Together Again:

Business, Government, and the Quest for Cost Control

Cathie Jo Martin
Boston University

Abstract Corporate America leads the pack in the collective anxiety attack over health care costs. But will the business community add its considerable political power to the movement for national health reform? Conventional wisdom suggests not: businessmen seldom rally for collective concerns, have traditionally been biased against government action, and have diverse interests. This article guardedly offers grounds for greater optimism about corporate participation, arguing that the proper institutional context can help businessmen to see their preferences as consistent with health reform. Business groups have already proven critical to the issue development stage, where a dedicated group of corporate health reformers were key to getting reform on the national agenda. Business may also respond to strong leadership from President Clinton and assist in the legislation of national health reform. Yet the price of this corporate support is a decidedly conservative slant to the proposed legislation.

Health care cost containment and the Holy Grail have a lot in common: elusive but ever-inspiring, they capture our imagination but escape our grasp. Past cost containment efforts faltered under the attack of providers, who used their political power and administrative expertise to weaken cost control legislation and evade its implementation. Confined to the domain of incremental adjustment, these interventions lacked the scope and power necessary to effect real change. Providers, insurers, and businessmen all rejected more comprehensive national reforms as costly, invasive of physician power, and ideologically incorrect.

Of late, however, the escalating costs of health care have triggered a collective anxiety attack, intensifying the crusade for containment. Joined
to the concerns about costs are worries about the 34 million uninsured Americans, many of whom are working poor (Fuchs 1988: 9). For the first time in fifteen years a fundamental national overhaul of our health financing system is on the public agenda. In a remarkable reversal of fortune, national health reform has become associated with keeping costs down rather than driving them up. As a result, although corporate America has in the past rejected national health insurance as one step short of Moscow, some businessmen are at the forefront of the latest national reform effort.1 Worried about international competition and budget deficits, these businessmen fear that Americans now face a choice: between tightening the belt or tightening the noose. The gluttonous health sector, expected to consume 15 percent of the annual GNP by the year 2000, seems a prime candidate for fiscal dieting (Polzer 1990: 30).

Even providers no longer present a unified front against national health reform, with some groups now recognizing the great impetus toward national health reform and offering their own proposals (Peterson 1992). The American College of Physicians and the Catholic Health Association go so far as to support global budgets (Pear 1992a; Catholic Health Association 1992: 18). But the most powerful provider organizations (the American Medical Association and the American Hospital Association) seem inspired by a desire for damage control. They support assorted incremental reforms but continue to oppose the more threatening cost containment proposals (Kosterlitz 1992).

A strong business showing for national reform could counteract the traditional dominance of providers and insurers in health policy. Bringing businessmen to define their interests as consistent with the collective goals of controlled costs and expanded access would create the political openings for genuine cost containment. The essential problem is whether a critical mass of the business community can be mobilized, either alone or in consort with other reformist forces, to offset producer power.

The conventional view of business participation in policy-making is skeptical about mobilizing corporate support for health reform. Corporate activism happens when a firm's interests are concentrated, but corporations tend to be complacent about collective matters or about issues outside the fundamental concerns of companies (Olson 1965). For example, Sapolsky et al. (1981) found in health what Bauer et al. (1972) found in trade two decades earlier: a quiescent corporate crowd largely oblivious to the burgeoning medical claims on their financial statements.

The conventional view is that nonincremental policy changes only transpire either when a dominant business sector's primary interests coincide with those changes or when government bureaucrats are sufficiently insulated from narrow sectarian demands to create policy designed to meet the collective interest (Ferguson 1984; Skocpol 1985; Morone and Dunham 1985). In the latter case, business is a hindrance rather than a help to the process. The former case offers some potential for business participation in reform processes. But this involvement is unlikely in health reform, since corporate consumers of health services do not have concentrated interests in reforming the system. Although health costs have greatly increased in magnitude since Sapolsky et al.'s seminal study (1981), they remain only one of many factors in production.

In addition, despite the considerable incentives for business as a whole to engage in the health reform crusade, three other constraints impede corporate action. First, businessmen are ideologically predisposed to distrust the state: a national plan that increases federal control over health financing decisions will elicit an automatic "no" from many corporate quarters. Second, although business as a whole has impressive reasons for wanting cost containment, individual interests vary widely. Large, unionized, export-oriented firms now subsidize the costs of the uninsured, many of whom work at minimum-wage jobs without benefits. A health system that seeks to distribute the costs more equally among employers obviously creates new winners and losers. Third, corporate executives may choose to join the political struggle for aggregate cost containment or may opt instead for short-term, self-interested solutions, such as cost shifting, that do little to halt the overall growth of the health burden.

In this paper, I break with the conventional view by offering a scenario in which corporate consumers of health care (with less concentrated interests than producers) can aid in the reform process. Business mobilization around this collective reform is possible but depends on two important developments in the political, institutional realm.

First, for business to contribute to the development of the issue, a core group of corporate reformers must organize. Some part of the business community must decide that health reform is a top political issue and that greater government direction is appropriate and necessary. This requires changes in corporate preferences. Whether these preferences change depends on specific developments in the institutions that mediate shared

1. National health reform is not necessarily the same as national health insurance, as will be made clear below; however, both entail a national plan for regulating the health care financing of all Americans.
business interests. Thus, the particular characteristics and strategies of
business associations will greatly influence the prospects for reform.

Second, at the legislative stage, business must be organized to support a
given proposal and to lend resources and energy to the legislative battle.
For a wide spectrum of business to take an active positive role at the
legislative stage usually requires top-down mobilization by sympathetic
political entrepreneurs, often strategically placed within the administra-
tion. Business groups alone have difficulties mustering the leadership and
organizational scope necessary to focus on a chosen option and to coordi-
inate the warlike campaign for legislation.

This sanguine view of business participation in the political process
leaves us, however, with certain ironies. First, business seems to be criti-
cal to the policy-making process, but it is incapable of taking action on
its own. Business activism depends on top-down mobilization by gov-
ernment. It seems, then, that government cannot act without business
participation, but that business cannot mobilize until government acts.

Second, corporate involvement in the reform process greatly improves
the chances of its political success. But recruiting business to overcome
provider intransigence does not guarantee a happy ending. As soon as
business is brought into the process, the dynamics change. Business mo-
mobilization has its own set of costs. Corporate reformers may have relaxed
their ideological opposition to government coordination of health financ-
ing, but they have nonetheless pulled the debate to the right. Whatever
we consider the merits of a single-payer system to be, corporate opposition
has diminished the chances that it will be passed into law. Although
President Clinton may be able partially to reconcile conflicting interests,
it is by no means certain that this consensus position represents the best
possible solution to the health care crisis. Even if the business commu-
nity chooses to engage in collective political solutions, the many details,
exclusions, and transition rules of the legislation will certainly favor its
political supporters.  

Options for Health Care Reform

Four major reform proposals for restructuring the health financing sys-
tem organize the national debate: the single-payer system, the play-or-pay

2. An alternative to mobilizing business is to use the disarray of the business community to
increase the relative power of the state. This strategy works quite well when different producer-
groups lobby for their own narrowly concentrated interests; the state gets leverage to pursue a
middle way. In the case of health, however, businesspeople enter as consumers, have more
collective concerns, and can act as counterweights to providers.

plan, the Heritage Foundation's tax credit proposal, and the managed
competition approach.

