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

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Abstract Existing accounts of the Clinton health reform efforts of the early 1990s neglect to examine how the change in big business reform interests during the short period between the late 1980s and 1994 might have altered the trajectory of compulsory health insurance legislation in Congress. This article explores evidence that big employers lost their early interest in reform because they believed their private remedies for bringing down health cost inflation were finally beginning to work. This had a discouraging effect on reform efforts. Historical analysis shows how hard times during the Great Depression also aligned big business interests with those of reformers seeking compulsory social insurance. Unlike the present case, however, the economic climate did not quickly improve, and the social insurance reform of the New Deal succeeded. The article speculates, therefore, that had employer health expenditures not flattened out, continuing and even growing big business support might have neutralized small business and other opposition that contributed heavily to the failure of reform. Thus in light of the Clinton administration's demonstrated willingness to compromise with business on details of its plan, some kind of major reform might have succeeded.

In March 1990, Bethlehem Steel, Chrysler, Lockheed, Westinghouse, and Xerox joined forces with several dozen other major corporations and a number of national labor unions in endorsing a rather un-American idea: corporatist regulation of government-mandated, employer-provided health care. The universal system envisioned by this National Leadership Coalition for Health Care Reform (NLCHCR) was to collectively set

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provider prices and fees and so place a lid on the rapid growth of America's health expenditures. Other corporations signing on were from sectors ranging from paper, food manufacturing and retailing, utilities, banking, and the media—for example, Anheuser-Busch, A&P, Dayton Hudson, Georgia-Pacific, International Paper, Northern Telecom, Pacific Gas and Electric, Safeway, Southern California Edison, and Time Warner among others (Swoboda 1990b; Pear 1991; Martin 1993).[1] Their immediate purpose in joining with important labor organizations in this cross-class coalition was to rein in their own health-related expenses and to shift some of their costs onto employers currently not paying into the system. That year, premium charges to employers who offered health insurance rose 17.1 percent, towering far above the overall inflation rate.

Business participation in the NLCHCR—including over forty corporations in 1992—was no isolated phenomenon. Around the same time, a survey of Fortune 500 executives found that 53 percent supported the idea that government should force all employers to pay for their workers' health care (Cantor et al. 1991: 99–101). In 1993, the U.S. Chamber of Commerce endorsed an "employer mandate," and the National Association of Manufacturers (NAM) signaled to the Clinton administration that comprehensive reform combining effective cost controls with universal coverage was something well worth talking about. By a 3-to-1 margin, its members favored legislation to impose universal coverage. Because most of them provided benefits, compulsion would eliminate the competitive advantage enjoyed by companies that did not provide insurance (Pearlstein 1994; Pear 1993a). Many companies in these organizations resented being charged by insurers and providers for health care received by the uninsured and for coverage of their employees' spouses and all their children when the spouses worked for companies not providing coverage. As a result, "when President Clinton first proposed his plan, many companies welcomed his ideas"—if not the exact details of the plan (Uchitelle 1994).

Not since the New Deal had major social insurance reform received as much apparent sympathy if not encouragement from big employers as the Clinton administration's efforts on behalf of universal health cover-

1. The NLCHCR proposed a universal health care system subordinated to a European-style corporatist rate-setting board composed of public officials and representatives from business, labor, and consumer interests (Pear 1991). Ten unions representing workers in steel, textiles and clothing, food, construction, communications, and retail and other services signed on. AT&T, Du Pont, Arco, Eastman Kodak, 3M, and Burger King, finding the proposal too extreme, dropped out and set up another group, the Corporate Health Care Forum, to look for other solutions (Martin 1993: 379–380).

age. Drafters of the Social Security Act had been emboldened by, among other things, a number of big businesspeople (and policy experts highly sensitive to their needs) who expressed favorable interest in or at least pragmatic tolerance for compulsory social insurance (Swenson 1997, 2002). If anything, big business interest in completing the New Deal with government-mandated health insurance, though by no means uniform, was stronger. Therefore voter opinion was probably not the only or even the main reason the issue first caught fire in the special Senate election in Pennsylvania in 1991. Harris Wofford, once the state's secretary of industry and labor, landed the Senate post after promoting comprehensive reform. In his earlier job, Wofford no doubt noticed the potential for a broad-based alliance with major business interests in reform. One of the corporations most eager for change was Pennsylvania's Bethlehem Steel, a member of the NLCHCR.

Inspired by the Wofford phenomenon, Clinton ran for the presidency with health as a central plank of his campaign. James Carville, his campaign consultant, had previously worked for Wofford. After winning, Clinton brought in his friend Ira Magaziner to craft legislation, a man to whom corporations paid millions for telling them what changes they needed to make to cope with intensifying global competition. Magaziner was busy at the time analyzing health care cost problems for the state of Rhode Island. Once in the Clinton administration and after coming into contact with Boston and Cambridge economic and business advisers, Magaziner became a full supporter of "managed competition"—competitive mechanisms combined with new regulations and tax incentives designed to change the balance of bargaining power between employers and private providers and thus to hold down costs in a universal system. Clinton, neither enemy of big business nor close confederate of organized labor (as his NAFTA efforts indicated), had already begun to fall under the sway of the idea during his election campaign (Johnson and Broder 1997: 15, 78, 104; Hacker 1997: 108–116).

