Abstract   This essay examines the role of business health care purchasers in keeping market solutions at the center of the health system. One might assume that employers would have a clear ideological preference for market solutions, but big business managers are ambivalent about market interventions at both the firm and public policy levels. Although currently enthusiastic about market-oriented managed care, large employers have been periodically disappointed by firm-level market experiments during the past two decades. They viewed with skepticism the Republican proposal to apply private-sector market cures to the public Medicare and Medicaid, fearing that the proposals would accelerate cost-shifting to private business payers. Big business objections have been muted, however, by the organizational weakness so vividly illustrated during the national health reform debate.

Introduction

Health care is a favorite example of market failure in Economics 101, and every freshman econ major can rattle off the reasons. Third party insurers interrupt the natural balance between providers and patients or supply and demand. Health is (often literally) a life-and-death issue where rational decision making is at its most problematic. As a society we are unwilling to forget about the sick patient who is unable to meet...
the costs of his or her amelioration; therefore, we must come up with collective mechanisms for financing the uninsured.²

Yet markets seem to be omnipotent in the world of health today; indeed, managed care is revolutionizing health care delivery. At the firm level, employers are purchasing increasingly from medical delivery systems that compete on the basis of both cost and quality. Even states such as Massachusetts and New Jersey, the traditional stalwarts of rate regulation, have adopted market reforms (Thorpe 1997). The past few years have seen an ideological sea change in national health policy: regulatory play-or-pay proposals were replaced with market-based health alliances in Democratic health plans. Finally, as Jonathan Oberlander (1997) notes, in the post-1994 era markets are making such inroads into our collective political psyche that they are colonizing traditionally public sector arenas such as Medicare.

The market-defying aspects of health care delivery leave us with a puzzle: Why have private market solutions exercised such a grip on the health financing system when medical intervention seems to reject market rationality? Of course some believe that markets and health care can be compatible under the right circumstances; yet the ability of markets to solve health problems has been so widely debated that one wonders how market measures have achieved their current hegemony. This paper explores the contribution of employers to this puzzle, looking at the role business purchasers of health have played in keeping market solutions at the center of the health system. Most analysts agree that in the absence of a well-organized working class, business exercises extraordinary influence in matters of public policy. Therefore, it makes sense to investigate the corporate contribution to our conundrum.

It is easy to imagine that business managers would exercise a preference for market-based solutions to cost containment based both on ideology and interests. In America it is often useful to follow the dollar signs, and indeed, health care is big business. Providers and insurers prefer to be left to their own devices and resist undue regulation.

But the history of corporate purchasers' engagement, both with companies' own health costs and with the policy arena, suggests a far more nuanced rendering: Big business managers at least are ambivalent about market interventions both at the firm level and at the level of public policy. Big corporate purchasers of health care have been rather inconsistent in their enthusiasm for firm-level market interventions in the past two

². See Rice 1997 for a lively discussion of market forces in health care.
decades. As primary organizers of health financing, big companies have a bureaucratic interest in retaining the employer-based system that prevents their acceptance of a single-payer plan. As health care administrators they are prone to resist what they view as troublesome and often expensive government regulations. But as consumers and major purchasers of health care, they also have every reason to support any intervention that might stop the relentless escalation of health costs. Although they might be drawn to the market fix for ideological reasons, they will be driven away when they believe that market interventions have done them a disservice. Indeed, Linda Bergthold (1990) has argued that the regulatory versus market debate is less relevant to business purchasers than we might believe. A snapshot view of large employers at the moment finds most expanding into managed competition (if they have not already made the transition) and guardedly hopeful that this new technique will solve their woes.

The public policy arena presents another story. The business community was deeply divided during the national health reform saga and has not been thrilled with the political direction since the Republicans gained control of Congress in 1994. The conservative Republicans’ proposal to bring private sector market initiatives into the traditionally public domain of Medicare and Medicaid was met with skepticism by large employers, who doubted that market controls would benefit these public policy arenas. Managers feared that the bone-cutting Medicare proposals would accelerate cost shifting to private business payers. The Republican cause célèbre was a new federalism that devolves regulatory power to the states, eliminates unfunded mandates, and ends intergovernmental relations as we know them. But big-business managers much prefer national standards to state experimentation: “protect ERISA preemption” is a battle cry on the order of magnitude of “remember the Alamo.” The big business voice, however, has been muted. The same organizational weakness that prevented large employers from getting what they wanted in the effort to legislate health reform interfered with their exercising a strong political presence after the reform bill’s demise.

By comparison, the small business community, a proven political juggernaut in the Republican assault on national health reform, continued to prefer a market strategy and worked closely with the GOP party in the Medicare campaign. Energized by the defeat of national health reform, the small-business Davids (with their big-business fast food and insurance allies) engineered an impressive show of force in the early days of the Medicare campaign, resulting in the quick passage of the bill in both
houses. Only Clinton's veto pen ultimately thwarted this Republican/small-business juggernaut.

Thus large employers in the 1990s are at a high point of enthusiasm for market interventions at the firm level, but suspicious about these tools for national policy. Indeed, the proposed market restructuring of Medicare threatened large employers' interests and revealed their political weakness.

**Market Reform and Company Efforts to Control Health Costs**

A primary reason for the importance of market solutions to health care cost containment reflects the nature of medical financing in America and the role of employers in this process. The centrality of the privatized, employer-based system means that predominantly public arrangements challenging the employer role, such as the single-payer system, are not even considered most of the time.

For years corporate America has been a major provider of social benefits, filling the vacuum left by the very limited government welfare state (Stevens 1986: 13–19). Employers began developing employee benefits in the late nineteenth century to deal with labor unrest and a tighter labor market. Initially hostile to these company plans, unions viewed benefits as weapons to halt the advance of collective bargaining and to trap workers in onerous jobs. But the onset of World War II and the creation of the National War Labor Board (NWLB) precipitated a dramatic expansion of the employee benefit system. Anxious to prevent inflation, the NWLB specified acceptable wage increases but allowed benefits to be calculated separately. Thus workers and employers negotiated benefit increases as a way of expanding the total compensation package. The excise profits tax also pushed the growth of benefits, because companies could pay for benefits with pretax dollars. Shortly after the war the labor movement expanded its earlier campaign for greater government social provision to include private sector benefits as well (ibid.).

Today, while other countries have public health insurance, training programs, child allowances, and pensions, we have a patchwork system of benefits largely provided through our jobs. Employers have been at the heart of the health care system in this country: almost two-thirds of our nonelderly population are covered through employers (Field and Shapiro 1993). Where health care claimed only 2.2 percent of salaries and wages in 1965, it climbed to 8.3 percent by 1989 (Levit et al. 1991: 117, 127–129). Companies spent $50.6 billion training their workers in 1994 (Industry
Report 1994: 30). Even the biggest government benefit program, Social Security, has enormous help from the private sector in funding retirement income: in 1993 Social Security old-age benefits (combined with disability insurance) paid individuals $297.9 billion, and private employer pensions paid out $192.6 billion (Pemberton and Holmes 1995: 14). All this has taken a toll on wages: in 1951 benefits devoured 18.7 percent of payroll; by 1980 this had doubled to 37 percent (Stevens 1986: 24).

Just as market solutions are natural in a system where much of the provision of health occurs through the private sector, market fixes are ideologically attractive to firms, and many health system innovations at the company level have aimed to restructure markets. But this does not mean that large employers are antithetical to regulation or that they are entirely satisfied with innovations to alter market dynamics. Government regulations that are market-conforming, or that do not challenge the dominance of the employer-based health system, have been explored by business managers at different points in time. Indeed, the history of firm-level experiments displays something of a pendulum swinging between alternative avenues of hope. Employers turn to regulatory interventions when they become disillusioned with market efforts and vice versa. Cost controls at the company level today reflect two decades of experimentation.

**Firm-Level Market Interventions**

When medical costs first emerged as an irritant, large firms eliminated the middlemen by self-insuring or using insurance companies to administer their plans but not to bear the risk. Companies reasoned that eliminating the insurers' cut would be an immediate cost-saving device. An additional reason for self-insuring was the Employment Retirement Income Security Act (ERISA): ERISA specified that companies which self-insured would not be made to comply with state regulations in areas such as pensions and health care.