The single-payer approach creates a single pool into which all pay; this pool negotiates with hospitals and doctors. It is a tax-based rather
than a premium-based system. Some plans abolish private insurance and
depend entirely on government administration. Other plans allow for priv-
ate insurance or at least allow these insurers to administer the public
plan. Representative Marty Russo and Senators Bob Kerry (D-NE), Tom
Daschle (D-SD), Howard Metzenbaum (D-OH), and Paul Simon (D-IL)
have all sponsored single-payer bills.

Woolhandler and Himmelstein, in an unpublished manuscript (undated)
argue that a Canadian-style system would save $69 to $83.2 billion in admin-
istrative costs. Critics retort that the Canadian national debt is twice
as high as ours per capita and that the Canadian federal government is
shifting costs to the provinces (Brown 1989: 29). Others worry that the
national government is not competent to administer the plan and that
quality will decrease without competitive market pressures. There is also
concern that increasing taxes is not politically feasible; however, Blen-
don (1988) finds that 66 percent of Americans would tolerate a small tax
increase targeted for health care.

The "play-or-pay" system is a mixed public-private system that im-
poses global budgets to limit costs, regulated rates to reduce inequities,
and mandates on employers to expand coverage. The play-or-pay feature
means that employers either play or offer health insurance, or pay a
new payroll tax of 5 to 8 percent, used to expand the public program.
Play-or-pay has been the Senate leadership's approach of choice since the
Health America bill (S. 1277) was proposed in June 1991. 3

Critics of the initial Democratic proposal charged that it had no cost
containment mechanism (Knox 1991). This may be attributed in part to
Senator Kennedy's close relationship with providers. But during markup,
the committee strengthened the powers of the health expenditure board to
contain costs. 4 Critics worry that the rate regulation of play-or-pay will
generate some of the same market problems as price controls. The man-
deate has also been widely debated. Swartz (1990) argues that mandates

3. The bill was proposed by Majority Leader George Mitchell (D-ME), Edward Kennedy
(D-MA), John D. Rockefeller IV (D-WV), and Donald Riegel (D-MI). It requires a payroll tax
of 7 percent. Funds from this tax would be used to create a new public insurance plan called
AmeriCare, which would also absorb Medicaid (Kennedy 1991).

4. In the leadership's original bill the board would provide a forum for the negotiation of
rates between purchasers and providers. But in the marked-up version, the board would have the
power to set the rates in the event of a stalemate (Rovner 1992b).
will fragment the insurance market and reduce the risk pool. Wilensky (1989: 32) asserts that mandated benefits will create a new burden on business, increase the hourly cost for workers receiving the minimum wage by up to 80 cents, and precipitate a loss of jobs. But Brown (1990) responds that the alternative to mandating benefits is to increase general revenues to cover access; mandates may not be an ideal option, but they are better than the alternatives. Finally, play-or-pay has been criticized as a first step toward a single-payer system. This view gained credence with the proposed setting of the “pay” rate at 7 percent of payroll. Many large employers’ health costs are as much as 14 percent of payroll. Thus, skeptics conclude that the system was designed to give individuals an incentive to opt into the public plan (Zedlewski et al. 1992).

The Heritage Foundation tax credit or voucher system seeks to reintroduce competition into the health care market. This plan changes all employment-related benefits into direct wages: workers pay for premiums directly. Individuals and families get tax credits from the government adjusted for income, so that all sources of insurance (and out-of-pocket expenditures) are treated equally. All heads of households are required to buy at least catastrophic insurance, but state mandating of specific benefits is illegal. The plan limits malpractice suits and “experience rating” by insurers and encourages the use of a single, universal insurance claim form. In its pure form, the Heritage plan entails almost as much government monitoring as play-or-pay (Kinsley 1992). It differs in leaving the reform process to the private market, rather than to government regulation and administration.

The plan presented by President Bush adopted pieces of the Heritage approach but fell far short of comprehensive reform. Also, Bush’s plan included no realistic funding strategies. While the Heritage proposal ended the tax deduction for employer-funded health benefits, Bush avoided antagonizing business with this politically difficult move. The maximum tax credits stipulated by the plan ($1,250 for individuals and $3,750 for families) are unlikely to be enough to cover the costs of health care for poor

families. All states would be required to guarantee basic plans that could be purchased with the vouchers. But would these plans meet the needs of the very ill? Governors worried that the plan would pass the problem along to the states.8

A final option is the managed competition proposal. This approach, based on the work of Alain Enthoven, seeks to change the market incentives for both providers and consumers, primarily by aggregating consumers into large purchasing cooperatives. The Democratic Leadership Council’s version of these groups, called regional health insurance purchasing corporations (HIPCs), would evaluate plans, negotiate rates, and offer their members a choice of the best plans. States would be responsible for regulating HIPCs, but the entities could take various forms (Rosner 1993).

The health plans themselves would also be regulated in order to ensure quality and minimize costs. A national board would determine a standardized benefit package; only plans that provided the package would be certified as “accountable health plans.” Consumers would only receive a tax credit for their health care costs if they bought a certified plan. The proposal also restricts employers’ deductions of their contributions: employers must offer their workers a choice of at least two certified plans, and deductions would be limited to the cost of the cheapest accountable plan in the region. The rationale for this is to redirect consumers toward less costly managed care plans (such as HMOs) or catastrophic plans if the consumer feels that he or she does not need the extra coverage. By limiting the tax deductibility to lower-cost options, it is argued, health decisions will become more cost effective (Rosner 1993).

According to its advocates, managed competition would move all consumers to the managed care market and would accomplish dramatic changes in the health care landscape without excessive government intervention (Faltermayer 1992). But since the plan stipulates that mandates and regulatory boards, the government would remain very involved (Abramowitz 1992).

One reason for the popularity of managed competition is its political

5. In health financing, third-party payers (insurance companies and government purchasers) upset the supply-and-demand relationship because neither patients nor providers experience price constraints. Thus one way of keeping costs down is to reintroduce market incentives.

6. Routine care would be cheaper if purchased out-of-pocket. The current system directs government assistance to those employed workers who need the assistance the least. There is no reward in the system for providers who offer services efficiently, since consumers hardly notice the cost of health care (Haislmaier 1992).

7. The traditional Republican culprit—waste, fraud, and abuse in Medicare and Medicaid, plus a corresponding slack in the commercial insurance industry—was idealistically expected to produce much of the necessary funds (Rovner 1992c).

8. Nelson Rockefeller pointed out the case of a family who, after losing its job-related coverage, would be required to pay $9,000 for individual coverage but would only be eligible for a voucher of $360 under the president’s plan. The states would be required to run the tax credit system and to ensure that basic coverage would be available. Also, the plan changed the way in which Medicaid reimbursements are given to the state. These reimbursements are now awarded retrospectively, based on the amount spent by the state. Bush’s plan would change this, giving the states an annual amount prospectively based on the number of Medicaid recipients (Rovner 1992c).
feasibility. First, market approaches tend to be more acceptable ideologically. Second, the plan builds on the employer coalition movement of the 1980s. Throughout the eighties, firms in many regions tried to restrain costs through purchaser coalitions, a smaller-scale type of consumer cooperative that shares much with the managed competition idea. Although these efforts had varied success, an institutional legacy was established (Jaeger 1983; Cronin 1988).