Among employers, large manufacturers with high health-related labor costs competing in the international marketplace looked most favorably upon reform. The idea of shifting some health costs off their backs and onto other employers currently not providing insurance appealed to them. So did the efficiency benefits of forcing providers to compete on the basis of cost and quality. Government assumption of responsibility for early retirees not yet eligible for Medicare attracted big unionized firms in sectors like autos and steel trying to cope with the expenses and inefficiencies of an aging workforce. But although there were strong objective

interests in reform, business preferences for government action were anything but uniform, unreserved, and unchanging. There was considerable open-minded tolerance for the exploration of ideas involving invasive government action. Of course reformers could not count on these labile attitudes translating automatically into enthusiastic, unified, and forceful support for any particular piece of legislation down the road (Brown 1994). But this was the time to act.

Business support for universal coverage was not an unprecedented phenomenon. A similar opening had also occurred in the early 1970s—not so long after the passage of Medicare, which business organizations opposed—when a committee of the U.S. Chamber of Commerce proposed a compulsory employer-based system of health insurance (Center for Public Integrity 1994: 60). As in the early 1990s, reform was in the air. But business support, in both cases, was unstable. In fact, while big business openness to reform grew in the period leading up to Clinton's election and his administration's early efforts to draft a bill, it fell markedly by the winter of 1993–1994. According to one analyst, 1992 was "the high-water mark of business support for the Clinton approach" (Pauly 1997: 29; see also Greenhouse 1992). By the time the Clinton plan was submitted to Congress in November 1993, business hostility was growing perceptibly and continued to grow as the legislation shattered against the rocks of congressional politics in the summer of 1994 (Uchitelle 1994). Later discussion will show how these changed attitudes accompanied a simultaneous change in interests.

Evidence about the arc of rising and declining business interest in the suspenseful drama of health care reform poses fascinating though ultimately, perhaps, unanswerable questions. Might national health insurance have passed in some form or other, if not exactly in the shape of the Clinton plan, had business interest not flagged in the course of the debate? Might the initial momentum have been sustained, and the dynamics of legislative bargaining—possibly through to final passage—have been fundamentally different?

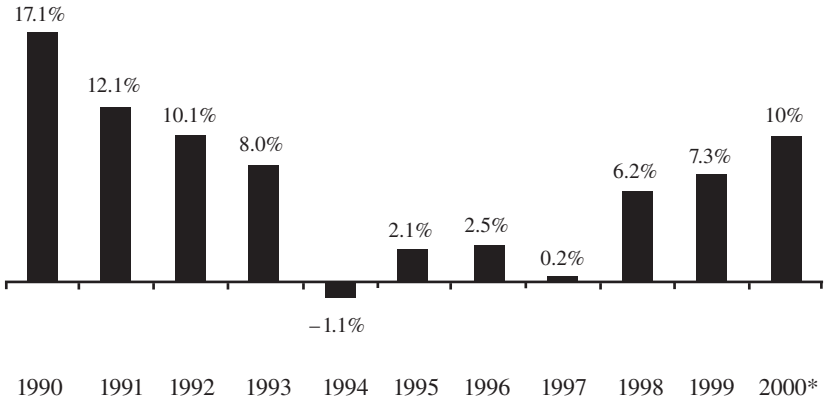
The Argument

Instead of a foolishly confident answer, this article offers a modest proposition: that no account of the reform process can be complete without analysis of these changing interests in legislative action and related preferences for specific reform plans. Acknowledging the trickiness of the concepts, we refer to interests as economic and objective in nature. Pref-

erences, by contrast, are strategic and subjective, only partially and sluggishly responsive to interests, and often clouded or, as the case may be, illuminated by ideology or distrust of government. We argue that during the late 1980s and early 1990s many big employers regarded the general idea of reform with open minds, if not outright favorably, because of their objective interests in cost control. In other words, many transcended their ideological tendencies and distrust of government to think kindly of the idea of controlling health care inflation with state action that reserved for them considerable control over employees' benefits as a managerial instrument. For one thing they would be well served with help in squeezing health care providers instead of cutting their workers' pay and benefits. They were already cutting benefits but facing predictably disruptive and demoralizing consequences in their industrial relations. Hardball management of health care financing and delivery could help reduce the need for harsh pay and benefit policies.

Thus while "support" for reform may well exaggerate what reformers like Clinton experienced in general even early on, what they did indeed experience was a somewhat tolerant climate on the whole and a friendly one in parts. As the editor of *Business and Health* believed, shortly after the Clinton plan came out, some benefits executives would favor it, some would oppose it, but most were probably "somewhere in between." The bulk of the NAM membership was "open, but undecided," according to Jerry Jasinowski, the organization's president (Burns 1993a: 6; Johnson and Broder 1996: 317; see also Starr 1995: 27). The big business community's friendly political visage was not simply a mask donned for diplomatic leverage in dealing with a Democratic president, though there would have been an element of that, too. Thus politicians threw themselves into an unusually frenetic level of reform promotion in electoral and legislative politics. Here, now, was a rare opening created by a broad-based coalition reflecting big business interest as well as broad-based popular support.

By no means, however, did employers regard legislation as the only remedy for the problem of health cost inflation, which translated into double-digit increases in the insurance premiums they paid between 1990 and 1992 (Miller 2000: 1) (see Figure 1). Whether government action would be a necessary component of a solution remained a matter of great uncertainty. Being professional business executives first, not political activists, they simultaneously pursued, with great energy, all manner of private solutions to controlling their expenses. "Businesses are not waiting," as the editor of *Business and Health* put it (Burns 1993a: 6). In gen-



*Average of projections from employer surveys.