By self-insuring, companies became directly responsible for searching for ways to keep costs down. To this end they introduced cost controls that changed the incentives of both providers and consumers in the health care marketplace (or, as many would argue, the lack thereof). Employers tried to alter the demand for health care by changing consumer incentives; for example, cost shifting required workers to bear a greater share through increased premiums, deductibles, or copayments. Firms introduced flex benefits, which give workers financial incentives to choose less comprehensive health coverage and, thereby, to assume some of the
risks of illness. Typically, flex benefits allocate a fixed sum that workers can distribute among competing social needs: day care, health insurance, and sometimes ready cash. The approach rested on a betting person's logic: Since healthy individuals use the health system less, they should pay less up front and put their money where they need it more. For example, an innovator of this technique, Quaker Oats, offered all employees $400, which they could contribute to a premium for an expensive plan, keep in a tax-sheltered account for out-of-pocket health expenses, or take as added taxable income. The company bragged that its costs increased only 6 percent a year from 1983 until the early 1990s, a figure considerably below the industry average (Stern 1991: 14–21).

Flex benefits offer savings by giving employees an incentive to join more cost-effective plans, but they have a darker side as well. Flex benefits narrow the scope of the risk pool and alter the previously understood nature of insurance. By definition, insurance offers a mechanism for equalizing pain, by using healthy people's resources to aid the sick and injured. Flex plans by design remove healthy people from the pools, thus reducing the resources available to the less fortunate and returning the risk to the individual for his or her own future ailments. In addition, flex plans, like block grants, have often been used to disguise a real reduction in benefits: if I need day care and you need health care, a reduction in our total benefits through a flex plan means that we can take the hit where we are least likely to feel the pain.

Another cost-saving device aimed at changing individual incentives and behavior was the wellness movement. Wellness programs rest on an obvious assumption: medical costs go down if health improves. Reflecting the general physical fitness craze of the late eighties, some companies decided to give their employees incentives to lead healthy lives. Since smoking, exercise, and diet have well-confmed impacts on general health, firms began with incentives for changing individual behavior in these areas. Hershey Foods, for example, developed a complicated formula to reward exercise, nonsmoking, and weight maintenance with deductions from monthly premiums; bad behavior resulted in penalty surcharges. Some employees endorsed this approach energetically; others felt it smacked of social control (Frieden 1991: 56–60).

Firms also experimented with supply-side techniques to change provider incentives, to limit excessive medical intervention, and to ensure appropriate care. During the 1980s, systems of utilization review were put into place in which independent physicians randomly monitored medical decisions and identified excessive interventions. In some sys-
tems patients were required to seek prior authorization from a "patient advocate" for all but the most emergent interventions. Employees were asked to seek a second opinion for planned surgical procedures. From 1983 to 1985 a sample of large companies with utilization review programs in place jumped from 17 to 45 percent (Friedland 1987: 15). By 1990, 82 percent of a sample of large- and medium-sized firms were using the technique (Grobman 1993: 21–30). Utilization review techniques initially seemed promising; yet, over time, doctors found ways to avoid the constraints imposed by the procedure.3

Recently, managed care has swept through the corporate world. The story of managed care, of course, begins with HMOs, first as a Kaiser company innovation and West Coast cooperative movement in the 1930s and then as a matter of public policy in the 1970s. HMOs (in their purest form) pay doctors' salaries; by doing away with the piecework payment of fee-for-service, the physician has no incentive to offer inappropriate care. In addition, doctors often receive a share of the yearly profits as further incentive to restrain unnecessary intervention. HMOs seek to limit hospitalizations with preventive care, thus keeping patients healthier and restraining inpatient costs. Studies report that HMOs have lower hospitalization rates, although these may reflect relatively healthier populations (Herzlinger 1985: 108–120).4

Next Preferred Provider Organizations (PPOs) were created that offered special discounts to firms when employees sought treatment from the physicians in the network. But health costs seemed to escalate just as rapidly.5 After initial enthusiasm, only 20 percent of one sample of companies in 1991 found the PPOs to be very effective (1991 National Executive Poll 1991: 61–71).6

Managed care went through another important permutation in the mid-1980s when the major insurers began to reinvent themselves as organizers of medical services. Although Prudential and Cigna had offered HMO options since the 1970s, most other insurers remained restricted to tradi-

3. For example, the Houston Area Health Care Coalition provided the Employee Benefits Research Institute (EBRI) with two years' worth of inpatient claims in which 55 percent were subject to utilization review. EBRI found that the inpatient charges for those covered by utilization review were 15 percent lower than for those without (Vibhert 1990: 40, 37–46).

4. In addition, some companies believe that HMOs engage in shadow pricing: their rate increases follow those of traditional fee-for-service plans (Odynocki 1988).

5. A Health Affairs study found that premiums for conventional fee-for-service plans increased by 20 percent from 1988–89, and PPO premiums increased by 18 percent (Gabel et al. 1990).

6. Some companies contracted with centers of excellence for high-priced interventions such as organ transplants. These special arrangements often offered both somewhat lower prices for interventions and much better medical outcomes (Christensen 1991).
tional indemnity plans. In the mid-1980s, however, insurers began to offer a new managed care option, the point-of-service (POS) plan. Halfway between HMOs and PPOs, the point-of-service plan assigns patients to a family practitioner who acts as a gatekeeper for other services and often has financial incentives to restrict inappropriate health care. 7

Corporate providers of health have flocked to managed care in droves since the 1980s. In 1992 Foster Higgins found nearly three-fourths of its sampled companies offering a managed care option (either POS or HMO) (Foster Higgins 1992: 5). HMO enrollment alone went from 2 million in 1970 to 51 million in 1995 (Findlay 1995a). A Foster Higgins survey found that by 1995, managed care networks had come to cover 71 percent of workers who received health benefits through their jobs (Freudenheim 1995b: D1).

Three phenomena contributed to the expansion of managed care. First, corporate America was becoming more desperate about the price of health. Bergthold (1990: 26–30) points out that beginning in the late 1970s, when companies began to make the connection between plunging corporate profits and rising health costs, the term crisis was increasingly applied to health care delivery. Managed care forms (first HMOs and then point-of-service plans) were important forms of experimentation in cost control.

Managed care appealed instinctively to big companies as market-shaping reforms, but as Bergthold (ibid.: 27) points out, it also conveyed the ideology of corporate rationalization. In addition, managed care mirrored what was happening in manufacturing processes during this period. Cognizant of superior Japanese production techniques, American firms became interested in quality and in longer-term relations with suppliers and customers. Where traditional indemnity plans resembled arms-length contractual relations in manufacturing, managed care arrangements operated much like the closer relations between suppliers and purchasers that were becoming popular at that time (Robinson 1995:117–130). As one manager explained it:

[The company] started focusing on emphasizing quality in manufacturing processes. Around this time there was a major manufacturing effort to reduce the number of suppliers in the manufacturing process: it went from roughly 4,500 suppliers to about 10 percent of that number. . . . The benefits people thought that this was an interesting parallel to our situation. We also wanted to reduce suppliers and emphasize quality. We felt that the HMOs were the right vehicle for changing the

7. But like the looser PPO, there tends to be greater freedom of physician choice in the point of service plan.
delivery system and getting an organized system of care . . . A lot of alliances were being formed in manufacturing at this point. These cooperative alliances coexisted with competitive behavior because they were in the best interests of all parties . . . So benefits said, "Let's apply the same principle in health." 8

Second, large insurers felt increasingly shut out of their traditional industry by the self-insure movement among large companies and realized that they could reinvent themselves as organizers of medical services. The health insurance industry in the 1980s was in financial turmoil: managed care offered a way to regain profit margins (Kosterlitz 1987: 936). Large insurers launched a major sales drive to advertise their new quick fix for escalating health costs, and big business was impressed. Small insurers were badly hurt by the decline of the fee-for-service market; therefore, managed care served to enhance the power and market share of its big-insurer proponents.