Third, managed competition has been helped politically by the recent rage in corporate cost controls—managed care networks. These networks, administered by the large insurers, use their strength in numbers to secure advantageous rates for their customers. In a Foster Higgins sample, 45 percent of the employees are enrolled in a managed care plan; nearly three-fourths of the companies offer a managed care option (Foster Higgins 1992: 5). Companies using managed care in a Tower Perrin study reported that their growth rate decreased from 18 percent to 12 percent (Tower Perrin 1992: 2). The cognitive step from managed care to managed competition is a small one: businessmen are instinctively drawn to a national solution that is close to what they are already doing at the micro level. Finally, the move of big insurers into managed care offers another reason for the political feasibility of managed competition: these giants hope to administer the purchaser cooperatives (interview by author, September 1992).9

Managed competition has its share of detractors; criticism will undoubtedly increase as the details of the proposal emerge. Some worry that managed competition will increase administrative costs, as managed care networks have done at the micro level. We may find a way to pay doctors less, but do we want to pay insurers more? Others wonder if the competitive strategy will really work. Although managed care has worked at a micro level, this success may be partially due to cost shifting. Although competition generally drives prices down, in the past in health care it has driven them up. The Congressional Budget Office, for example, predicts very limited savings from this approach, at least in the short term (Pear 1992c). Another issue is what to do about Medicare (Marmor 1993). Do we push the elderly into purchaser cooperatives that are likely to move them away from fee-for-service arrangements with their long-time doctors? As a trade association representative remarked, "I don’t want to have to tell my mother. Do you want to tell yours?” (interview by author, December 1992).

All of these approaches are national in scope and profess to expand access to all Americans. The single-payer and pay-or-pay plans entail government regulation of prices and aggregate limits to health spending. The tax credit and managed competition approaches use improved market incentives to contain costs, albeit with considerable government oversight. The pay-or-pay and managed competition proposals preserve employer provision of health benefits; the single-payer and Heritage plans end the employer-based system. The single-payer system occupies the left flank; the Heritage Foundation tax credit approach, the right. The pay-or-pay and managed competition approaches fall in the political center.

To date President Clinton gives signs of offering a blend of the pay-or-pay and managed competition proposals, similar to the plan developed by John Garimendi, California’s insurance commissioner. In keeping with the spirit of pay-or-pay, Clinton has proposed that all employers be mandated to provide health benefits to their employees. To contain costs, Clinton has proposed that a national board would set spending targets for the amount to be spent on health care. Combined with these regulatory efforts to contain costs is the market-oriented managed competition proposal. Employer-paid premiums would be aggregated into nongovernment purchasing cooperatives that would coordinate coverage and restrain costs. This policy has attracted considerable support from Paul Starr (1992, 1993) and other health policy experts.

Clinton’s appointment of Judith Feder as head of the transition team on health issues signaled his commitment to the global budgets and mandates found in the pay-or-pay approach (Feder served on the staff of the Pepper Commission, which developed pay-or-pay). Clinton’s appointment of Ira Magaziner to coordinate the development of health policy within the administration suggested an interest in Garimendi-style managed competition. Most importantly, the president’s appointment of Hillary Rodham Clinton to head a special health panel indicated a serious commitment to action (Friedman 1993). The form of this action, however, remains to be seen.

The transition team report created a flap in predicting a $150 billion shortfall between what it would cost to provide universal coverage and what would be saved by the proposed price controls. At this point, the special commission led by Hillary Clinton was organized, signaling to some a decline in the fortunes of pay-or-pay advocates and a rise in the status of managed competition (Gosselin 1993: 10). Yet the pressures of the budget deficit may inspire a return to rate regulation as the easiest way to cap rising costs immediately. Many important decisions will have to be made concerning the details of the plan. The administration must
decide whether to make employee-funded benefits above the cost of the minimum plan taxable to the employee. The number of health insurance purchasing corporations (HIPC's) in a region must be determined. Important to employers is whether companies will be allowed to have their own HIPC's or forced to join one regional HIPC and, thus, be lumped into the regional risk pool. If price controls are joined with the managed competition approach, will the accountable health plans also be subject to these price controls, or will they be free to organize their own internal prices in negotiating services with the HIPC's? If caps are developed for overall spending, will they be adjusted to reflect the different costs of health care in different regions?

**Business and Cost Containment**

American business as a whole has good material reasons for desiring health care cost containment. Health care costs have risen dramatically in the past forty years, increasing from 5.3 percent of the GNP in 1960 to 11.6 percent in 1989. A large proportion of this increase has fallen on corporate employers. In 1965 households funded 60.5 percent of the nation's health care; business, 17.0 percent; and government, 20.7 percent. By 1989 each sector paid about one-third. Employer health spending jumped from 2.2 percent of salaries and wages in 1965 to 8.3 percent by 1989 (Levit et al. 1991). In 1991 American employers spent on average $3,573 per worker on health insurance, an increase of 13 percent from 1990 (Bethlehem Steel Corporation undated). The expanding corporate share has resulted in part from cost shifting, in which governments negotiate ever lower rates for their share of health care, leaving business and commercial insurers to pay more. Someone must fund the uninsured, and this burden has increasingly fallen to business. For example, government policy transferred primary responsibility for the elderly from Medicare to employers, saving the Medicare Trust Fund $1 billion in fiscal year 1986 alone (Amkraut 1987). In 1989, the Financial Accounting Standards Board issued new accrual accounting requirements in a regulation called FAS 106. These requirements have altered the way corporations treat their future liabilities for retiree health benefits. Firms are now required to reflect these enormous liabilities on their bottom lines. This change has greatly enhanced the salience of the rising costs of the health system.

Since business purchasers of health care as a whole are getting badly stung by rising health costs, we might expect them to be major players in the reform battle. A critical mass of the business community, acting alone or in consort with other reformist forces, could provide an important counterweight to the traditional dominance of health policy by provider groups. But three constraints stand in the way of concerted corporate action: ideology, divided interests, and the option of choosing a short-term, self-interested strategy over a collective political solution.

Ideology is an initial constraint against widespread business support for government-led, national health care reform. Historically, business groups have resisted government intervention at the federal level, and have instead favored market interventions. For example, John Sloan (National Federation of Independent Business) called the Kennedy-Waxman proposal "nothing more than a first step towards socialized medicine" (Rovner 1989). Theodore Marmor, Judith Feder, and John Holahan noted in 1980 that national health insurance generates an ideological intensity matched by few other issues in American politics. The antagonists in the debate are well defined and well known, and they have remained relatively stable over time.

This historical antagonism has been receding, driven back by the assault of health costs on corporate profits. The number of business executives who strongly agreed that we are "facing a health care crisis" increased from 30 percent in 1985 to 54 percent in 1990 (William M. Mercer 1990). Cantor et al. (1991) found that 80 percent of the 384 Fortune 500 executives in their study believed that "fundamental changes are needed to make it [the health care system] better." Over 32 percent favored a public health insurance system either now or in the future, and 53 percent supported employer mandates. A study conducted by *Business and Health* found 30 percent of its corporate respondents in favor of and 25 percent neutral toward national health insurance (Wisnewski 1990: 36). As one corporate lobbyist put it, "Business from the far right has moved to the center in saying that the federal government needs to be involved" (interview by author, May 1991).

Although business seems more receptive to a national comprehensive solution to the health crisis, ideology may still play a role in guiding corporate America toward one reform option over another. In choosing an approach, businessmen must balance their predispositions toward market solutions with their evaluations of the relative merits and anticipated effectiveness of the plans. Single-payer systems entail the most government intervention and enjoy the least corporate support. Play-or-pay approaches have a larger share of corporate advocates, who are drawn to
the aggregate limits on costs but are also reassured by the continuing hegemony of the employer-based system.