Figure 1 Growth in Private Health Insurance Premium Charges (Cost to Employers). *Source*: Miller 2000: 1.

eral, employers were learning how to use their purchasing power as wholesale payers for health care to force insurers and providers to find efficiencies or accept lower incomes. One important result of private reform, of course, was the spread of "managed care," very often realized in the form of Health Maintenance Organizations (HMOs), into which employers had been eagerly herding their workers since the late 1980s. The move away from traditional arm's-length insurance practices to one in which, figuratively speaking, MBAs zealously watched over physicians' shoulders in the examining room, was nothing short of revolutionary in structure and scope. Sometimes unions, albeit with growing reluctance over time, assisted employers in the intrusive managing of care, having been once the main proponents of the idea for the leverage it gave in power and distributional conflict between industrial producers and health care providers (Garbarino 1960: 157–166; Munts 1967: 59–66, 74–78; Krajcinovic 1997: 75–106, 132–138). Thus the legislative solution enjoyed no obvious advantage in terms of cross-class backing.

Private cost containment efforts delivered results more quickly than the political process, and that may have been legislation's downfall. Indeed, inflation in employer health costs began taking first a gradual and then a precipitous dive in the three-year period leading up to the political shipwreck of the Clinton plan in the summer of 1994. Further, the U.S. economy had swung up out of recession, the dollar had subsided, and

many employers' competitiveness problems dissipated. Big business, in short, had good reason to lose interest in national health care reform.

This loss of interest, we can surmise, gave freer play to the full force of ideologically aroused distrust of government action and allowed attention to focus on objectionable details inevitably contained in any and all reform designs. Declining health care inflation was an argument used by the Health Insurance Association of America (HIAA), one of the most powerful lobbying forces against the bill (interview with Chip Kahn, formerly of HIAA, June 2001). The decline in inflation probably gave Senator Daniel Patrick Moynihan (D-NY), chairman of the important Senate Finance Committee, an argument to undermine the Clinton efforts. In September 1993 he declared on *Meet the Press* that there was "no health care crisis." Moynihan maintained further that government intervention could only increase health care inflation despite anything the fiscally conservative Clinton administration, desperate to tame the burgeoning Medicare and Medicaid budgets, might conjure (Johnson and Broder 1997: 351–58).

Had big employers not begun to perceive success in their efforts to solve cost problems on their own—as the urgency to do so became somewhat less acute—would political efforts on behalf of comprehensive national health have met such enormous adversity? Would big employers have stood by idly and indifferently without influential figures among them endorsing efforts to keep up the search for legislative compromises? Would the top business organizations have so resolutely turned against the Clinton administration? We think not.

How Business Figures in Other Accounts

The role of big employers' changing interests in reform has not been a focus of attention in scholarly accounts or explanations of the rise and demise of the Clinton plan (see for example Brodie and Blendon 1995; Morone 1995; Weissert and Weissert 1996; Hacker 1997; Skocpol 1997; Rushefsky and Patel 1998). Instead, researchers tally up numerous other factors: the intensive lobbying by providers and insurers; the ferocious attack on employer mandates and universal coverage by small business and those among big employers who relied on low-wage, no-benefit labor; the scorched earth, with-us-or-against-us tactics of Republican Party opponents of the plan; strategic errors of the Clinton administration; and fragile and incoherent public support. Others suggest that the supposedly fixed structure of partisan preferences in the 103d Congress,

the conservative bias of American institutions, or even the weakness of the American working class made failure practically inevitable (Brady and Buckley 1995; Steinmo and Watts 1995; Navarro 1995).

Some accounts do take note of a damaging shift in position by business organizations like the U.S. Chamber of Commerce. In these accounts, however, forces external to the organizations acted upon them to change the internal balance of power between advocates and opponents. They do not attribute the shift to a decline in interest among advocates. There are, for example, the "cross lobbying" and "reverse lobbying" arguments (Schick 1995: 241–44; Judis 1995; Martin 1997: 418–19, 2000: 181–188). "Cross lobbying" by the National Federation of Independent Business (NFIB), representing mostly smaller employers, supposedly accounts for the change in position of the Chamber of Commerce. The chamber had been initially favorable to reform under its new pragmatic leadership and maintained an open position with respect to the Clinton plan in particular. According to John Motley of the NFIB, however, the chamber had "sold out its small-business membership to its large-business membership," implicitly identifying big employers as supporters (Victor 1993: 809). Because the NFIB could ominously threaten to cause a defection of large numbers of its small business members, the chamber joined the opposition. Recent instability in membership and dues levels made it all the more jittery about this prospect (Schick 1995: 252; Victor 1993: 806).

The reverse lobbying argument attributes the policy shifts of business organizations to external forces affecting the dynamics of intraorganizational conflict and compromise between reform-friendly corporations and their opponents. For example, by 1994 the Republican Party's leadership bullied business organizations into withdrawing their support for the Clinton plan, even threatening retaliation in other policy areas. (They threatened individual companies like Ameritech, Caterpillar, and others with targeted legislative punishment.) Again the Chamber of Commerce figures prominently in this argument. Most dramatically, when its president was scheduled to testify before Congress in early February in support of a plan including an employer mandate, managed competition, and a standardized minimum benefits package, conservative congressional Republicans "read them the riot act." The chamber president toed the line, changing his testimony overnight (Rich and Devroy 1994; Schick 1995: 243; Martin 1997: 418). Thus it could be that reverse lobbying also helped move the Business Roundtable and NAM to drop their initially encouraging positions and declare outright opposition to the Clinton plan. All three major organizations did so within four days of each other

on 2 February 1994. In the case of the Business Roundtable, whose policy committee repudiated the Clinton plan in the first few days by a vote of sixty to twenty, reverse lobbying might at most have marginally shifted the balance in the favor of determined opponents among insurance companies and corporations like Pepsico whose fast-food franchises depended on low wages and no benefits for employees (Stout and Wartzman 1994: 1).