A few of the early innovators in managed care attracted considerable publicity, making it easier for others to follow suit. For example, Southwestern Bell and Allied Signal were among the first to move into managed care. Southwestern Bell claimed that with its managed care plan, company costs increased less than 10 percent from 1988 to 1989, compared with a national average of 20 to 24 percent (Bell 1991: 20). Allied Signal hired Cigna to develop a national HMO network called Health Care Connection (HCC). By 1992 Allied Signal claimed that HCC was 35 percent over previous costs (Bell 1992: 34).

Third, the corporate purchaser coalition movement, to which I will now turn, also made managers more favorably disposed to managed care arrangements. Although the coalition movement primarily attempted to change market dynamics by aggregating consumers on the demand side and thereby increasing purchaser power, the coalitions also considered arguments for improving market performance by restructuring the supply of health care.

**Restructuring Markets at the Community Level**

The story of efforts to restructure markets would not be complete without reference to the regional coalitions that exercise leverage on markets at the community level. Groups and networks in general were important

8. Interview with industry representative, June 1993.
in sensitizing large employers to issues of cost control, but the purchaser coalitions were most important to the burgeoning managed care movement. Alain Enthoven developed the concept of community-based purchaser coalitions to reinstate market rationality into the health system. By banding together in purchasing coalitions, firms can leverage lower health rates with their greater market power (Cronin 1988: 4-7; Jaeger 1985).

Gradually coalitions targeted quality of outcomes as well as costs. Walter McClure, the Moses of quality, preached productivity in health care to his corporate following. The heart of his message was simple: too many health dollars are wasted in unsuccessful treatments. If we can identify and implement successful interventions, cost containment will follow. This focus on quality was politically appealing because it suggested that the productivity of health care can be improved and costs lowered without sacrificing benefit levels. One benefits manager recalled this attraction for CEOs:

The CEOs were in a very uncomfortable position. They were between three rocks: health care costs . . . significant employee relations problems, and the medical people or doctor problem . . . The CEOs did nothing about the health problem because they got beaten up any way they went. Quality gave them a way out. First, it clearly had appeal and had a chance of actually working. Second, it didn't cost them anything financially. Third, it gave them a good guy position in the community. People thought about how it would play in the papers.10

The coalition movement was helped enormously by the efforts of McClure disciple, Dale Shaller. Shaller brought a background in community action to the task of organizing a backyard revolution in the corporate world. Shaller believed that business must be mobilized the same way that others in society are propelled to political action: systemic change begins in the community. As a consultant to many regional coalitions, Shaller offered his organizing skills to help employers overcome the limits of collective action.

The coalition movement received early seed money from several sources. The Washington Business Group on Health helped to set up local coalitions in a number of regions, as did the National Chamber of Commerce. The Robert Wood Johnson Foundation invested in the coalition

9. For discussions of the role of groups see Martin 1995 and Bergthold 1990.
10. Interview with business participant, May 1993.
movement (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 n.d.).

But the true stories of coalitions are local, just like the politics that describes them. In some communities coalitions quickly gained a position of prominence among employers; in others the coalitions were dissolved. Some regional groups moved quickly into collective purchasing arrangements; others remained informational in function. The coalition movement seemed to be strongest in the Midwest and West, perhaps because regulatory solutions were more popular in eastern states. But even within the heartland, success varied greatly and seemed to depend on the dynamics of local business movements.

The Cleveland Health Quality Choice Coalition has been a poster child of the coalition movement with a joint purchaser-provider effort to produce outcome measurement techniques for sixty diagnosis-related groups (DRGS). Hospitals are evaluated in terms of their performance in each group; employers can use this outcomes data to steer their employees to the best providers.

The Cleveland case is interesting both because of the high level of cooperation between business and providers and because the business community took the initiative in trying to change the health care delivery system. The story began with a coalition of employers called the Health Action Council of Northeast Ohio (HAC), which covered 350,000 lives and had been meeting since 1982 to try to reduce health costs. According to Executive Director Pat Casey, participants tried the full gambit of usual interventions to restrain costs, but nothing worked. HAC member Don Flagg, the vice president for human resources at the Nestle Corporation and "a good egg breaker," began railing against rising health costs and the hospitals' role in this escalation. Flagg aroused provider ire but drew considerable attention to his aggressive campaign. One participant believes that Flagg "may have pre-softened" hospitals with this early attack.

When Flagg left Nestle's, he was replaced by Powell Woods, a born mediator with a peaceful, humorous manner who ultimately left the corporate world and went to seminary school. In 1988 Woods and the HAC met Walter McClure and were "blown away" by his philosophy. McClure

11. Employers and thirty-two hospitals participated in the effort.
had been working to develop a statewide data collection system in Pennsylvania; however, providers had stonewalled the effort. Therefore, the Cleveland employers decided to limit the scope of their ambitions to the community level.\(^\text{12}\)

Woods, Casey, and the HAC set out to sell Cleveland's CEOs on a McClure approach to cost containment, armed with information and the spirit of true believers. The HAC commissioned a study which found Cleveland's per capita hospital costs to be 50 percent higher than those at the Mayo Clinic. Woods recruited his former CEO John Morley (Reliance) to agitate at the chief executive level, and Morley invited the HAC to present its findings to Cleveland Tomorrow, a group of fifty CEOs that had sponsored reforms in a variety of policy spheres since the city nearly went bankrupt in the 1970s. One CEO wag remarked, "We could send our people to the Mayo Clinic with their families and still pay less." Woods remembers that the model had an enormous impact on the CEOs, because it allowed them to be the "good guy on a social issue of immense importance. . . . They could be the white knights on this issue."

Cleveland Tomorrow and the HAC joined with prominent small business organizations and local hospital and physician associations in setting up the Cleveland Health Quality Choice Coalition. Hospitals devoted $80,000 apiece to the effort, and participating businesses came up with an additional $600,000 (Kisner 1992: 20–27). The employers decided that providers had to be involved from the beginning "so that they couldn't just say that the system stinks." Hospitals were adamant that the data on which they were to be judged had to be correct and different from Medicare's HCVA data. Hospitals also demanded that the data be provided only to employers trained to interpret them. Employers responded with a velvet-glove ultimatum: either the hospitals must generate acceptable data, or employers would base purchasing decisions on cost.\(^\text{13}\) Pat Casey attributed Cleveland employers' success in negotiating with hospitals to the focus on quality over cost. Cost-based negotiations suggest zero-sum dynamics, whereas quality suggests a win-win situation. Woods agreed that the logic was hard to deny: "The CEOs could say to the hospital, 'Everyone knows that these are the best hospitals in Cleveland, so isn't it time to let everyone know it? If they are not, we need to be the first to know.' The hospitals couldn't disagree."

But the other \textit{realpolitik} ingredient in Cleveland's success was the

\(^{12}\) Interview, April 1993.

\(^{13}\) Data had to have adequate risk adjustment, to cover the high cost/high volume procedures, and to look at the patient's evaluation of care.
extreme unity of the business community. The top ten companies were members of the coalition, as were small-business managers. As one hospital executive put it, “These guys are all over my board.”

Although the Cleveland effort to control health costs was exceptional, it was not unique. Like Ohio, Minnesota has a strongly unified business community and a coalition committed to quality of care. Minnesota has a progressive history dating back to the Democratic Farmer Labor party; the spirit of cooperation among business managers is powerful in the state. The Business Health Care Action Group was formed by fourteen of the Twin Cities’ largest firms in order to collectively purchase health benefits from a network of doctors called the GroupCare Consortium. But the group was not content to negotiate merely about price; it also decided that it wanted to play a role in actively changing the health care market and in improving the quality of care. Like the Cleveland effort, the group sought to ensure quality, but in this case it did so by developing clinical practice guidelines. According to Fred Hammacher (Dayton Hudson), “People don’t understand the health care marketplace—it’s a dumb market. . . . The mission statement of our group is to change the health care marketplace [in Minnesota] for the benefit of everyone.” The group has already developed approximately forty best practices and hopes to complete eighty in all. Each has been developed by a subcommittee made up of business managers, physicians, and hospital representatives. As Hammacher puts it, “you need to develop them at the grass roots so that you can get ownership.”