Many businessmen are instinctively drawn to the market assumptions of the Heritage Foundation and managed competition proposals; however, some worry that the cost containment measures are insufficient. The failure of market competition strategies in the eighties have made some businessmen more open to grand solutions. One participant explained his shift from a market competition approach to a national regulatory one: “Most of us recognize that the things we did in the mid-’80s didn’t really work” (Polzer 1990).

A second constraint against business leadership in the struggle for health care reform is the uneven manner in which health costs affect firms. Rising health costs have a very different impact across the business community. Larger firms are more likely to fund employee health benefits and thus are more likely to feel the pain of escalating costs. Unionized firms are more motivated than nonunion companies: escalating health costs have increased labor-management conflict as employers push workers to fund a larger share of their premiums. Health benefits caused only 18 percent of strikes involving over 1,000 employees in 1986, compared with 78 percent in 1989. Export companies who compete with firms from countries with national health insurance are hurt by rising costs. Health care supposedly adds $700 to the price of an American-made car, compared with only $200 to an auto made in Japan (Schneider 1990). Health costs for each Canadian steelworker on hourly pay are $3,200 a year; for his or her American counterpart, it costs $7,600 a year. Firms with older employees also pay higher rates. Small firms that provide health insurance pay very high premiums, since their small pools limit their ability to negotiate favorable rates. Because firms have fairly diverse patterns of health care financing, they want different things from the reform process.

A related problem is that many more companies have now entered the business of providing health care services, especially with the expansion of for-profit facilities in the past decade (Salmon 1987). Conglomerates often experience internal dissension on the issue of cost containment, between divisions that are consumers of health care and those that are providers.

A final constraint against the political participation of business in the reform effort is the availability of short-term, self-interested alternatives. If firms are able to engage in cost shifting, passing their health care costs on to their employees, they will be less likely to pursue a collective political solution. Cost shifting may help individual firms for the short term, but it will do little to limit the aggregate costs of health over the long term.

Two Theories of Business Mobilization

The critical question, of course, is whether business can overcome these constraints and emerge as a positive force in the health reform effort. One’s optimism on this point depends on one’s views of human nature and political action: how corporate preferences for public policy are formed, and what it takes to mobilize the business community.

The literature on corporate involvement in public policy is dominated by the economic view of “preference.” According to this approach, people in business have stable preferences, based on the material circumstances of their firms. These interests are readily apparent. In other words, businessmen know what their interests are; one can calculate their political preferences from the economic structures of their firms (Frieden 1988; Jacobs 1988; Kurth 1979).

The economic view is that mobilization of businessmen around collective issues occurs when their self-interests can also be gratified through selective side benefits of the proposal. Sometimes a firm will assume the costs of political action without side benefits, but only when it expects to receive so much from the collective outcome that it is willing to bear the entire cost itself (Olson 1965; Stigler 1971). Political mobilization in any policy area typically involves those with the most narrowly focused interests. Producers have more focused interests than consumers, since the policy is key to the former’s livelihood. Thus, producers are more willing than consumers to dedicate resources to influencing public policy.

The economic approach offers only limited hope that the constraints against business mobilization for national health reform can be overcome. First, the economic view of interests has difficulties accounting for the

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10. Indeed, paradigm shifts are often related to the failure of the dominant paradigm to solve the problems of the day (Hall forthcoming).
11. A national health plan has been viewed by both sides of the bargaining table as a way to end battles between labor and management over who pays the bill (Victor 1990).
12. Part of the costs go to retiree benefits (Williams 1991). Critics charge that this method does not reflect the different factors that are included under the rubric of wages in the United States and Japan.
13. Claus Offe (1985) argues that business can rely on an "individualist and purely instrumental form of collective action," whereas for workers "interests can only be met to the extent they are partially redefined."
persistence of ideology or suggesting ways to overcome it. Second, if corporate preferences are relatively fixed by the material conditions of the firm, then there is little room for compromise between divided interests. Unless interests can be partially redefined, a consensus position is unlikely. Finally, the economic view is pessimistic about getting firms to pursue a collective political solution instead of cost shifting. National health reform is a collective benefit; it purports to solve health care problems for everyone, whether or not they participate in the events leading to its enactment. This is a disincentive for firms to commit resources to the legislative process, since if they succeed in bringing about reform, all will enjoy the benefits of that reform, whether or not they worked to achieve it. Also, business consumers of health services might be reluctant to devote considerable resources to a campaign that addresses only one component of their total costs (Olson 1965).

Before we declare defeat and go home, I would suggest an alternative view of corporate preference and mobilization, one that allows for greater hope for our political project. It is the institutional view. This approach takes issue with a purely material definition of interests, not because economic circumstance is unimportant, but because it can be interpreted in varied fashion. Groups have multiple objectives: the firm itself should be viewed as a "nonunitary actor" with conflicting and ambiguous interests (Thompson 1982: 233; Plotke 1992). With such indeterminacy, social context becomes critical in helping us interpret our situations and arrive at our objectives (Moe 1987: 277; Fliedstein 1990: 102; Hall 1986). Ideas are vital in the interpretation of a problem; these ideas are disseminated through institutions and social networks (Eckstein 1988; Snow et al. 1986; Klandermans 1988: 173–76). Preferences are developed in collective institutional settings.

The institutional context is also essential to the mobilization of interests. The economic approach conceptualizes political mobilization as a decision made by rational individuals who calculate the costs and benefits of such action. By comparison, institutionalists perceive the cauldron of political mobilization to be the small groups in which people endlessly air their grievances and then, at a magical moment, decide to do something about them (McAdam 1988). Institutions and organizational networks are also critical to the swelling of the mobilization effort as the core group contracts others sympathetic to the cause. Contacts are generated through the organizational networks in which the core group is located. These networks spread the ideas of the movement, enable the recruitment of new members, and constitute a resource in political battles (Klandermans and Tarrow 1988). Just as decision makers in state institutions are influenced by policy legacies, actions of groups in society must be guided by previous political experiences and attitudes. Thus an institutional analysis looks at the group's makeup and the organizational strength of groups from which members are drawn.

Public institutions as well as private ones can be critical to rallying business. An economic view of corporate mobilization all too often neglects government leadership in the political organization of business. But the interests of political entrepreneurs may converge with interests of groups in society. Government leaders can augment their power against their own political enemies by mobilizing interest groups who will support their policy position. Alliances cutting across the private-public divide can, thus, facilitate reform.

The institutional approach offers some optimism about overcoming the constraints against business participation in health care reform. First, institutionalists argue that individuals can reinterpret the ideological content of a policy collectively; organizational networks provide the avenues of change. Second, an institutional view of business preference suggests that, sometimes, groups with different material situations can redefine their interests and locate common ground. Finally, the institutional approach is sanguine about the possibility of collective action. Businesspeople become mobilized around health reform through the small groups or networks in which they formulate their political identities.

The institutional approach suggests that mediating institutions and organizational networks can help the business community become a positive force for national health reform. But in order to evaluate the likelihood that business will mobilize in the health area, we must identify the specific institutional characteristics that facilitate such action. Corporate involve-

14. My institutional approach represents a composite approach in that it draws from several traditions: state-centered theory, public choice new institutionalism, and new social movements theory. All share the assumption that preferences are developed collectively within institutional settings and that institutions and networks provide the building blocks for political mobilization.