As important as the cross and reverse lobbying phenomena may have been in organizational shifts, they are unlikely to explain fully the change in attitudes of individual executives. Corporate leaders' opposition to the Clinton plan had been increasing in recent months, according to interviews of business executives reported in the *New York Times* in May 1994. By this time Clinton's health security bill was in critical condition. The *Times* survey suggested that big company executives now seemed as opposed as their noninsuring small business counterparts to even a simple employer mandate (Uchitelle 1994). After all, the business executives had minds of their own and therefore an ability to assess company-specific interests that were shifting over time with changes in their market environment. As collectively or individually aggressive "price makers" in local health markets, they even had the power to change that environment and thus the perceptions of their own interests. Consequently, if their interests were converging independently in the direction of their putative opponents within the business community, then external intervention in their organizational relations with other employers can hardly be the entire story. A changed alignment of interests over time may have to account in large part for the result, not just a changed balance of power.

To be sure, two authors identify a plausible economic reason for individual companies to have lost interest in defending reform within their organizations and testifying in its favor in public and congressional arenas. Over time, apparently, as small business began to mobilize against the Clinton plan, the administration's strategists responded defensively in a "mad political scramble" to appease small employers at the expense of growing costs and rigidities for larger ones. Thus they "drew criticism from big companies that had been among the most vigorous champions of reform" (Schick 1995: 244; Martin 1997: 410). The cost-shifting advantages of compulsory reform were now being watered down, even as benefit mandates were being added to appease liberal opposition. Overall cost control would now be increasingly dependent on highly intrusive government regulation in the form of premium caps. These strategic moves fed latent ideological suspicions about big invasive government among

bigger firms previously open to accepting the risks of government intervention when the payoffs seemed bigger and clearer. At the end of the game, many big employers saw no sure benefits to compensate for increasingly certain "government interference with the internal operations of private business" (Silow-Carroll et al. 1995: 62).

Once again, however, this account attributes the positional shift to power relations within the business community and between business and politicians—not to a politically exogenous halt in employer health cost inflation in the context of improving macroeconomic performance and international competitiveness. The power of determined opponents, according to this argument, caused politicians to change the design of legislative plans at supporters' expense. "In the end, the mistargeting of incentives lost some big business support without winning anything from small business lobbies" (Schick 1995: 244). But even if this argument for a decline in interests among former supporters may explain some of the change, it does not logically exclude other, probably more important, factors.

By far the best and most exhaustive journalistic investigation of the politics of the Clinton plan supports our suspicion that employers' independent efforts to bring costs under control, and therefore flagging interests, were a powerful and possibly even decisive factor in the failure of reform. *It certainly had a demoralizing impact on reformers in Congress.* According to the prize-winning journalists Haynes Johnson and David Broder, the chairman of the House Energy and Commerce Committee John Dingell saw the loss of big business support early in 1994, especially from the Business Roundtable, as "a defining event" leading to "a big shift in sentiment inside my committee." For pro-reform Republican senator David Durenberger on the Finance's Health subcommittee, it was "the moment of truth."At that point, according to the two journalists, "Durenberger and others like him . . . knew they were swimming against the tide" (Johnson and Broder 1997: 323–26, 381–382).

Johnson and Broder inquired among "executives involved in the debate" why Clinton now faced a rising wall of opposition. This is what they learned:

> From their perspective, the Clintons were latecomers to a battle they, the CEOs, had been waging for years—the fight to control their companies' health care costs. For much of the 1980s, it had been a losing struggle, but lately—out of sheer business necessity—their firms had developed strategies that were beginning to pay off; a transfer of costs to employees or retirees; tougher bargaining with insurers and pro-

> viders; a shift to managed care programs with more predictable costs; an emphasis on exercise regimens, anti-smoking drives, and other "wellness" programs. (Ibid.: 326)

That was also how Senator Durenberger understood the turn against reform, according to the journalists. It was not duplicity or selfishness on the part of big business but "a hard-headed judgement" made in light of "the forces of change in the marketplace" already underway (ibid.: 381).

As James Mortimer, president of the Midwest Business Group on Health (MBGH), put it, one of the key factors that "knocked the wind out of the Clinton plan" was the temporary flattening of employer health costs for employers, confirming Dingell's and Durenberger's observations about the shift in political tides inside Congress (interview with Mortimer, July 2001). Later we will return to corroborating evidence about this corporate turn against government reform and the political response—after putting our argument about the importance of that shift into historical perspective.

From Welfare Capitalism to Welfare Statism: A Historical Precedent

The history of employer-provided social benefits in the United States lends plausibility to our argument that the rise and decline of big business interest are important and underappreciated factors behind the trajectory of the 1990s health reform effort. History suggests, in other words, that the political climate for compulsory social insurance is strongly affected by the economic climate faced by employers torn between private social commitments to workers and the need to meet the imperatives of market competition. When the economic climate is good, employers have usually been indifferent at best to social reform. But when the weather turns foul, friendship with reformers can evolve. Emboldened, reformers seize the opportunity and take unusual action.

The early 1990s was not the first time in U.S. history that large employers, who tend to see their social protector role as mostly adequate to the needs of American society, became interested in compulsory social insurance. The same thing happened before the big bang in welfare state development in the 1930s, when the economic climate had turned foul. Up to that time, from early in the century, employers had been building a system of labor market segmentation in which only some workers enjoyed good benefits, usually alongside good wages. By introducing

company benefits they intended to secure a loyal workforce and thereby ward off unionization. They also sought the benefits of extra productivity identified by economists' "efficiency wage" theory. According to this theory, paying premium wages and, by the same token, better benefits, helped firms attract a larger and better pool of applicants from which to select workers. Once in the firm, workers stayed longer (turnover costs declined) and worked harder (Akerlof and Yellen 1986; Weiss 1990).