St. Louis also has a well-organized business community with an activist coalition, but the balance of power between purchasers and providers of health is quite different, and early efforts to control health costs collectively failed. Hospitals and medical schools in the city were very strong, and employers were essentially outflanked. One business manager estimates that the greater metropolitan area has about 2,669 extra beds—a powerful testimony to provider power. Thus the backdrop for regional reform differed greatly from that in Cleveland or Minneapolis.

Undaunted by this impressive medical-industrial complex, corporate purchasers of health care decided in the late 1980s to reduce health costs by publishing hospital prices for selected inpatient services, a system they called the Prospective Pricing Initiative (PPI). The St. Louis Area Business Health Coalition led the effort with a CEO group called Civic

Progress, representing the twenty-nine largest companies in St. Louis. St. Louis employers had been pooling claims data organized by DRGs since 1983, but now they were going public with the prices. Employers also had hoped to interest managed care administrators, but the latter showed little interest. One administrator responded, “I’ve already picked my providers, and have already gotten my discounts from them.” Employers took this as a sign that the current discounts meant little.

The coalition began by surveying outpatient hospital rates and found a wide gap between the highest and lowest priced provider. Next the employers moved on to inpatient care, asking thirty-six hospitals to give them “real live market prices” on 250 DRGs. Although participants felt that they had cultivated provider support, on the day of delivery only three out of thirty-six hospitals complied entirely; another five offered partial information. The employer coalition spent the next five months trying to persuade the top hospitals to comply, and the coalition’s executive director, Jim Stutts, even approached the Federal Trade Commission, but the resistance was unified and immutable.

Despite the failure of the PPI initiative, St. Louis employers later reorganized as the St. Louis Quality Alliance and began a project to measure outcomes data. Learning a lesson from their past failure, employers began to build alliances with other interests and moved away from their past strategies of conflict. Stutts reflected on the newfound spirit of cooperation:

In the old days business would have tried to take on the hospitals by themselves to get them to scale back their beds. But more recently the major employers have discovered that they must work with a lot of other people. So they got six other organizations to be involved in the project: the Blues, Cigna, Association of Insurance Brokers, City Health Dept., United Auto Workers. All participated at public testimony at the hearings. For the community this was quite important.

Unlike in Cleveland where the business efforts remained private, in St. Louis, employers worked closely with state government. For example,

15. Wyatt Company in DC processed the data for thirty-nine companies for $150,000 a year.
16. The coalition hired a consultant, Mediqual, and Civic Project donated $250,000 to the four-year initiative (1987–1991). They risk-adjusted by DRGs. The project made an effort to pick high-volume DRGs with the least variation in terms of severity of illness, and used generous outliers.
17. Some participants feel that physicians may be more progressive than hospitals. One aspect of the project is to form user groups to discipline managed care vendors. Employers and doctors meet to discuss quality and credible data.
the public and private sectors worked together to pass a health care data disclosure law in 1992. Stutts felt that regulation was a natural outcome of providers’ resistance to a voluntary data project:

Prospective pricing was employers’ last chance to say, “This can be done voluntarily.” We did all we could do to do it voluntarily and the providers said “No.” So we finally said [to state government], “Go do what you want to do.” Odd bedfellows have developed in health care in Missouri. Business and labor have a lot in common on this issue. Some of our most conservative members were thrilled at state regulation for data disclosure even though it entailed a lot of government intervention.

**Firm Efforts to Control Costs after National Health Reform**

Despite some successes in controlling health costs, by the late 1980s many employers felt frustrated with firm-level and community market interventions and began to contemplate systemic regulatory change at the national level. The Clinton national health reform plan reflected the growing frustration with market mechanisms, although in reality it constituted a blend of regulatory and market concepts. Theda Skocpol and Jacob Hacker in this volume argue that managed competition won out over play-or-pay in part because corporate America had moved into the managed care market. Important corporate forums such as the Jackson Hole group and the Managed Health Care Association pushed policy makers to build reform around the managed care concept (Traska 1990:12).

Components of the Clinton health plan initially attracted considerable corporate support. In my study of high-level managers from randomly sampled Fortune 200 companies, over half of the business respondents (54 percent) supported mandates and another 19 percent were mixed on the subject. Forty-one percent of the companies had already either developed a supportive position on employer mandates or were about to take a position, and another 13 percent found top management divided and deliberating over whether to become involved. Cantor et al. (1991: 99–101) found that 80 percent of the Fortune 500 executives in their study believed that “fundamental changes are needed to make it [the health system] better,” and 53 percent supported employer mandates. A National Association of Manufacturers (NAM) survey in the late summer of 1993 found a clear majority of its members supporting mandates
and health alliances for firms of over five hundred employees.\textsuperscript{18} A 1994 Washington Business Group on Health survey of large firms showed 72 percent supported requiring all companies to offer insurance, 59 percent wanted firms to pay a portion, and 71 percent objected to an arrangement that allowed small business to escape the mandate.\textsuperscript{19}

Managers have described their path to systemic reform as one of increasing frustration with firm-level efforts to change provider behavior. One person told me that her support for a single-payer system emerged in a survey to identify the solution to the U.S. health crisis: "I realized at that moment that the only thing that would make a difference was to have a national solution." Another manager explained, "Most of us recognize that the things we did in the mid-1980s didn't really work."

But although national health reform was a response to the legacy of failed market interventions, company attitudes today are shaped by the legacy of failed government policy. In the wake of the downfall of national health reform, firms have returned to private and community efforts as the mainstay of their efforts to curb costs. Are they more satisfied with these efforts than they were in the period before health reform? The evidence is mixed.

On an optimistic note, the growth in company health costs seems to have dropped off. Katharine Levit et al. (1994: 14–31) found that total health spending grew by only 7.8 percent from 1992 to 1993, the lowest since 1987, and that much of this growth was concentrated in the public sector. In 1992 companies using managed care in a Towers Perrin (1992) study reported that their growth rate decreased from 18 percent to 12 percent. Towers Perrin consultants found health costs for employees (in their sample firms) increased only 6 percent in 1994 and 2 percent in 1995, as opposed to 14 percent in 1991 (Towers Perrin 1996). A Foster Higgins study found health costs in 1994 actually declining by 1.1 percent for the first time in a decade (Freudenheim 1995a). A large employer study of employees' feelings about health plans found the greatest proportion (86 percent) pleased with HMOs. The authors surmised that this reflected the low cost sharing inherent in the managed care plans (Jones 1995: 33).

But all is not peaceful on the western front. Huskamp and Newhouse (1994) have cast doubt on the aggregate health spending figures. Using National Income and Product Accounts data instead of Health Care Financing Administration data, and employing a different deflator for

\textsuperscript{18} Unpublished survey provided by the administration.

\textsuperscript{19} The NAM survey is described in an interview with Ira Magaziner, Washington Business Group on Health 1994.
inflation adjustment, the authors concluded that the health care spending slowdown "is modest at best" (ibid.: 32–38).

Many employers fear that costs were artificially restrained during the health reform political cycle (in an effort by providers to demonstrate that national legislation was not necessary to curb increases) and are again on the rise. Foster Higgins found a 2.1 percent increase in 1995, although the increase was concentrated in traditional indemnity plans. The cost of benefits in managed care plans continued to decline (Freudenheim 1995b). Towers Perrin (1996) found health costs for employers up 4 percent in 1996, a modest growth rate but still above the 1995 figures.

Some analysts believe that the declining growth rate in health care costs simply reflects a movement out of fee-for-service plans: when this process is completed, health costs will continue to rise (Donlon and Benson 1996: 52). In addition, business managers fear that the initial savings from moving into managed care will not be sustained over time. An early innovator in point-of-service plans reported that after the first few years the plans began to engage in shadow-pricing: the POS plan prices rose at the same rate as the traditional indemnity plans, albeit at a slightly lower level. Administrative costs for point-of-service plans also seem to be higher than those for traditional indemnity plans. There is also the problem of adverse selection—only the healthiest may be willing to join managed care (Bell 1992: 32–38).