15. In an important corrective, state-centered theorists have focused on the role of relatively autonomous politicians and bureaucrats in bringing about policy reforms. Reform efforts occur when government bureaucrats link their ambitions, interests, or good policy goals to that reform. They create the political space to achieve the reform by insulating themselves from private pressures. According to this view, the business community has little to offer the reform effort, since the impetus for reform is located within the state. I would suggest, however, that business groups may have more to offer government reformers than the state-centered folks admit. The options for government actors are not only being captured by private interests or insulating themselves from those interests (Martin 1989).
ment in public policy-making is significant at two stages of the process: issue development and legislation. First, at the issue development stage, a critical mass of businesspeople must develop preferences for national health reform; health must become an issue in the corporate community (Kingdon 1984). Businessmen must set a high priority on solving the health problem and determine that government regulation is an appropriate solution. Second, a critical mass must mobilize around a given proposal and fight for that proposal during the period of legislation.

The institutional characteristics important to the two stages are somewhat different. The issue development stage requires considerable commitment from a core organization (or organizations), which will focus business attention on the health problem and engineer a transformation of preference in the larger business community. I would suggest that organizations that spearhead policy transformations in the business community are usually new additions to the pattern of groups representing business interests. But these groups must also be at least somewhat connected to the preexisting institutional network of interest intermediation. Thus these new groups maintain a delicate balance between independence of prior policy positions and connection to established networks.

Independence is necessary because traditional trade associations tend to be fixed in the old mode of thinking about the issue. The new groups leading the effort must be free from past commitments in order to move corporate thinking in a new direction. This group can help businessmen to rethink their interpretation of their material circumstances and to review the ideological content assigned to the policy problem and its solutions. But connection is equally important, since the group must be able to tap into the existing networks of intermediation within the business community. These preexisting networks allow corporate reformers to disseminate the reform concept and to link the health reform issue to other areas of corporate concern.

The legislative mobilization stage has different strategic objectives and requires different institutional characteristics. As the issue moves toward the legislative stage, organizations need to focus more narrowly on one concrete proposal and to widen membership or organizational scope. Focusing requires leadership—it takes leadership, from either the public or private sector, to focus enthusiasm for the chosen option and coordinate the campaign for legislation (Schattschneider 1960). To mobilize political resources for legislating the proposal requires a large membership or wide organizational scope. Organizational scope brings together diverse political factions and reduces infighting at the point of legislation; and organizations with many members, aggregating a broad cross section of business, are better positioned to concentrate attention on higher-order universal concerns. This can be a means to reconcile seemingly contradictory interests.

The general institutional structure of corporate interest intermediation in the United States makes it difficult to get leadership from business in policy change. The political representation of business is fragmented into single-sector trade associations (Maitland 1983). Umbrella organizations lack jurisdictional monopoly and tend to cater to minority interests.

Leadership in the United States, instead, often comes from political entrepreneurs, who help businessmen to crystallize their support for a given policy alternative and to overcome the resistance to collective action by organizing the movement from above. Although umbrella business groups find it difficult to resolve intrabusiness splits, the packaging of a proposal measure by political entrepreneurs may overcome these limitations and unify diverse factions. When big omnibus proposals bring diverse interests together, companies are forced to swallow bitter pills in order to get their own concerns met. The ability of the government to organize business is furthered by a “follow-the-pack” syndrome: the desire for business groups to be players may overwhelm their points of contention with various aspects of the bill. As one lobbyist put it, “Divisions may seem insurmountable, but once the legislation gets rolling anything can happen” (interview by author, September 1992). The success of pulling together a broad coalition, a process subject to many political contingencies, thus greatly affects the potential for reform.

Building Business Consensus

I will now examine the institutional terrain in which corporate preferences for health policy have been constructed and mobilized in order to evaluate the corporate contribution to the reform process. Health reform emerged as an important issue for many in the business community in the eighties. This process was fostered by several key groups, the most important being the Washington Business Group on Health (WBGH). WBGH was led by.

16. Business is divided in America for reasons apart from the institutional mechanisms of interest intermediation identified here. The historical division between manufacturing and finance in this country is reinforced by our method of financing corporate growth (Zysman 1983). Also, the general weakness of labor has increased corporate infighting.

17. Examples of state-led coalition built around reform can be found in tax, trade, and environmental policy. See for example, Martin 1991.
Willis Goldbeck, a man generally acknowledged by both admirers and critics to be ahead of business on most health issues. In the seventies the group worked with local communities to set up purchaser coalitions. In the early 1980s WBGH opposed Reagan’s deregulatory efforts to phase out health planning and physician peer review (Dempkovich 1983). Goldbeck’s endorsement of progressive principles in health offended many in conservative corporate corridors; yet his boundless enthusiasm for health reform attracted a sizable business following. As of 1990, 185 Fortune 500 companies belonged to WBGH (Burke 1990: 32). But Goldbeck’s departure in 1989, combined with the increasing presence of provider groups in the organization, eroded the organization’s leadership capability, though it has recently become more active again in its support for managed competition.

Another forum for enhancing employer awareness of the health issue was the Dunlop Group of Six. John Dunlop, a former secretary of the Department of Labor, organized this group as a meeting place for the heads of the primary business, labor, insurer, and provider associations. Dunlop’s semicorporatist approach sought to deliver collectively beneficial outcomes by bringing all to the bargaining table. To this end, the group encouraged the development of coalitions at the community level (Berghold 1990: 47–50).

Also important to the development of corporate awareness have been the health foundations. The Pew Foundation funded a number of programs to heighten corporate awareness, such as the corporate fellows program at Boston University. Developed by Richard Egdahl, the program brought benefits managers together to discuss a variety of problems facing corporate America. Many of the business activists currently involved in the national reform effort describe their participation in the Pew program as a critical formative experience.

The Robert Wood Johnson and Hartford Foundations also worked to heighten corporate awareness, largely through their contributions to the local health care coalition movement (Craig 1983). The coalitions have been criticized for failing to contain costs, in part because voluntaristic, community-based efforts do not have the scope to address the structural sources of cost increases (Brown and McLaughlin 1990). But the coalitions did provide forums in which local executives could come to learn about health issues.

These organizations fit the criteria of being both independent of and connected to the important political institutions of the business community. The origin of WBGH is emblematic of the balance between inde

pendence and connection. In 1973 the Business Roundtable hired Willis Goldbeck as the staff for a new task force on health reform. Goldbeck quickly determined that a separate organization dedicated to health reform was necessary in order to make big business “a credible participant in national health policy” instead of simply a force lobbying in the health field. Goldbeck wanted the entire Roundtable to be members (in addition to others) yet wanted independence from the parent organization (Berghold 1990).

As the health issue has moved toward the second stage, that of unifying business consensus around a specific legislative proposal, institutions of interest intermediation have had less success. The experience of the National Association of Manufacturers (NAM) exemplifies the difficulty faced by umbrella organizations in providing leadership in health care reform. NAM members as a group pay very high health costs and are big losers in the cost-shifting game. A 1989 NAM study, conducted by Foster Higgins, found that health care costs in 1988 represented 37.2 percent of employers’ profits; 99.3 percent of employers surveyed offered employee health care benefits.18 In 1990 the board set up a health care task force to develop a reform position. After meeting for a year, the task force presented a play-or-pay plan, but the board voted against it. The plan was killed by a confluence of interests and ideology. NAM’s tax task force fought the proposal on ideological grounds, seeing play-or-pay as a tax on firms. Other influential actors opposed, because their interests could be hurt by health care reform. NAM supporters of reform have now commissioned another survey, hoping to use member opinion to move the organization toward a more dominant reform role. But to date, despite majority interests in reform, no action has been taken.