Early on during the Great Depression, a number of what some have called corporate liberals from large "welfare capitalist" firms, most notably Gerard Swope of General Electric, Walter Teagle of Standard Oil of New Jersey, and Marion Folsom of Eastman Kodak, gave clear signals that various aspects of the New Deal, especially elements of the Social Security Act (SSA), would help stabilize competition for better employers being undercut in the depression economy by low-wage, low-benefit producers. In truth, these men were moderate conservatives more than liberals. According to economic historian Sanford Jacoby (1996: 67; 1993: 549; 1997: 206–207), Folsom, for one, was "a pragmatic businessman eager to level the playing field" for Kodak as well as other progressive firms, and through social security, even "profit from the situation." The Industrial Relations Counselors (IRC), a research and consulting firm financed by John D. Rockefeller Jr. and in close communication with welfare capitalists across the country, helped substantially in the deliberation and drafting of the SSA (Domhoff 1996: 117–176).

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

Better, then, to avoid the bruises of ruinous competition and bitter workplace conflict by imposing new social insurance costs on product market competitors. Government intervention with the welfare state now under consideration would help check the cutthroat competition and displace the distributional conflict onto outsiders to the firm. While such outspoken supporters of social legislation like Folsom, Swope, and Tea-

gle were few and far between, their reasoning bespoke of broad interest in the business community of which reformers were well aware. As the editor of *National Petroleum News* observed, "most if not all of bigger oil companies now have, and some have had for many years, various forms of pensions" and other social benefits, while 20,000 to 25,000 "legitimate" oil-producing and market companies lacked them, as did "some 200,000 and more price-cutting retail dealers, cooperative oil companies, and straight price cutters who have no protective features for their employees." Come to think of it, he ventured, when asked about the industry's position on social security, "if these last were forced to contribute to such protection as bigger companies are now doing, it might help to lessen some of their price cutting by bringing up their costs" (U.S. Senate, Committee on Finance 1935: 796; for more evidence on the regulatory and cost-shifting aspects of the SSA, see Swenson 2002).

In this stormy weather of intense predatory competition and related class conflict, prominent welfare capitalists looked favorably, though not without uncertainty and ideological misgivings, on the welfare state as a way of providing market security for capitalists as well as social security for workers. The New Dealers expected that many other businesspeople would accept their reforms and not mobilize to undermine their legislative efforts, and they were proven correct ("What Business Thinks" 1939). Later, however, while the sun shone over the postwar years, big employers ceased playing a progressive role. Instead they mostly reapplied the brakes, supporting broad but only basic or minimal social insurance. This setup would reserve for them the role of providing grateful workers with generous company retirement and unemployment benefits to supplement meager public ones. Although executives like Marion Folsom and Charles Wilson of General Motors remained champions of the basic welfare state after the depression, they were adamant that social security could not be allowed to displace welfare capitalism (Jacoby 1997: 207; Wilson 1958: 1001; Drucker 1978: 275; Sloan 1990: 405).

Health Care after the New Deal

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

from the medical profession inhibited its development before the New Deal (Starr 1982: 203). Except in certain sectors of the economy such as lumber, mining, and railroads, physicians had fairly successfully fought all forms of contract practice, corporate medicine, or pre-paid group practice. Early precursors of what we now call managed care, these arrangements were introduced by employers, because of severe provider and insurance market failure, to attract and keep workers in rural industry.

Despite the rising costs of medical care and a stunted insurance market, the Roosevelt administration shied away from antagonizing organized medicine and dropped the idea of including compulsory health insurance in the SSA. The worry was that big medicine's opposition would endanger passage of the entire bill. By contrast, when Roosevelt's cabinet-level Committee on Economic Security also contemplated dropping old-age insurance (OAI) from the bill, their big business advisers unambiguously advised them to keep the ball rolling. In addition to its promise of leveling the competitive playing field, they were probably motivated by the prospects that OAI would relieve many big employers of unaffordable pension promises they had made to their workers. The company pension plan, all too often, was an actuarial disaster, a "juggernaut" they realized they had set in motion by the late 1920s (Brown 1972: 21–22; Swenson 2002: 208, 212–213; Sass 1997; Cowdrick 1928: 33). The parallel with auto and steel companies' worries in the 1990s and beyond about the expensive care they had promised employees upon retirement, and their desire for government bailout is striking (Wayne 2002).

The surge in private employer-provided health insurance had to wait until the 1940s and 1950s. By then the American Medical Association (AMA) and many state medical societies backed down, rattled as they were by the initial moves to include national health insurance in the SSA, by subsequent state-level campaigns (for example Governor Earl Warren's repeated attempts in California) and of course by the Wagner-Murray-Dingell and Truman efforts at the federal level in the 1940s. A Supreme Court ruling against the AMA in the 1930s put an end to state and county medical societies' worst strong-arm tactics against physicians willing to participate in early employer-based managed care. So organized medicine now begrudgingly collaborated on its own terms in the spread of new forms of employment-based group insurance (e.g., Blue Cross and Blue Shield) for low-income working Americans (Cunningham and Cunningham 1997). Company-based health insurance started taking off around 1943, when employers seized upon health benefits, allowed by the National War Labor Board, as a way to attract and retain employees

when wartime wage controls prohibited wage increases in extremely tight labor markets (Seidman 1953: 127–130; Stevens 1986).