Fears about the future of managed care price restraints have been exacerbated by the current wave of mergers and acquisitions within this field. Managed care became predominantly a for-profit enterprise in the mid-1980s (Davis, Collins, and Morris 1994: 178–185). The future of health care provision increasingly looks like "the battle of the Titans" and one wonders what this will mean for cost controls. For example, Aetna recently acquired U.S. Healthcare for $8.8 billion (Freudenheim 1995b). The managed care industry had 1,100 mergers and acquisitions in 1994 totaling $60 billion (Donlon and Benson 1996).

Some believe that increasingly larger units could give an oligopolistic structure to the industry. Reducing the number of competitors may eventually allow premium prices to rise. Profits in the for-profit HMO sector increased by 40 percent from 1992 to 1994 (Findlay 1995b). Others disagree, arguing that the increasing competition among managed care providers is further reducing price increases (West 1995). For example, James Robinson (1995) suggests that the Pacific Business Group on Health's collective bargaining for its members has contributed to a 9 percent decline in HMO premiums. The Pacific Business firms have found that they do
not need to offer many different plans in order to push down costs; rather they can negotiate good prices with a small select group of providers.

Big business managers are also very concerned about the "any willing provider" legislation now being considered in many states in response to aggressive lobbying by the medical profession. These laws could stop employers from having exclusive contracts. As one employer humorously put it, the "any billing provider" legislation could effectively prevent firms from controlling costs at the state level.

**Business Involvement in Public Policy: Medicare Reform**

Meanwhile, market solutions are making inroads in the public policy arena, and large purchasers of health care are much more ambivalent about this occurrence, as witnessed by the recent Medicare reform episode. The Republicans came to power with far-reaching legislation that combined tax reduction, spending reduction, and budget balancing, all in one ambitious package. An essential part of the Republican plan was to secure savings from the Medicare program: a big-ticket item in the budget, and due to its entitlement status, one that is usually considered off-limits to deficit reduction. Medicare provides universal coverage for 37 million citizens over sixty-five, at a cost that totaled $159.5 billion in 1994 and that rises 10 percent per annum (Toner and Pear 1995).

The Republicans proposed to cut $270 billion from the Medicare budget over a seven-year period, by reducing Medicare spending by 14 percent in the next seven years (ibid.). The Republicans would glean these savings from a variety of sources. First, Medicare premiums would double from the current rate of $46.10 to $87.60 by 2002. Second, the Republicans would encourage recipients to move into managed care systems, by offering benefits to managed care patients that fee-for-service systems do not currently cover. Originally the Republicans had hoped to use strong financial incentives to pressure more elderly into managed care arrangements by offering rebates for lower-cost plans. But they ultimately bowed to public pressure and moved away from this more radical stance (Overheard 1995).

Behind the Republican desire to "save" Medicare seemed to be broad goals to restructure social provision in the health area and to reduce the size of government. First, many felt that the Republican proposal was designed less to save Medicare than to reduce overall government spend-
ing and to pay for huge tax cuts. Because only about one-fifth of the national budget is discretionary domestic spending (the remainder represents military expenditures and entitlements), the GOP ambitions could not easily be realized. Entitlements were an obvious area of expansion and Medicare was an obvious entitlement to begin with, since the immensely popular social security program is out of bounds. In fact, the New York Times claimed that the magic number of $270 billion was actually calculated simply because that was how much was needed. The Republicans figured out what it would cost to balance the budget by 2002 and to cut taxes by $245 billion, and what they could get out of other government programs; the shortfall was $270 billion (Rosenbaum 1995a: A26).

The Republican portrayal of Medicare's trajectory toward bankruptcy gave weight to this cynical view. In reality, the Medicare trustees have predicted insolvency since 1980, but Congress has always increased taxes or changed benefit levels to meet new revenue demands. The real problem is that medical inflation is increasing faster than prices in the rest of the economy; therefore, Medicare is commanding an ever greater share of the federal budget. The Democrats argued in 1993 (and continue to argue) that the solution to rising health costs should not be limited to Medicare, but should address the total health system (Rosenbaum 1995a:18).

Second, some believed that the Republicans were trying to challenge the social right to health care for the elderly and the poor. As Judith Feder (1995) argued in the Washington Post, the proposed caps on Medicare spending would change the program from one offering a defined benefit to one offering a defined contribution, a change that was even more explicit in the original Republican plan. Under a defined benefit plan (one that promises to pay beneficiaries' health care premium every month) an elderly person is assured of having his or her health care covered. Under a defined contribution approach, beneficiaries would be given a dollar limit for health care, but would have to come up with the remainder themselves. The obvious advantage of the second approach for government payers is that public funds would cover smaller future increases and would give budget predictability and control that are now lacking. Once a dollar commitment was made, the government could announce that it had done its part and the problems of coping with rising costs would be passed on to the elderly consumer. Republicans defended this defined contribution system as a measure to encourage
consumers to make more fiscally responsible decisions and to quicken the move out of costly fee-for-service plans and into more efficient managed care arrangements. The leadership moved away from explicitly endorsing a defined contribution system, but Feder and others argued that the cap pushed the program in that direction. Feder also worried that providers would have incentive to limit the number of Medicare patients that they would accept (ibid.).

The Republicans' proposed changes in Medicaid further eroded the social right to health care. Medicaid was originally set up as an entitlement, or a guaranteed benefit not subject to annual budgetary allocations. The Republicans, however, wanted to include Medicaid in a broad block grant to the states, thereby allowing individual jurisdictions to decide where to use their money and ending the right of the poor to medical assistance.

Third, the Republicans wanted to end Medicare as a universal financing scheme for elderly persons' health insurance by allowing recipients to opt out of the public program and into the private insurance market. Recipients would be allowed to buy into private HMO and Provider Service Network plans with Medicare dollars or to set up medical savings accounts. In medical savings account plans, patients pay very low premiums but very high deductibles; the dollars saved from the premiums could go into a fund to cover the deductibles or could be applied to other life needs. Critics charge that medical savings accounts will fracture the pool of Medicare patients, giving incentives for healthy patients to opt out, thereby driving up costs for those who choose to stay in the plans (McIlrath 1995a). The plan thus alters the incentive structure and logic of insurance: "save for a rainy day" becomes "take the best right now." Because the elderly by definition get sicker (and often poorer) over time, such logic is questionable for this group.

The Congressional Budget Office (CBO) was skeptical about this privatization plan. The CBO estimated that only 21 percent of Medicare recipients would be in HMOs by 2002, as opposed to 14 percent currently (Pear 1995a). It estimated that the Republican bill would mainly save money by increasing costs to the beneficiaries (saving $71 billion out of $270 billion) and by decreasing reimbursements to providers (saving $152 billion out of $270 billion). The CBO also blasted medical savings accounts, predicting that they would increase total Medicare costs by $2.3 billion over seven years, rather than cutting costs (Pear 1995b).
Republican Allies: Providers and Small Business

In addition to broad spending cuts, the Republican Medicare proposal also contained a number of specific provisions to restructure the health care system. Critics charged that these provisions were designed to attract support from key interest groups.

Doctors were an essential source of political support, and given the huge scope of the intended cuts, a surprising one as well. To some extent the Republicans assuaged physicians’ fears about the cuts by promising that Medicare fees would not be reduced for seven years; indeed, because current law was to have lowered physician reimbursement, this represented an actual savings. But the bill also provided for added controls on doctors’ fees, should the requisite savings not materialize (Clymer 1995a).