The ERISA Industry Committee (ERIC), a benefits organization with a wide corporate membership, experienced difficulties similar to NAM’s in trying to develop a health reform position. ERIC was founded in 1976 to respond to the increased regulations created under the Employment Retirement Income Security Act (ERISA). Although the group was originally primarily concerned about pensions, in recent years the focus has shifted to health benefits. In the final months of 1991, the organization set up a separate task force on health care benefits, which leaned toward play-or-pay. However, the board rejected the task force’s recommendations and instead issued an “Interim Policy Statement” outlining a broad

18. The average cost hike was 19.1 percent for the largest companies (those with 5,000–20,000 employees), but 33.3 percent for the smallest companies (those with fewer than 25 employees) (DiBlase 1989).
list of goals, few of them specific. Despite this earlier deadlock, ERIC is continuing to try to formulate a more developed position, and seems to be heading toward an endorsement of managed competition.

The National Leadership Coalition tried to overcome the limits on umbrella organizations by emphasizing focus over scope. The coalition grew out of an earlier group of thirty-six individuals (mainly providers) called the National Leadership Commission, funded by the Pew Foundation in 1986 and conceptualized by Henry Simons, the current chairman. The commission produced a report in 1989 entitled For the Health of a Nation that argued that access, cost, and quality problems in health demand systemic reform. Press coverage was considerable and the coalition's staff began to meet with corporate boards, labor organizations, state legislators, hospitals, and "anyone else who would listen" (interview by author with a National Leadership Commission executive, June 1992).

Although the original coalition was scheduled to end, the speaking series generated considerable enthusiasm for the group to continue. By the spring of 1990 a new coalition had come together, this time composed of business, labor, and consumer groups. A number of companies and trade associations joined with their unions, especially in sectors where labor-management accords committed both sides to participating in the national policy debates. Member firms also recruited others from their industrial sector: Bethlehem Steel displayed early, avid interest in the health care cost problem and sensitized others in the steel industry. In like manner, Chrysler was a leader in the auto sector; James River Company, in the paper industry; and Safeway, in the food retail sector. New members were also drawn by the full-page advertisement in the New York Times in January 1992, which stated, "National health care reform without cost control is like moving furniture into a burning house."

In the fall of 1991, the newly organized coalition formally presented a detailed plan for systemic reform of the health care system (National Leadership Coalition 1991). The coalition aimed to reduce the growth rate in health costs by 2 percent per year until the annual increases matched GNP growth (Couch 1992). The proposal endorsed play-or-pay to curb costs. The states would run an expanded public program, Pro-Health, and would be responsible for making sure it met its spending target.

The National Leadership Coalition deserves points for focusing attention on a single proposal. Its success in avoiding the policy stalemates which plague umbrella groups can be attributed to an important organizational rule. In order to belong to the coalition one must agree to its charter and plan. Unlike other organizations that have been hampered in action by the desire not to give offense, the coalition is more willing to take tough positions. If a member objects to a proposal but has no alternative, the objection is ignored. The group is prepared to have members walk away (interview by author, September 1992).

There have been costs to this strategy. The rule has helped to prevent deadlock, but members have been lost in the process. Some corporations departed because they felt the coalition's position was too radical. As David Helms (senior benefits consultant at Du Pont) put it, "Maybe someday we can look at prices and mandates, but we have not exhausted all of the less radical solutions yet." Others felt that Henry Simons had a preset agenda: play-or-pay was destined to be the group's choice from the beginning, and employer input was an exercise in legitimization. Labor groups were put off by the tax on workers' income, which would fund the public parts of the plan. Many unions were also unwilling to support anything other than a single-payer plan (Burke 1992).

Some companies who left the National Leadership Coalition formed a new group, the Corporate Health Care Forum, "in order to address


20. Bethlehem persuaded its trade association, the American Iron and Steel Institute, to set up a task force to deal with the issue (interview with steel industry representatives, June 1992).

21. Joseph Califano established a task force on the board of Chrysler in the early eighties, including Lee Iacocca, Bill Milliken (former governor of Michigan), Doug Frazier (president of United Auto Workers), Jerome Holland (American Red Cross), and Wally Maher (senior employee benefits). The task force recommended to the board that there was a limit to what the company could do and what the private sector as a whole could do. The recognition of the need for greater involvement in national policy resulted in the creation of a permanent health person in Washington, D.C.—Wally Maher. This health person would "work to try to seed the business community, to develop coalitions, and to impress the public sector that health care reform was hurting the competitiveness of private industry" (interview by author with auto industry representative, June 1992).

22. Details of the plan are as follows: Employers must either provide health care or opt out and pay a payroll tax of 7 percent; employees would pay 1.75 percent of their wages. To fund those not included in the employment-based system, the proposal would create the expanded public plan, Pro-Health. The public plan would be partially paid for by the 7 percent tax on noninsurance firms and by a fee of 0.5 percent applied to all companies' payroll and to workers' wages up to $125,000. Employer health plans would have to have maximum deductibles of $200 for individuals and $400 for families and would have to cover 80 percent of the costs of health care interventions. The out-of-pocket expenses would be capped at $1,500 for individuals and $3,000 for families. A National Health Review Board would be created to regulate rates and to restrict aggregate spending by setting annual targets for total expenditures tied to annual GNP growth (Geisel 1991). The coalition also called for expanding health maintenance organizations and other forms of organized care.

23. These firms included AT&T, Du Pont, Arco, Eastman Kodak, 3M, and Burger King (Garland 1991).
the interests and concerns of companies that believe that play or pay and global budgeting is not the way to go." To these firms, an obvious forum for their interests was lacking. One participant explained that he did a presentation of the play-or-pay approach to the top management of his company. The top executives were troubled by the mandate on small business and shared the Urban Institute's analysis that play-or-pay constituted an avenue to the single-payer system. His company is enormous capital-intensive with high profit margins and would be hurt by that part of the payroll tax assessed on corporate earnings to cover the uncompensated care pool. In addition, it has a very low rate of unionization. Thus, its interests are markedly different from the interests of the unprofitable, heavily unionized auto and steel manufacturers (interview by author, December 1992). Although the Corporate Health Care Forum does not yet have a formal position, it is sympathetic to managed competition.

Despite the National Leadership Coalition's strength in focusing, it has been less successful in widening its organizational scope in the business community. Although the group claims to represent a fairly broad spectrum of business and labor, important gaps remain. A major gap has been the absence of support from small business. The National Small Business United (NSBU) participated at the beginning but ultimately was unable to support employer mandates.

The divide between large and small business is formidable, for reasons of ideology and interest. Ideology prejudices small business groups against the active government role in play-or-pay. According to one association representative, small businessmen have "a basic mistrust in government and strong, an almost visceral belief that the market will produce a better solution" (interview by author, June 1992). Only about 25 percent of a National Federation of Independent Business sample supported government mandates or wanted government to pay premiums for those unable to pay (Hall and Kuder 1990: 11, 13, 37). But ideology seems to be slowly changing among small businessmen. The NFIB reports that "health insurance ranks twice as high as the second most important concern of small business" (National Federation of Independent Business 1992). Sixty-nine percent of NFIB's membership believes that health care is a basic right (Hall and Kuder 1990: 12).