After the war, unions kept up the pressure on businesses to grant collectively bargained measures. They also put pressure on the government to provide a supportive climate for private benefits, having been discouraged by the political obstacles to national health care (Lichtenstein 1989: 148–154; Derickson 1994: 1353–1356; Gordon 1997: 277–279). Employers put up no genuine resistance, for by and large benefits came out of wages, not profits. Often a dollar of benefits had more recruitment and managerial payoff than an extra dollar of wages. One reason was that the law made benefits deductible from taxable corporate income, and employees paid no income taxes on their benefits (Stevens 1988; Pauly 1997). The most dramatic success came in 1950 with the creation of the United Mine Workers' Health and Retirement Fund, a core component of the stable cross-class alliance between dwindling numbers of high-pay union miners and the larger mechanized underground mine operators of the 1950s and 1960s (Krajcinovic 1997: 41–49). The result: while in 1940 less than 10 percent of the population had job-linked health insurance, by 1966 over 80 percent did (Reed 1967: 9, 12–13). By 1999, as one estimate has it, without the tax subsidy 20 million adults would lose their employment-based health insurance (Custer, Kahn, and Wildsmith 1999: 118).

In more recent years two further developments rewarded big employers for diverting money into benefits instead of wages. First, experience rating or the differentiation of insurance premiums gave big firms with healthier-than-average workers a double advantage in competition over the best labor with more marginal firms: they could pay lower premiums for similar coverage (Cutler 1995: 35). A cross-class alliance of forces promoted the practice, shattering the more egalitarian "community rating" principle observed initially by the Blue Cross–Blue Shield movement, and thus stratifying the insurance market. In other words unions as well as employers sought better deals for their members and workers (Gottschalk 2000). Second, one provision of the 1974 Employee Retirement Income Security Act (ERISA), inserted after corporate lobbying, insulated big self-insuring companies from expensive state-level regulation and malpractice litigation. Because firms with small workforces were unable to self-insure they were already paying higher underwriting and other costs. ERISA-induced self-insurance also reduced big firms' and therefore their workers' health care costs relative to others (Weissert and Weissert 1996: 220–221; Battistella and Burchfield 2000; Traska 1989;

see also Fox and Schaffer 1989; Jacobson 1999; Grogan 1995). Employment-based health insurance was still a great bargain and government action uninteresting at best.

Foul Weather Again

Until the steep takeoff in medical cost inflation, starting around the late 1980s, it was fairly smooth sailing for the employment-based system. But by 1988 Chrysler was spending more per car on health care than on steel (Himmelstein and Woolhandler 1994: 40). With this heavy cargo, employers steered themselves into stormy seas: rough international competition, stiff interest rates, and a strong dollar. The recession of 1990–1991 made things worse, putting even greater pressure on big employers to hold back on health benefits and other labor costs, or even dump some of them overboard. In 1990 health care costs for businesses generally exceeded profits, and recent increases in the cost of health care exceeded the percentage increase in all other labor expenditures combined (ibid.: 11, 41). Ford complained in 1992 that the company had to sell at a $500 per car competitive disadvantage compared to Japanese automakers because of health care costs (Greenhouse 1992; Pauly 1997).

If there was not always open mutiny among the crew, there were morale problems. Relations with unions suffered when employers tried to pay for health cost increases out of current or future wages, increased co-payments and deductibles, and the like. Workers naturally wanted to increase or at least maintain their sagging wages and preserve existing health benefits. As Alcoa CEO Paul O'Neill put it flatly, a major problem is that rising health costs "exert pressure on company/union negotiations." Although ultimately workers paid most of the bill one way or another, as economists are inclined to think, employers did not come away unscathed (Iglehart 1991: 80–81). Harris Wofford discovered in Pennsylvania that "increasingly, every labor dispute, every strike, turned in whole or in part on the issue of health care" (Johnson and Broder 1997: 59). Indeed, efforts to hold the line or cut back on health benefits were the cause of 78 percent of all strikes involving over 1,000 workers in 1989 (Victor 1990: 704–706).

Reducing nominal wages, apparently, is the last thing employers want to do in a recession, including the early 1990s, largely for morale reasons (Bewley 1999). So in the course of the 1980s and early 1990s, many employers cut back or restructured benefits in ways that allowed them to keep nominal wages stable or even increase them (Bergthold 1990:

34). These changes ensured that a higher proportion of future increases in health costs would come out of workers' paychecks, especially when employers increased the share that workers paid for insurance premiums. But there were limits to this approach, as the high proportion of strikes caused by pressure for continued cutbacks indicated.

Under these circumstances it made sense to neutralize the distributional conflict between big employers and their workers. Through cost-control measures and an employer mandate, it could be displaced and reconstituted as a conflict between a cross-class alliance of capital and labor against other interests, especially providers and noninsuring employers. That was the logic behind the work of Dr. Henry Simmons, president and founder of the NLCHCR. Political entrepreneurs like Clinton, like New Dealers before him, also seized the chance to broker a cross-class reform coalition. Bypassing the NLCHCR, the Clinton administration devised a different plan requiring less controversial microregulation of provider prices. Instead, it combined the broadly appealing principle of managed competition with the possibility of controls on the growth of premiums to install more indirect and broad but still powerful mechanisms of cost control. The Clinton plan promised to squeeze health care providers like physicians and hospitals by setting up large purchasing cooperatives consisting of most, but not the biggest, employers. The "employer mandate" element also promised to dig into the pockets of other free-riding employers and their workers where company-based health benefits were lacking. For a long time bigger employers had privately cross-subsidized the employers of the uninsured, whose workers often enjoyed dependent coverage through spouses at better workplaces. Also, some companies already providing benefits would have been happy to see extra costs imposed on product market competitors not currently paying for employee health. Subsidization of benefits for early retirees would shift costs onto a much wider population.