But much more attractive to the doctors was the provider-sponsored network proposal that enabled physicians to form their own provider groups without an HMO license and to cut out insurance middlemen. Currently doctors cannot refer patients to facilities with which they are financially involved; the Republicans wanted to change this practice. The Republican bill would eliminate regulations of medical laboratories and nursing homes, and would require Medicare to reimburse for-profit hospitals for local property taxes. Thus, although the American Medical Association calculated that the biggest savings in the Republican House plan would come from providers (53 percent), it endorsed the measure, drawn to provider networks and tort reform (McIlrath 1995b). Many doctors viewed with alarm the Republican decision to roll Medicaid into block grants. Although the American Medical Association did not officially oppose this decision (since it was told that the block grant goal was nonnegotiable), it did suggest that uniform standards of care be recommended to the states and that the Medicaid budget reductions be softened (Pear 1995c).

For-profit hospitals were with the Republicans from the beginning.

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20. This has to do with the dollar conversion factor. Each procedure has a value. To determine the actual reimbursement, this value is multiplied by a fixed monetary amount, called the dollar conversion factor. Current law has the dollar conversion factor going down in the next seven years; however, the Republicans promised that this would not occur. As a result some estimates suggest that Medicare spending could actually increase under the Republican's plan (Pear 1995a: A1).

21. Drug companies liked the end of a regulation requiring them to give discounts to public hospitals and AIDS clinics, and were wooed with a provision banning punitive damages in a lawsuit if the drug in question had been approved by the Food and Drug Administration (Gottlieb and Pear 1995: A1, 20).
drawn to the many special benefits. The American Hospital Association, representing mostly public hospitals, was much more skeptical of the Republican House and Senate plans, feeling that the enormous cuts in Medicare offset any special incentives (Weissenstein 1995). But the Republicans made a series of concessions, especially in the Senate, to assuage the concerns of the big teaching hospitals.

Insurers were attracted to the Republican Medicare concept because they liked the party’s efforts to move the elderly into the private insurance market. Most of the largest managed care programs are run by the large insurers. Senator Edward Kennedy (D-MA) charged that this represented a “conspiracy between the insurance industry and the Republicans” to kill Medicare. If all seniors traded Medicare for private insurance options, the industry premium revenue would balloon by $1.25 trillion over seven years (Fisher 1995a). Private health plans received progressively larger concessions throughout the legislative process, culminating in major giveaways in the joint conference committee. In the final bill (vetoed by Clinton) these plans were to receive an 8 percent annual increase in Medicare reimbursement in the near term. Private plans would also be eligible for Medicare money for medical education and treatment of the uninsured, even if those plans did not send members to teaching hospitals or treat the uninsured. These concessions were largely responsible for the erosion of revenue savings in the Medicare bill.22

Small business groups were energized by their political success in the fight against national health reform. In the post-reform era these groups have continued to work closely with the Republican party in the budget and Medicare campaigns. Small business groups supported the Medicare changes both because they were part of the larger budget package and because they saw the reforms as a way to restrain the rise in payroll taxes. The Chamber of Commerce publication, Nation’s Business, suggested that the Medicare Trust Fund was considering raising payroll taxes from 2.9 percent to 4.23 percent to pay for Medicare hospital insurance. To make Medicare solvent for seventy-five years, according to the Chamber, the payroll tax would be increased to 6.42 percent, and 3.2 million jobs would be lost in the process (Warner 1995: 8).

Efforts to satisfy different interests were not entirely congruous. For example, the Health Insurance Association of America (HIAA) objected to the provision making it easier for physicians to form managed care

22. Originally, the House bill was to save $33.6 billion in seven years, and the Senate would save about $10 billion more; by comparison, the final bill’s savings dropped to $26.9 billion with the extra concessions to the private plan (Gottlieb 1995: A1, 26).
arrangements (Clymer 1995b). The leadership added subsidies for recipients in rural areas shortly before the House vote, but took this money away from big city hospitals, already hit hard by provisions that reduced Medicare subsidies for teaching and for giving assistance to the poor. This prompted four Republican legislators from New Jersey to vote against the House bill (Fein 1995: 1, 8).

**Large Employers and Medicare Reform**

The subtext for big-business involvement in health policy is the lack of an effective political organization to represent large employers' collective concerns. Despite the widely held myth of big-business power, large employers are so politically fragmented that associations representing their interests engage only in the most reactive political activities. Companies are extremely effective at stopping what they perceive to be hostile regulation and in gaining narrowly concentrated public benefits. But the organizational structure and rules of American trade associations make it very difficult for large employers to pursue their self-defined, long-term collective goals.

Democrats disdained the many concessions to special interests in the Republican proposal; for example, suggesting that the concessions to doctors only encouraged greater incidents of medical waste, fraud, and abuse. The Republicans responded that they preferred to worry about catching all the real criminals out there menacing society, and ridiculed the Democratic concern about Medicare crooks. Pete Stark responded, "To put O. J. Simpson, the Menendez brothers, and Claus von Bulow in the same category as physicians who get kickbacks and who steal from the government is not the issue."

Thus large employers were quite concerned about the general thrust of the proposed Medicare changes, but did little to influence the legislative course beyond damage control—what large employers do best. Large corporate purchasers' single largest objection was to a program for keeping employees in private health plans (as yet voluntary). As the Business Roundtable put it, the government had an obligation to cover Medicare recipients and should not transfer this responsibility to business (McIlrath 1995b: 1). Large employers disliked the proposal to increase the age of Medicare eligibility; to this end the Corporate Health Care Coalition attacked the Republican plan (Pear 1995d: A22). Some managers also feared that the radical Right would try to slowly phase out the employer-based system altogether and to return health care to indi-
individual responsibility. In addition, big-business managers felt threatened by the broad Republican goal of turning policy back to the states, because they worried that these efforts might ultimately threaten the ERISA pre-emption. A representative of a large food-products firm explained, “Gingrich is scary to business on many fronts, especially the ERISA issue. We’d hate to be at the mercy of 50 different bodies.”

Large employers had been alarmed when the Clinton administration proposed cutting Medicare to pay for expanded access, and they continued to worry that the Republicans wanted Medicare reductions to balance the budget (and pay for the tax cut). Large employers worried (and not without reason) that the Medicare cuts would result in greater cost shifting by hospitals to private payers. Many noted that the Republican plan had no incentives to move beneficiaries into more cost-efficient plans from fee-for-service arrangements (Freudenheim 1995b: 49). Thus the benefits manager for a large food-manufacturing company observed, “The Contract with America’s attempts to cut Medicare are cost shifting back to the business community.” Business managers also worried that the Republican’s proposal to turn Medicaid into a block grant would result in greater cost shifting to private employers. Seeking to reduce cost shifting onto private insurance, employers for some time had argued that government should pay its full share of the health care burden by fully funding programs for the poor. Now they sought to prevent actual cuts in government financing. Business and Health warned,

To the extent that states have been able to control Medicaid spending, they have done so by sharply limiting payments to providers. . . . And guess who makes up the difference? Employers and private insurers. This Medicaid cost shift has been estimated to add between 5 and 10 percent to the cost of health care for private payers. With less money from the federal government under a block grant program, the pressure to ratchet down payments to providers will be even greater. . . . The business community has a strong vested interest in seeing that the Medicaid program gets overhauled carefully. One way or another, it ends up paying the bills. (Findlay 1995: 55)

As in the battles over the Clinton plan, large employers did relatively little to resist the Republican Medicare plan. To some extent big business contributed little to the Medicare discussion because it was busy with more urgent issues, such as deficit reduction, taxes, and regulatory relief.

23. Interview, 10 May 1995.
The Business Roundtable group, Coalition for Change, planned to spend $10 million in advertising to support nonpartisan deficit reduction (Stone 1995a).

Large employers were also wooed by the Republican leadership during the period of Medicare proposal development. The Thursday Group pondered how to get large employers to board the Medicare reduction bandwagon. They surmised that if they could shift as many Medicare recipients into HMOs as possible, large employers would be reassured that they would not be subjected to more cost shifting. Early on, the leadership moved away from trying to keep retirees in company plans. Gingrich also personally reached out to some of the large corporations that had been supportive of the Clinton efforts in order to convey the message that he was concerned about the big employers’ issues on Medicare. To some extent, the Republicans’ dealings with these very specific fears of large employers diminished their expression of broader concerns about the impact of the Medicare cuts.

