatives. These single-issue coalitions have an explicit mandate to take political stands and have no other reason for existing; therefore, they cannot afford to slip into inaction. Also, coalitions find it easier to take action that might alienate potential members because only one issue is involved. Thus the major small business associations have been able partially to overcome the least-common-denominator politics that handicaps much of the other business sector (Martin 2000). These coalitions have also gained power in their close connections to the Republican party; indeed, small firms are closer to the party than are large employers (“Big Business vs. the GOP?” 1995).

One sees the themes of poor organization of large employers and much better organization of small businesses continuing to play out in the various national policy debates about health care financing today. Indeed, to some extent the fault lines established in the Clinton reform battle continue to shape employer engagement, with the exception that large employers are perhaps even less organized than they were ten years ago. Those managers concerned about escalating health costs do not have one primary organizational home, although several organizations and groups are searching for solutions to concerns about cost controls, financing, quality, and access. In comparison, the small business groups that in conjunction with insurers and for-profit providers defeated health reform continued to have a vivid Washington presence in the patients’ rights debate (with some backing from large employers as well) and are likely to remain an important force in future legislative battles. Indeed, large and small employers have moved in somewhat different directions, with small employers remaining strongly focused on (and usually opposed to) governmental efforts to legislate public policy. Managers from large firms have been taken up with enhancing quality measures in national and community levels and discussing in various strategy groups cost control mechanisms such as defined contribution plans.

The political coalition developed to fight patients’ rights legislation, the Health Benefits Coalition, is a direct descendant of the coalition of small business managers and private health care providers that defeated national
health reform, the Health Equity Action League. But the Health Benefits Coalition has a broader reach than does the Health Equity Action League, because the patients’ rights legislation has been able to achieve a remarkable unity in the business community—everyone is against it. So the Health Benefits Coalition at least in the past could boast the Association of Private Pension and Welfare Plans and the Business Roundtable in its membership, as well as the usual suspects. The Health Benefits Coalition is chaired by Dan Danner (of the NFIB) and includes health groups, such as the American Benefits Council and the Health Insurance Association of America; major small business groups, such as the National Association of Wholesaler-Distributors, the National Restaurant Association, the National Retail Federation; and the umbrella business associations—the National Association of Manufacturers, the Chamber of Commerce, and the Business Roundtable.

The Health Benefits Coalition has repeatedly mobilized to hinder the legislation of patients’ rights legislation and to seek changes limiting employers’ liability. An advertising blitz in the summer of 1999 focused on recent Congressional Budget Office predictions that the Kennedy-Dingell bill (which expanded patients’ rights to sue their health plans) would increase premiums by 6 percent (Health Benefits Coalition 1999a). When a bipartisan offshoot, the Dingell-Norwood bill, was announced in August 1999, the coalition called the measure “The Health Insurance Elimination Act” and predicted that it would leave millions of additional individuals uninsured (Health Benefits Coalition 1999b). In September 2000 the group announced the initiation of a $1 million ad campaign against the Dingell-Norwood-Kennedy bill.

In comparison, the most visible organization for large employers at the national level is the Leapfrog Group, which focuses on the improvement of the quality of health services. The group sprang to life after the Institute of Medicine produced an alarming report in November 1999 that pointed to a chasm in the quality of hospitals. According to the report, between 44,000 and 98,000 hospital patients die yearly from preventable medical errors, with these errors costing between $17 billion and $19 billion a year (Kohn, Corrigan, and Donaldson 2000). The Leapfrog Group was organized by the Business Roundtable and includes the major purchasing coalitions, as well as a number of Fortune 500 companies such as AT & T, Bethlehem Steel, Caterpillar, DaimlerChrysler, Eastman Kodak, Ford, General Electric, Honeywell, IBM, LTV Steel, 3M, Motorola, Siemens, and Sprint. Many of these firms were active in encouraging Congress to consider a comprehensive overhaul of the health system ten years ago.
The group reasons that employers can use their purchasing power to increase consumer knowledge about health care providers and, thereby, to improve safety. Leapfrog members are urged to encourage the referral of patients to hospitals that have the best survival odds, that staff intensive care units with doctors having credentials in critical care, and that use error prevention software to prescribe medications. Thus the Leapfrog Group seeks to deal with some of the same issues as patients’ rights legislation but suggests that the prevention of medical mistakes can be achieved through the power of the marketplace rather than with the threat of a law suit.

Recently several groups have formed to work on costs control, although none can claim the title of a clear leader in this area. The Wye River Group on Healthcare was created to promote patient-driven health care benefits, especially defined contribution plans. The idea behind defined contribution plans is to reinterject consumer sensitivity back into health spending decisions.3

The Center for Practical Health Reform was formed as a nonprofit, nonpartisan group to brainstorm about and to advocate for national health reform. The group draws members from health care providers and consultants, insurers, and employers. Executive Director Brian Klepper is a health consultant, and the group includes employers such as Southwest Airlines, Dupont-Dowell, Wal-Mart, Microsoft, and Medtronic. Members have agreed upon goals of universal coverage, choice, retaining the private health care system, quality enhancements, and a desire to develop pragmatic changes that will improve the existing private-sector system. The group hopes to do roundtable discussions around the country to foster discussions on possible solutions (Klepper 2002).