Designed in part to attract big business support, the Clinton plan allowed very large employers to retain considerable control over health costs and benefits by exempting them from participation in the governmental purchasing cooperatives or alliances (Pear 1993b). All they had to do was meet basic national standards, though the level of those was not easy to predict given the nature of politics, and therefore still the cause for some anxiety regarding long-run cost control. That the plan allowed the largest firms to tailor health benefits to their particular managerial and personnel recruitment needs is not surprising; Ira Magaziner consulted repeatedly with officials of the Chamber of Commerce while devel-

oping the mandate provisions (Center for Public Integrity 1994: 60). At least in broad outlines and general principles, the plan potentially harmonized with many big employers' long-range need for a relatively uniform and restrained system of national standards applying to all employers, reserving room—as Kodak's Marion Folsom and General Motors' Charlie Wilson would have recommended—for upward differentiation.

In short, unfavorable exogenous macroeconomic and price shocks turned a significant number of big employers into foul weather friends of a major expansion of the welfare state. The same dynamic of employer-friendly politics proceeded, it seems, at the state level. In seven states, ranging from traditionally progressive Minnesota to conservative Tennessee, businesspeople played catalytic roles in initiating efforts in alliance with governors and other political actors, demonstrating the depth of business interest in reform (Paul-Shaheen 1998: 328). Politicians at this level were in part motivated by the desire to increase coverage, but they were especially moved by the budgetary blows medical cost inflation was delivering them through Medicaid, "the monster that ate the states," according to a former governor of Oregon (Fox 1994: 143). Many of these efforts combined prospective cost control with universalism and were based on a mixture of employer mandates, competitive managed care, and state regulation of benefits standards (Weissert and Weissert 1996: 211–220; Brown 1994: 32, 38; Leichter 1994: 97, 121).

Doing Something about the Weather

As mentioned above, a defining feature of the Clinton plan was some form of "managed competition," a scheme marrying government regulation with the market force of purchasing alliances against providers. It would also create strong incentives for employers and workers to choose managed care arrangements like HMOs. While premium caps would be new and intrusive, there was however nothing new and ideologically offensive about purchaser alliances and managed care. Around the country employers had already begun experimenting with purchasing alliances without waiting for government compulsion (Bergthold 1990; Hilzenrath 1994a; Pauly 1997). The move en masse by big employers to HMOs, after a slow beginning in the 1970s and early 1980s, commenced more or less with Allied Signal Corporation's famous conversion in 1988 (Brown 1983; Swoboda 1990a; Anders 1996: 16–19). In the meantime, companies persisted with other private strategies—shifting costs to workers and retirees, promoting "employee wellness," and the like (Crenshaw

1992; Freudenheim 1992d; Pear 1993c; American Business Publishing 1994).

A marked decline in health costs was not to be felt immediately. But when it was, starting in 1993 and accelerating in 1994, journalists and commentators began positing, as did Louis Uchitelle (1994) of the *New York Times,* that "broad corporate resistance presents a big obstacle to passage of the White House proposal," having once observed encouraging signs from the same quarters. Only two years before, throughout 1992, according to *New York Times* health beat reporter Milt Freudenheim (1992a, 1992b, 1992c, 1992d), results had still been mixed on the bottom-line effects of managed care for employers. Some even found it ended up costing more money than it saved. Though some employers reported success, experts from places like the Congressional Budget Office and the Employee Benefits Research Institute still found no discernible systemwide effects of managed care. Wages, instead of the care sector's income, were taking the biggest hit. Meanwhile, bankers were beginning to put the heat on companies providing generous health benefits. Standard & Poor's lowered its credit ratings for such companies—General Motors, Navistar, and Bethlehem Steel among them. High health care costs were now translating into higher borrowing costs as well as tensions at the workplace and in collective bargaining.

Skepticism about private, voluntary cost-control efforts began giving way to optimism in early 1993. Xerox Corporation reported that 60 of the 190 HMO's serving its employees were limiting their price increases to only 5.5 percent, though the others could still not go that low. Even better, S. C. Johnson & Sons *reduced* health spending around 7 percent per employee by joining a regional purchasing alliance in Racine, Wisconsin, which used its clout on the managed care market to negotiate discounts. But success of this magnitude was still rare and did not spread immediately. A national survey of employers early in 1993 indicated that managed care was helping to moderate medical inflation, though interviews with benefits executives said that "national legislation was still needed to shield corporate profits from high health care costs for employees." According to Sharon Canner, health care policy specialist at the NAM, "unless there is some force to make managed competition happen, the change for the better is just going to take much too long, while corporate profits erode." Mary Jane England at the Washington Business Group on Health seemed to concur that there should be managed competition "in the entire health-care system," though without going all the way to insist on government compulsion to impose it (Freudenheim 1993d, 1993c, 1994).

As 1993 wore on the picture got brighter for employers. Notably, for example, they scored major victories in forcing hospitals to reform their arbitrary and at times outrageous billing devices ("a joke" at the time, according to health economist Uwe Reinhardt). Hospitals were now accepting administratively simple capitation or per diem payments instead of fees for individual services (Freudenheim 1993a). The "dawning of competition" among hospitals and other provider interests, induced by aggressive shopping by employers in the state of New York, helped produce the lowest increases in health care costs in twenty-one years. Meanwhile, managed care expanded its membership and aggressively competed for corporate accounts. In December 1993, Healthnet, an HMO owned by New York's Empire Blue Cross and Blue Shield, planned not to seek a 1994 rate increase. "It's been a revolution in the past year or so," according to the president of the New York County Medical Society, who had personally abandoned the fight for the old regime by signing on with ten managed care networks (Freudenheim 1993b). Employers playing hardball across the country brought the lowest annualized growth rate in twenty years for the third quarter of 1993, according to a health consultant for the business community (Ingwerson 1993). The yearly growth in health insurance premiums charged to both employers and workers for HMO-insured firms then fell yet again to 2.7 percent in 1994, from 7.8 percent in 1991, 6.8 percent in 1992, and 5.3 percent in 1993 (U.S. GAO 1997: 28).