Large employers were also coerced by the Republicans. The Republican leadership felt that many in the corporate lobby were Democrats with a pernicious influence within the firm. Republicans sought to change the positions and composition of business groups and company government affairs offices by demanding that these groups and firms support the contract and hire more GOP lobbyists. For example, the American Insurance Association approached Vin Weber, former Republican Minnesotan legislator, to supplant its Democratic lobbyist Beryl Anthony (Moore 1994: 2912). Gingrich aide Ed Cutler warned a lobbyist who had worked on the Clinton health plan, “You better be on the right side this year.” The leadership circulated information to legislators about the party affiliation of individual lobbyists. Bill Paxton (R-NY) circulated to House Republicans a detailed inventory of contributions from the four hundred largest PACs that “reminds Members who our friends are.” Although the Republicans denied that they were planning to blackball Democratic lobbyists, some admitted that access to the leadership at least required the correct political credentials (Moore, Cohen, and Stone 1995: 1341–1343). John Boehner complained: “For years, CEOs have hired liberals for their Washington offices who’ve kept them in the dark on many things. There’s been little change since the election, and that’s widened the disconnect between Republicans and the business community” (Big Business 1995: A14).

When large employers did intervene, they felt that the Republicans (like the Democrats before them) paid little attention to their complaints.
Some business managers blamed the politicians; for example, one complained that the Republican party was not interested in input from large firms. A representative of a big midwestern office-supplies company remembered working hard to convince the Republicans that "business wasn't as bad as they thought." Another recalled:

I was very surprised that big business had no stature or weight with the Democrats and now I feel that it is equally true with the Republicans. We're not saints but we have been in the benefits area for years. We were ignored by Clinton and have been ignored by the GOP. The message is not getting through that we have something to offer. It is startling how poor a job we have done in establishing credibility.

Other managers realized that their inability to influence the Medicare debate reflected the same organizational weakness that prevented large employers from getting what they wanted in the effort to legislate health reform. As a manager from a large northeastern manufacturing firm observed, "Corporate America is preoccupied with short-term issues and now we don't have short-term health care problems." A manager from a utility reflected, "Business did itself a disservice by not taking a cohesive position on it [Medicare]." An oil company manager explained: "We are not going to put our nose up on Medicare at this point . . . I don't think that large employers have the clout to rein in the Republican agenda—especially in the House, where many first and second termers have no affinity for big business."

National health reform exacerbated the underlying weakness of big business, because some managers had tried to engage their peers and failed. At the height of the battle over national health reform, one had a sense of history in the making, of a defining moment that once passed could never be reversed or forgotten. For the various parts of the business community, health reform was also a critical juncture, at once a lesson in the politics of the possible and a snapshot view of the balance of power among the producing classes. Those big-business managers who had ventured timid support for health system overhaul went away as chastised and enfeebled political actors with renewed atheism about the power of public policy. Business leaders were reluctant to expose themselves to such glaring defeat again. A Washington lobbyist put it baldly:

Business got a little embarrassed by its association with Clinton. Old manufacturing industries were quick to jump on a Clinton bandwagon. But it divided the business community and embarrassed those like the
automobile industry that were too close to the Clinton process. The ARCO CEO (Cook) got a nasty piece written about him in the Wall Street Journal. Other CEOs were made to feel like they had knifed business in the back.

The Republican Business Mobilization Strategy

An interest group strategy was central to the Republican efforts to pass the Contract with America, and the small-business groups that nixed health reform were the House Republicans' best friends. The Monday health care strategy meetings between the House Republicans and their small-employer allies were moved to Thursday, but otherwise business continued as usual. Business participants were organized into committees and given responsibility for different parts of the contract. The House leadership asked an old ally to run each coalition. Some individuals were obvious candidates for the job; for example, Dirk van Dongen (National Association of Wholesaler-Distributors) had been fighting product liability for a long time; Paul Beckner (Citizens for a Sound Economy) had a special interest in the tax committee; and Pamela Bailey (Healthcare Leadership Council) had been a central player in the Republican battle to defeat national health care reform.

But the new Republican majority broke with past interest-mobilization strategies in building interest group support. Rather than developing one broad policy coalition to push forward the budget battle, as Ronald Reagan did in 1981, the leadership formed separate coalitions to address general budgetary concerns, taxes, and Medicare. Some participants felt that the leadership's coalition structure served to fragment support and would have preferred a more cohesive strategy with all in a single coalition. They believed that Gingrich designed separate coalitions in order to dissociate tax reductions from the Medicare spending cuts. One business insider felt that the Congressional leaders were "fooling themselves" in trying to keep these two issues apart and feared that the multiple coalition approach produced too many messages: "The problem was when you had all these coalitions, you divided up your resources so that no single coalition could have the punch that you could have had if they were all joined together."

The Coalition to Save Medicare was composed of ninety-nine associations, including insurers, providers, small-business groups, seniors, and right-wing citizen activists. The coalition was cochaired by Bailey and
Jake Hansen (Seniors Coalition) (Miller 1995: 82). The Healthcare Leadership Council consisted of players from for-profit hospitals, insurance companies, and drug companies and was a leader in the campaign against the Clinton bill. The Seniors Coalition was begun by Richard Vigurie as a rightist counterpart to the American Association of Retired Persons, and now (with two other right-wing senior groups) raises about $18 million a year for Republican causes. According to Molly Ivins (1995: 136), the group has been investigated by both the New York and Pennsylvania Offices of the Attorney General.

The Republican interest group strategy was to offer specific benefits to small-business and conservative right allies in exchange for their commitment to support all parts of the contract. Thus business participants were promised full consideration on the issues near and dear to their hearts, but they had to promise to support the entire agenda of the party. To belong to the Thursday group, members had to take a blood oath to support the contract in its entirety and to restrain individual issues in favor of the broad legislative agenda. Van Dongen explains that the guiding principle for his product liability coalition was: "we have no independent goals; all goals come from the leadership. We will do whatever the leadership feels we should do." Another participant explained, "You're constantly having to pull people back into fighting for the collective good when their impulse is to fight for the particular good."

The Coalition to Save Medicare provided critical help in the early days of the Republican Medicare campaign. First, private interests generated a seemingly endless source of money. In the past decade the health insurance industry gave more to Republicans than to Democrats by a factor of 3.5 to 1 (Marcus 1995: A25). Groups connected to the Republicans spent much more money attacking Clinton's health reform than the Democratic groups spent criticizing the Republican's Medicare campaign. For example, the HIAA spent $15 million on advertising attacking Clinton in 1994; the American Hospital Association spent only $350,000, and the AFL-CIO spent $1 million criticizing the Republicans in the first part of 1995 (Serafini 1995). Supporters of the Medicare changes used public opinion polls to package their message to the public and developed an extensive advertising campaign.

Second, private sector allies helped the Republicans to define the Medicare issue in a manner that was appealing to the general public. The Republicans realized that the American public would not sacrifice Medicare for a balanced budget or tax reduction; therefore, the case had to be
made that Medicare needed saving in its own right. For example, political scientist Bob Blendon found that 73 percent of his sample supported reducing the growth in Medicare spending but that only 44 percent supported cuts to balance the budget, and 28 percent supported cuts to finance tax reduction (ibid.). During the problem-definition stage, the Republicans and their business allies did a full-scale media blitz to convince the public that Medicare was going bankrupt and to establish the legitimacy of the problem. The Republican National Committee started a $300,000 television campaign at the beginning of October to saturate the air waves with positive vibes toward Medicare reform at the critical point of legislation (Jasperse 1995: 4). The Coalition to Save Medicare held a series of “Medicare University” sessions to educate congressional staffers and journalists on topics such as the virtues of choice and the dangers of waste, fraud, and abuse in Medicare (Fisher 1995b: 36). The group, working in tandem with coalition whip Paul Coverdell (R-GA), persuaded Republican senators to put forth radio commentaries on Medicare reform (Stone 1995: 2152).

Allies of the party initially claimed that this campaign was wildly successful. For example, the Citizens for a Sound Economy’s initial focus groups showed a public largely convinced that there was no problem with the Medicare system; yet follow-up focus groups a few months later showed a public largely accepting of the Republican line.24 Later, however, public opinion shifted against the Republican plan.