Finally, a few recent groups with at least some business representation have formed to think broadly about access issues. The best known of these groups is CoveringTheUninsured.org, a “strange bedfellows group” that was partially funded by the Robert Wood Johnson Foundation with leadership by Families USA and the Health Insurance Association of America (HIAA) to raise public awareness of the problems of the uninsured. But to date the group has generated very little consensus about the appropriate policy directions for reducing the ranks of the uninsured, beyond a few incremental measures. Although the group’s thirteen members all

3. The group is chaired by John Comola, with additional direction offered by Marcia Comstock, previously of the Chamber of Commerce, and David Kendall of the Progressive Policy Institute. The Wye River Group on Healthcare can be found on-line at www.wrgh.org.
agreed that something must be done and most indicated that they would prefer to retain the employer-based system, they remain deeply divided (along predictable lines) as to the appropriate solutions, and each has its own pet peeves. Thus the Chamber of Commerce and HIAA continue to oppose mandates, the AFL-CIO wants liability legislation for health plans, and so on (Wechsler 2002; Lovern 2002). One health policy consultant to large employers concluded in an interview conducted in March 2002, that although large firms are extremely worried about rising health costs, “they have no clear sense of direction . . . they are flailing but don’t have a plan . . . . There is no thinking about broader solutions in the business community.”

Business and the Politics of Community Health Reform

In addition to these efforts directed at the national policy level, many employers are working at the community level to control costs and to improve the quality of health care through purchaser coalitions. Community-based purchaser coalitions see quality and cost as inextricably linked: efforts to advance the quality of health care provision help to control costs as well (Fraser et al. 1999). Arising out of a concept developed by Alain Enthoven, these inventions sought to reinstate market rationality into the health system by aggregating corporate consumers. By banding together in purchasing coalitions, firms could leverage lower health rates with their greater market power and collect information about quality so that individuals could make better health decisions (Bergthold 1990). The coalition movement received early seed money from several sources. The Washington Business Group on Health, the Chamber of Commerce, and the Robert Wood Johnson Foundation all helped to fund the development of early coalitions (Craig 1985). In 1992, the Hartford Foundation gave $2.25 million in a three-year grant to the National Business Coalition Forum on Health, an organization that represents forty-eight member coalitions and was quite active in protecting the community approach in the legislative cycle (Health Action Council of Northeast Ohio n.d.). Initially coalitions sought to alter health costs, but they gradually targeted quality of outcomes as well.

Today many of these coalitions have given employers a significant presence in community efforts to pursue goals of quality and cost controls. The National Business Coalition on Health found in its annual survey that most coalitions have developed at least some tools for collecting data...
about the quality of local providers (whether or not this data is subsequently utilized). Some coalitions, such as the one in the Minneapolis–Saint Paul area, contract directly with providers (as health plan consolidation has reduced the leverage power of employers), and most have contracts linking financial incentives to performance standards (Fraser et al. 1999). An opposing view is offered by a study of Fortune 500 companies that found little use of quality data either in decisions about health plans or in being passed on to employees (Glascoff 2001).

Business efforts to improve quality, cost controls, and access have been quite successful in many communities. For example, the Pacific Business Group on Health (PBGH n.d.), representing approximately three million employees, has worked for years to alter the delivery of health services in California. The California business community was an important player in a task force to improve managed care delivery in the state; for example, urging that plans use scientific data in decisions about installing new technology and offer more standardized, consistent plans (Bergthold, Koebler, and Singer 2000). PBGH recently endorsed a new project developed by the Integrated Healthcare Association called Pay for Performance. With this project the state’s largest health insurance companies have promised to endorse common performance measures for physician groups and to reimburse physician groups based on their performance on these measures (Integrated Healthcare Association n.d.).

Foundations have also played a role in helping employers to become involved with community efforts to improve the access to, quality of, and price of health care. The Community Care Network Demonstration Program, sponsored by the Robert Wood Johnson and Kellogg Foundations, sought to promote public-private partnerships to improve the health of communities. Localities were given $300,000 grants to develop these partnerships in support of a wide range of health goals. Stephen Shortell and colleagues (2002) have found that those communities that created partnerships with a wider range of members (including health sector, government, social service, and business leaders) were more likely to achieve significant health improvements.