Interests are difficult to reconcile, since the issue has been framed in redistributive terms, and has taken on the aspect of class warfare. The uninsured come largely from the population of the working poor: those with low-wage jobs and no benefits, who work for small business and service firms. The costs of treating the uninsured are shifted, in the form of higher hospital rates, to large, privately insured companies. Thus, many big businessmen see mandates as a mechanism to force small business to accept responsibility for their workers' health costs. Small businessmen, many operating at the margin, experience these mandates as a direct attack on their profits and ability to stay in business. Small businessmen have retaliated with a proposal to cap employer tax deductions for health benefits. They argue that large firms' provision of rich benefits to their workers should not be subsidized by the government (interviews by author, September 1992).

Despite the distributive consequences of health reform, there may be some room for compromise. Making the payroll tax for the public program graduated and offering 100 percent employer deductibility for health premiums would lessen the burden on very small firms. Small business groups have not yet taken defined positions on issues like global budgeting and all-payer rates. Mandates are the central sticking point, but creative solutions to the impasse may be possible (interview by author 1992).

In the fall of 1991 an organizational development occurred that widened the gap between large and small business and made the prospects of a comprehensive reform bill in the short term more remote. Major small business trade associations entered into an alliance with insurers and providers to fight the trend toward comprehensive national reform, forming the Healthcare Equity Action League (HEAL). Over 600 firms and groups currently belong to the coalition, and 110 belong to the Steering Committee, which costs $1,000 to join (HEAL 1992). HEAL has an aggressive membership drive, working especially to attract big business firms who dislike "play-or-pay."

The organization takes the middle road between fundamental reform and the status quo, calling for a variety of incremental reforms that enjoy widespread support from all parties. HEAL argues that incremental reforms are more politically feasible than sweeping change:


25. Also, the NSBU pointed out that most small businesses already pay 11 to 20 percent of their payroll for health insurance (Burke 1992: 53).

26. Pamela Bailey (Healthcare Leadership Council) and Mark Gorman (National Restaurant Association) are the cochairs of HEAL, representing respectively the insurer/provider and small business sides on which the organization is based (PR Newswire 1992a).

27. These changes include insurance underwriting reforms, revocation of state mandates, full deductibility of health insurance premiums, medical malpractice reforms, and legal changes to encourage the proliferation of managed care (HEAL 1992).
A lot of the grand solutions produce gridlock. . . . We have settled on a first pass to do things that are doable. When something is on fire, you continue to try to design the perfect fire engine, but in the meantime you throw water on the fire.” (Interview by author with HEAL representative, May 1992)

HEAL was organized by the National Association of Wholesaler-Distributors, the National Federation of Independent Business, the Food Marketing Institute, the Healthcare Leadership Council, and the National Restaurant Association. The small business founders, considering health issue in an informal group called the Powers Court Group, became aware that the Healthcare Leadership Council, a group of providers and insurers, was organizing a coalition in the health area.

The small business group determined that it was to their advantage to enter into dialogue with the medical group for two reasons. First, they favored reforms to help small businesses buy group health insurance but opposed employer mandates (Geisel 1991); they wanted to cultivate alliances but felt uncomfortable with the solutions generated by big business groups. Second, they felt that they could not afford to wait for fundamental reform. John Motley (of NFIB) explained, “Small business can’t wait another year to begin to resolve this issue. They’re getting hit with astronomical health insurance increases constantly. When you combine this with the effects of a national recession, everyone loses, especially employees” (PR Newswire 1992b). Also, small business had only recently begun to think about health care and had not been pushed to fundamental reforms out of frustration with incremental action. One member explained:

Some firms tend to want to create the totally perfect solution. It has become a lifelong chase for them. They are the ones who felt the pain before others because they were committed to a benefits package or engaged in international competition. The folks who got to the table first began to work on it first. It has been an incremental process for them. We only came to the process about a year ago. (Interview by author, June 1992)

Insurers joined the HEAL coalition for two reasons. First, incremental reforms offer a way of preventing more sweeping changes. Second, HEAL allowed insurer-provider groups to join forces with part of the consumer base (interview by author, September 1992).

Although tensions between the two sides have been restrained, the may yet emerge as the process progresses. One source of instability is the split within the insurance industry itself. The large insurers, who have largely moved into the managed care business in recent years, are solidly behind small market reform and the managed competition approach. The “Gang of Five” has worked intensely behind the scenes to advocate managed care networks as a central part of any reform proposal. This faction also believes that the creation of large-scale networks will help to weed out small companies, who have given the industry a bad name. By comparison, the small insurers oppose managed care networks and small market reform because they fear that these innovations will put them out of business.

The Health Insurance Association of America (HIAA), the main industry association, has suffered under the strain of these divisions. Several of the largest companies left the HIAA, when the industry association refused to go along with their wishes. The HIAA has been dominated by smaller companies, and until recently it concentrated its energies on resisting all types of fundamental reforms. It waged a state-level offensive with its $4 million “Campaign to Insure All Americans.” This included a series of polls showing public support for retaining the private insurance system.

In a surprising turnaround, however, HIAA recently proposed mandated basic benefits, community ratings, and limits on tax breaks for insurance premiums. It continued to oppose both global budgets and managed competition. How can we explain this sudden enthusiasm for a rate-regulation approach to health reform? The step marks a realization by medium-sized insurance companies, the major constituents of HIAA, that reform was imminent. Managed competition could put them out of business, since companies would bid to administer the networks and the larger companies would have a competitive advantage. Rate regulation, by comparison, could preserve a role for the smaller insurers. Also, community rating helps the smaller insurers stay in business because they tend

28. Small business groups support rating bands, or set ranges between which premiums are allowed to fluctuate, as a mechanism for keeping firm costs down. The insurers are not enthusiastic about any restrictions on premiums (interview by author with industry representative, June 1992).
30. So far twenty states have passed health reform legislation, and the industry’s proposal has been adopted by sixteen of them. HIAA achieved these legislative victories in part with strategically timed “fax alerts” sent to small businessmen, asking them to flood the telephone lines of state legislators (interview by author with industry representative, September 1992).
to have smaller risk pools and to pay higher rates (Pear 1992b; interview by author with industry representatives, September and December 1992). HEAL's future may be uncertain, yet its creation placed two obstacles in the way of national reform. First, the small business alliance with insurers created institutional constraints against a small business coalition with big business. Second, the insurers and the small business participants of HEAL have much greater lobbying capabilities than the National Leadership Coalition. For example, the strength of the small business lobby in the past decade has become legendary. A Washington observer remarks:

The slash-and-burn approach makes political enemies, but here small business has an advantage: It is so ubiquitous that most elected officials find it counterproductive to stay angry. "These folks are intimately acquainted with members of Congress," groused Rostenkowski, who once banned NFIB lobbyists from testifying before his committee. "If members don't play golf with them, they play tennis with them." Their grass-roots operation can flood the Congress with calls and mail almost effortlessly. (Borger 1992) 31

By comparison the National Leadership Coalition emphasizes education over lobbying. Its staff explains that they "don't want to move the system too quickly. Any bill that passes must have bipartisan support." Although members testify before committees, the group has no organized, grass-roots lobbying operation. The limits of this legislative strategy become clear when compared with the considerable organizational power of the other side.

HEAL had considerable influence with the Bush White House in urging action and in helping to develop the Republican proposal. The group convinced the Bush team that the administration could become a player in health reform without having to support a radical solution: "The issue could be controlled" (interview by author, June 1992). The president seemed reassured when he remarked, "When you see a coalition of this magnitude working for this common end, it gives me great confidence we can get something done" (Bureau of National Affairs 1992). HEAL worked closely with the conservative Democrats. The group's influence with Clinton remains to be seen.