Third, business allies worked with the leadership to offer the appearance of overwhelming public support for the Medicare legislation. Shortly before Congress broke for its August recess, the Coalition to Save Medicare held a “Mobilization Event,” offering legislators stirring testimonials to take back to the districts (Fisher 1995c: 8). The coalition also offered the occasional grassroots show of force, as when thirty seniors arrived at Congress with 100,000 “message-grams.” Bailey described this as a full-scale war.

The Rise and Fall of Medicare Reform

The Republican leadership learned much from the Clinton administration’s experiences with health reform. The administration got bashed for too much secrecy, but the lesson for the Republicans was that too many leaks was a bad thing. The Clinton bill was scrutinized and picked apart

for months before members of Congress actually had an opportunity to vote on the measure.\textsuperscript{25} In comparison, the Republicans' rush through the process reminded one of Grant's taking Richmond. Learning from Clinton's errors, the Republicans were careful not to unveil their proposal until they were ready to legislate, and rushed the bill through Congress.

The Clinton administration was criticized for being too partisan and for shutting Republicans out of the bill-writing process; the GOP pursued this tactic in earnest. By putting Medicare reform in the reconciliation bill, they could avoid the threat of a filibuster in the Senate. This removed incentives for real bipartisan cooperation; as long as the leadership could keep the Republican ducks in a line, they had little need to cross over to the other side of the aisle. At one point the Democrats held protest hearings in the rain on the front lawn of the capitol to illustrate their feelings of being shut out (Toner 1995: A26). It was not their finest hour.

Although the administration was slammed in the press for being obsessed with policy over politics, it had in fact made many concessions to special interests. The problem was that these concessions were made without sufficiently firm commitments and at a premature stage in the process. The Republicans also made many concessions to special interests but were able to secure firmer commitments in return.

At first the GOP strategy seemed to pay off. The House Republican members finally introduced the Medicare Preservation Act on Friday, 29 September; by the following Thursday the bill had been marked up by both the Ways and Means and the Commerce Committees. Formal Commerce Committee hearings were initially scheduled for only one day; each member was to be given five minutes to comment on the act. The urgency was emphasized with an electronic clock hanging on the wall, counting down the 197 million seconds until Medicare bankruptcy. At one point the conservative Seniors Coalition invaded the proceedings with 100,000 "message-grams," demanding that Congress save Medicare. Angry with the limited time given to scrutinize the bill and the rushed nature of the proceedings, former chairman John Dingell led the committee Democrats in a walkout (Fisher 1995d: 10).

The Medicare legislation passed in the House as part of the larger Budget Reconciliation Act in late October with all but ten Republicans on board (Gray 1995a: A1, D21). Whether the Republicans succeeded in convincing the public that God was on their side, they convinced their own rank and file that the Medicare legislation was a political asset.

\textsuperscript{25} On the many ironies of the two bills see Priest 1995: C3.
rather than a liability. Indeed, rather than hiding Medicare in the budget reconciliation, the Republicans chose to stand up and be counted with a vote (Clymer 1995c: B8).

When the bill got to the Senate, moderate Republicans neutralized some of the more punishing provisions in the House measure. They felt that pregnant women, prepubescent children, and the disabled should retain their federally guaranteed rights to Medicaid. The more moderate senators rejected radical House changes in nursing home regulations. The House bill contained a provision that would allow companies to borrow from their workers' pension plans to fund corporate takeovers, among other things. Senator Edward Kennedy (D-MA) mounted an energetic attack on this provision and the Senate voted 94 to 5 to strike it from the bill (Gray 1995b: A1, 8). But the Senate also passed a Medicare reform bill very quickly with little Democratic support.

The rapid congressional action on Medicare was to no avail when President Clinton put a halt to the process with his office's ultimate weapon. The president vetoed the reconciliation bill that included Medicare reform, signing it with the pen that LBJ had used to make Medicare law in 1965. The Republicans argued that this symbolic gesture was a "cheap trick." Richard Armey (R-TX) wondered publicly if Clinton would authorize troops to be sent to Bosnia with "the same pen that LBJ used to sign the Gulf of Tonkin resolution."

The Republicans tried to play hardball with the president by refusing to pass legislation to fund government during the budgetary impasse. But with a forbearance surprising to even his ardent supporters, the president refused to cave in to Republican demands and to acquiesce on Medicare and other issues. In part the president was emboldened by the shift in public opinion. By a ratio of 2 to 1, Americans criticized the Republican Medicare plan, and only one out of every four approved of the tax cut (Clymer 1995d: A1, D23). Ultimately the Medicare reform plan simply died.

The budget stalemate deeply frustrated the small-business groups who had worked so hard to enact the Contract with America. Employers blamed the Republicans for a lack of leadership and focus. Thus one participant remembered, "The leadership was too busy focusing on the numbers, daily sound bites, and on today's polls [to mobilize business] . . . There was not much clarity of what they [the Republicans] were looking for from them [business]." Another explained, "There was a real loss in momentum because the original game plan didn't work and they didn't know what to do." Many felt that the Republicans tried for too much too soon and set a priority on taking credit for political victories
over securing policy goals. A lobbyist for a large group of small businesses reflected: "Republicans have taken self-destruction to new heights. We all love amateurs, still, some [of the current congressional freshmen] are close to violating their oath of office in trying to shut the government down. They have been overreaching to such a large extent that they are likely to lose everything."

Perhaps in part because of the frustrations of the budget battle, the small-business lobby has recently worked with the bipartisan Kassebaum-Kennedy bill. Small-business trade associations have continued to desire health reform, because medical coverage for this population is extremely expensive, and access to managed care plans is limited. A *Health Affairs* survey found that 51 percent of firms with fewer than fifty employees provide benefits, but that only 41 percent of these firms offer a managed care option (Morrisey, Jensen, and Morlock 1994: 149–152). The irony, of course, is that the Clinton subsidies would have greatly benefited small firms, although many were deeply suspicious about the mandate (McLoughlin, Zellers, and Frick 1994: 221–233).

The small-business lobby supported the "no amendment" strategy in the Senate proposed by Kassebaum and Kennedy. Lobbyists explained that even though they might favor amendments, they feared that permitting amendments to the bill would "open the floodgates." This position has not sat well with their traditional allies, and small-business participants have had to endure Republican charges of supporting "Clinton lite."

**Conclusion**

The story told here leaves us in an odd state of affairs, one we normally do not associate with big-business attitudes toward markets. Although a current snapshot view shows large employers fairly optimistic about market solutions, history suggests that this may be a high point in a cycle of ambivalence. Large employers may be rushing into managed care and regional coalitions to keep costs down, and many now seem to be rather more sanguine than they have been in recent years. Yet many managers remember failed cost-containment efforts in the past and fear that this rosy scenario is unlikely to continue forever. As the large-scale move into managed care is completed, costs may once again resume a more rapid rate of change.

In the area of public policy, large employers have been more openly

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26. Interview with industry lobbyist, 23 February 1996.
hostile to market measures. Big business greeted with consternation the
Republicans' proposal to bring private sector market initiatives into the
traditionally public domain of Medicare and Medicaid, fearing that these
measures would only increase the big-business burden of health costs for
government populations. But large employers did little to protect their
interests during the Medicare reform cycle, and ultimately the legislation
was stopped only because a Democrat occupied the White House.

In the long term, then, it may be in the sphere of public policy where
large employers' interests are most at risk, not because liberal Democrats
add to their regulatory burden but because conservative Republicans
seek to alter the policy landscape. Large and small firms have very dif-
ferent interests in the zero-sum cost shifting of today's health world.
Health reform and its aftermath vividly illustrate that the power balance
within the business community is shifting: what the little guys lack in
size, they make up for in organization. Republicans seem to be much
more interested in gratifying their small-business allies than in address-
ing the concerns of large employers, whom they view with unease and
often with downright hostility. In the post-national-health-care-reform
era, Republicans and their small-business allies are the new Washington
political elite.

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