The Robert Wood Johnson Foundation (1999) also funded a $16.8 million program called Communities in Charge that seeks to expand access by helping communities develop “more efficient and effective health care services for low-income, uninsured individuals.” In Brooklyn, the Northern Brooklyn Health Care Consortium was formed to expand access to health insurance among small employers by developing an insurance product that small businesses could afford. The consortium includes com-
Community action organizations, the Chamber of Commerce, the local hospitals, and an insurer, Group Health Incorporated, that was chosen to offer the insurance plan. Brooklyn was a great place to begin this project because the city has a local tradition of community action. The premium is 50 percent lower than what small employers might otherwise pay and is designed to reach firms in which 50 percent of the employees earn less than $40,000. The premium is designed to be as user friendly as possible and to avoid competing with other plans. The community was involved with designing the product, and the organizers obtained funding from several sources: the Robert Wood Johnson Foundation’s program Community in Charge is helping to subsidized the medical administrative costs of the plan, the foundation’s Community Access Program is subsidizing the prescription drugs administrative component, and the local hospitals are giving the consortium an extremely competitive rate. The hospitals have been extremely motivated to participate, as they hope that the program will insure many of their currently uninsured patients (Gaeta 2002). The Midwest Business Group on Health (MBGH) and the Chicago Business Group on Health recently sponsored a conference for employers on dealing with the state’s 1.8 million uninsured people. Conference participants were encouraged to reflect on the role of business in solving the problem of the uninsured and some of the potential problems with expanding coverage such as adverse selection, employer mandates, and administrative efficiency (Chicago Business Group on Health, Health and Medicine Policy Research Group, and Midwest Business Group on Health 2001). MBGH has also begun a “synchronization initiative” in which managers from large firms have focused on two problems: developing a high-grade selection tool for quality and thinking about appropriate public policy to fix the health system (Werntz 2002). Chicago employers have also been involved with a project by the Department of Public Aid to expand enrollment in SCHIP (Gugenheim and Shapiro 2001). Many of these community efforts are doing a lot to accomplish the goals of health reform, especially in the areas of improving quality and expanding access by enabling small firms to provide health care. But admirable as these efforts may be, it is not clear that they can ultimately curb the overall skyrocketing trends in health costs.

**Conclusion**

Curing the ills of the national health system is a daunting enterprise, and employers seem to be better suited for leadership in some venues than in
others. Business leadership has arguably been frenetic yet counterpro-
ductive in the market place, energetic yet inconsistent in community are-
nas, and anticipated yet lopsided in national policy debates.

Private companies have certainly led in the marketplace, inspiring sig-
nificant demand-led changes in insurance products, and at least in the past
leveraging their considerable market power to achieve reductions in costs.
Yet we must question where these changes are leading us. Companies
used their purchasing power to secure low-cost managed care hybrid prod-
ucts, yet in retrospect these products seem to have done little to alter the
fundamental pitfall of health markets—the market failure and individ-
ual price insensitivity based on the third-party insurer disconnect between
supply and demand. While managed competition sought to reinstate mar-
ket rationality, the managed care hybrid models have fallen far short of
this goal (see Robinson, this issue).

Employers have demonstrated the most collective thinking at the com-
munity level; indeed, many efforts of local coalitions have often been quite
promising. As Michael Sparer writes in this issue, under the best of cir-
cumstances community-level coalitions have been able to muster the col-
lective clout and know-how of their strange bedfellows to solve local
problems of access, quality, and even costs. Employers have often been
vital partners in these regional movements to develop best practices in
health, to link quality of care to cost savings, and to expand access to those
usually neglected by the employer-based health system. Yet the politics of
partnerships is local and not easily replicated; community solutions may
work well in some areas but by definition function poorly as a strategy for
imposing rationality on the national health system.

Employer leadership toward comprehensive national health reform
seems quite unlikely, although it is equally probable that the juggernaut of
small business group and for-profit health providers will continue to exer-
cise considerable influence over national legislation. The ideas surround-
ing health reform, interests of employers, and business organization all
interfered with the effort to enact national health reform ten years ago, and
conditions in 1992 looked much more propitious for national health
reform than do the ones we face today. The legacy of the failed Clinton
health reform proposal left business supporters feeling gun-shy and ner-
vous about broad national solutions. The direction for health reform today
is vague, especially as much of the national policy debate has focused on
HMO reform, an issue that fails to address many concerns connected to
access and costs. The interests of employers in changing the health sys-
tem remain varied. Although many community-level business groups have
generated considerable consensus among their memberships for local solutions to health system problems, at the national level no organization has managed to claim dominance in the health area. On the small employers’ side the Health Benefits Coalition has taken up where the Health Equity Action League left off in opposing public policy. A few nascent groups have brought large employers into a deliberative process to study the broader issues of health financing and access; however, it is too early to determine whether these groups can offer leadership to the large business community.

The mobilization of employers in support of legislation often depends on the top-down mobilization by policy entrepreneurs within government, because American employer organizations usually lack the discipline and organizational scope necessary to generate consensus on a chosen option and to orchestrate corporate lobbying for a legislative end. Yet as I wrote ten years ago (Martin 1993), the conditions under which managers can play an important role in health reform are difficult to achieve: business seems to be critical to the policy-making process, but it is incapable of taking action on its own. Business activism depends on top-down mobilization by government. It seems, then, that government cannot act without business participation, but that business cannot mobilize until government acts.

References


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