Leadership from the State

I argued earlier that mobilization of the business community at the legislative stage usually depends on leadership from political entrepreneurs. Parts of the business community can be brought into a state-led coalition to engineer radical policy change. Peterson (1992) suggests that there is more policy entrepreneurial capacity than ever before in the domain of health reform. But until the election of President Clinton, the political landscape of health reform included limited government leadership on either side of the partisan aisle.

Democratic leadership in Congress tried hard to produce a consensus proposal but remained fragmented on health reform. The fragmentation within the Democratic Congress cannot be blamed on a lack of effort to find common ground. Indeed, after Harris Wofford's election in Pennsylvania, the Democrats chose health care to be a central issue of the 1992 presidential campaign. In the Senate a special Democratic caucus was appointed to develop a consensus position.

The split was over the appropriate form of reform: both chambers contain proponents of single-payer, play-or-pay, and market reform. On the Senate side play-or-pay enjoyed front-runner status, although the party's right wing supported a market reform approach. David Pryor (D-AR) and Lloyd Bentsen both feared the effect of play-or-pay on small business. Turf conflicts also existed, as over whether the leadership bill would be handled through the Labor Committee (headed by Kennedy, who favors play-or-pay) or the Finance Committee (headed by Bentsen, who favors market reform). A Senate aide remarked, "Trying to bring all the Democrats under the same umbrella on this issue is like trying to bring all the Republicans under the same umbrella on abortion." (Rovner 1991b).

On the House side, Speaker Tom Foley's (D-WA) promise to produce leadership proposal by the end of 1991 failed. To mask the divisions plaguing the party and perhaps to solve those divisions, the Democrats

31. HEAL has also brought in outsiders for spin control, the public relations firm of Brian Marsteiler. They published an ad in USA Today costing $40,000, which said, "Evidence that we need health care reform . . . [but] we cannot afford to scrap the current system costly new federal bureaucracy" (Lee 1992).

32. The decision to remove from an earlier draft the proposal eliminating the tax deduction of health insurance premiums has been credited to HEAL members (interview by author, industry representative, June 1992).
organized a series of “town hall” meetings on the “health care crisis in America” during a week in January of 1992. The meetings attempted to show how much the Democrats cared about the issue, in obvious contrast to the president. They also were designed to help the Democrats avoid another fiasco like the Catastrophic Coverage Act, in which the Congress believed that people wanted one thing but quickly encountered widespread resistance. Vic Fazio (D-CA) explained, “One of the ideas that we have here is going out and trying to find out what the American people think before we go forward” (Rovner 1992a).

In the spring of 1992, the House majority leader, Richard Gephardt (D-MO), and the Ways and Means chair, Dan Rostenkowski (D-IL), began pushing hard for a “first-step” bill that combined regulation (global budgeting) with market reform provisions to help small business. Yet some worried that this incremental approach might delay sweeping reform and give too much credit to the Republicans (interview by author with congressional staffs, June and September 1992).

Energetic fragmentation in the Democratic Congress was matched by complacent inaction by the Bush administration. Bush ignored health reform until it became clear that he needed a new domestic initiative. Despite considerable pressure to “do something,” the administration initially felt that the health issue was not a winning political issue. William Roper noted in 1990 that health care was not yet a mature issue: “The candidate who made universal access to health care a central theme of his campaign did not win the 1988 election” (Rovner 1991a). Even after the president announced his market reform proposal in February, the administration did nothing to push his agenda. Robert Mosbacher (campaign chairman) explained, “Health is not a first-tier issue for us, like education” (Dowd 1992).

The president’s Comprehensive Health Reform Program was finally presented to the public on 6 February, after much foot-dragging. The Bush plan met certain ideological requirements. It was designed to build on the existing system, what the president calls “the best in the entire world,” rather than radically reform it. It promised to preserve choice. Finally, Bush vowed to implement the system without new taxes, although it was projected to cost $100 billion over five years (Rovner 1992b).

With the election of President Clinton, these dynamics have changed dramatically. Clinton’s commitment to health reform in the campaign signaled to Washington and to the business community that a significant piece of legislation would be proposed and probably passed. The president’s choice of managed competition also helped to end the deadlock over play-or-pay, the earlier favorite. Whether or not one believes that managed competition will fulfill its manifold promises, it has brought new language into the process that may reduce some of the objections to mandates and expenditure caps (Kuttner 1993).

Clinton’s choice of managed competition illustrates the complicated involvement of business in policy reform. On the one hand, the president’s decision to highlight this approach in the campaign was a reflection of its acceptability by the business community and the major insurers. It demonstrates the importance of business in the development and the packaging of the issue. On the other hand, Clinton’s election and the showcasing of managed competition has suddenly inspired a flurry of activity among American firms. Companies have been prompted to take a closer look at the issue and have begun to formulate a position. Where business associations before had difficulty arriving at consensus, they can now more easily take action in response to the government’s agenda.

Conclusion

This paper considers the corporate role in the health care reform process. I argue that corporate employers could counteract the traditional provider opposition to the legislation of stringent cost control measures in health care financing. But the positive participation of the business community is by no means certain. Business typically does not get involved in collective issues, unless as producers they hold narrow, concentrated interests in the area. Ideological misgivings, divided interests, and self-interested alternatives also combine to hinder a show of force from corporate America.

I argue that the constraints against corporate action can be overcome with the right institutional developments in the organization of business interests. The issue stage requires committed core groups to heighten corporate awareness about health problems. These groups guide businessmen in redefining their preferences for health policy and in making the issue a high priority. Second, the legislative stage requires organizational leadership to help business agree on a particular policy option and to build a broad coalition around the chosen proposal.

Institutional developments within business at the issue stage have been fairly successful. A core band of corporate reformers has generated greater business and public awareness about the issue. Corporate energy has helped to push health reform to the top of the public agenda.

But the vast majority of companies are largely reactive, remaining silent until perceived action by government forces them to confront the
issue. At the legislative stage, this corporate inertia interferes with the project of building consensus and mobilizing a coalition around a specific reform proposal. Until recently, the poor strategies and inadequate organizational development of both public and private reformers delayed legislative action. The inherent difficulty of industry to coalesce around a specific health bill was matched by a lack of focus within the state.

We are now at a critical juncture, the outcome of which is yet to be determined. A dynamic new president who is committed to the issue could make a difference. The managed competition proposal has generated considerable enthusiasm. Whether or not one believes that managed competition can really contain costs, it has introduced new language into the debate and has broken the political logjam. President Clinton seems committed to combining aspects of play-or-pay with managed competition. In a sanguine view of the future, we will get the best of both: expanded access to all Americans, vigorous caps imposed by global budgets, and long-term movement out of fee-for-service arrangements and into more cost-effective patterns of care.

For those committed to reform, the worst-case scenario would be an opportunity lost. Clinton might decide to move incrementally and lose the momentum enjoyed by presidents in their first few months. Or we could all jump on the wrong bandwagon and enact legislation that takes us closer to solving the issue.

If corporate action depends on presidential leadership, does business really make a difference? In other policy areas, business supporters worked to bring Republicans in line and bring about legislative victory. the recent health battle one Democratic legislator was told, “If you work with us, we will deal with the Republicans” (interview by author, 1992). Business groups legitimate policy with parts of the country less than sympathetic to social initiatives: the Joe Managements of Street America.

But there is a cost to such support: business groups inevitably demand self-interested concessions. The ultimate paradox of reform is that it requires the mobilization of countervailing powers to neutralize the action of dominant interests. Yet these countervailing powers, losses to the old regime, demand special dispensations under the new. Reform compromised in the process.

References