Health economists and consultants were not sure if the reductions represented something ephemeral—a "Hillary effect" on providers, causing them to restrain their demands to head off legislation—or simply a low point in an underwriting cycle when insurers battled each other for new customers with discounted prices that could not be sustained for long-term profitability. While the White House promoted the idea of the Hillary effect in order to emphasize the long-term need for government-induced structural reform, the main causes were probably different. According to a principal with the Foster Higgins consulting firm, the question was whether it was "just another cycle, or a fundamental shift" in private behavior without government action. Many analysts believed, like the New York physicians and hospitals, that "structural changes" definitely bore a lot of responsibility whether or not there was a cyclical component. As one top HMO executive put it, providers were reorganizing themselves "at warp speed" (Freudenheim 1993b; Hilzenrath 1993; Halvorson 1993: 64).

Looking back, MBGH vice president Larry Boress recalled that employ-

ers wrongly perceived the dramatic decline in health inflation starting in 1993 as a result of increasingly successful efforts at imposing efficiencies. The Washington Business Group on Health's journal *Business and Health* reported large employers' belief at the time that long-lasting efficiencies were responsible, "not just discounts." Thus the subsequent rise in the late 1990s, revealing the important role of the underwriting cycle, engendered surprise and dismay according to Boress (interview with Boress, June 2001; see also Findlay 1993: 30, 35).

Given employers' increasing optimism about their own unilateral regulatory efforts in late 1993, Jerry Jasinowsky of the NAM began to worry that government regulation was becoming superfluous if not downright dangerous. The Clinton plan, he said, "could strangle the competition that is emerging and is absolutely essential to constraining the cost of health care services" (Pear 1993a: A20). By early 1994, the emerging competition he referred to had built up a strong head of steam. In January, Kaiser Permanente of Northern California actually rolled back the rate increase it had imposed on customers down to 2 or 3 percent from 5 to 6 percent, a trend that advanced across the whole industry through the rest of the year (Russell 1994). San Francisco businesses reported in June 1994 that they were negotiating 5 to 10 percent discounts on health care with their new HMOs. The emerging managed care market in Houston made national headlines with projected savings of 25 percent and no government involvement (Hilzenrath 1994a; see also Freudenheim 1995).

Not surprisingly, therefore, journalists and commentators with an eye on the business community began to posit in the winter of 1993–1994 that the trends may "take some steam out of Clinton's push to overhaul the nation's health care system" and "cost the health plan some political punch" (Hilzenrath 1993, 1994b). Conservative pundit James K. Glassman asked, "Is the government's health care cure really needed?" His answer was that "the free play of supply and demand" was already working quite well, thank you. In short, "the timing couldn't be worse" for the Clinton plan. He quoted the CEO of Columbia Healthcare Corporation, a large for-profit hospital network, who claimed "the private sector is fixing itself" and a top executive of pharmaceuticals giant Eli Lilly saying that "the politicans are several miles behind the market" (Glassman 1994: G1). The editor of *Business and Health* finally came out, in December 1993, with a forceful recommendation that "employers should oppose the Clinton Plan," explicitly citing their "substantial success in controlling costs and improving quality" in the past years (Burns 1993b: 6).

Employers' private efforts to bring their costs under control occurred at the same time that the urgency for such action declined. The economy had begun slowly building momentum in 1991 even before Clinton took office. By the end of 1991 manufacturers' production and sales, parallel with other economic indicators, pointed upward. The job market finally showed real improvement in the course of 1993 while the legislation was being drafted (OECD 1999: 23; U.S. Bureau of the Census 1998: 403). During the year-end quarter when Congress finally received the Clinton bill, manufacturing capacity utilization, which had hovered around 79 percent since early 1988, began to increase significantly. It rose above 84 percent by the summer of 1994, by which time the reform momentum was spent (OECD 1994: 29). Some of the upturn can be attributed to the decline of the dollar against Western European currencies and most of all the Japanese yen, reducing the pressure on firms that faced international competition (U.S. Bureau of Economic Analysis 1999: table 2A; OECD 1994: 38). Finally, the signing of NAFTA in 1992 gave American businessmen all the more reason to see fair weather ahead, and to the extent they did, Clinton's free trade efforts may have undermined progress on the health care front.

Thus the sharp downward turn in employers' health costs took place, in 1993 and 1994, in the context of an economy whose sun had now broken through the clouds. In short, the Clinton administration and congressional reformers were proposing remedies for a health problem that was already being solved, at least for the time being. The first big blow for the Clinton administration came on 2 February 1994, when the policy committee of the Business Roundtable (an organization of CEOs from America's largest corporations) voted to reject the Clinton plan by a vote of sixty to twenty, supporting the more incremental, noncompulsory Cooper plan. But even the twenty who had not yet jumped ship—mostly "NLCHCR types" according to Mike Lux, a White House liaison official in contact with the businesspeople—did not come forth to repudiate the Roundtable's slap in the face to comprehensive reform (interview with Lux, June 2001). According to the most detailed journalistic account of the Roundtable's decision, "it all boils down to a visceral feeling among many executives that . . . the administration is proposing a big-government solution to a problem better left to the market" (Stout and Wartzman 1994).

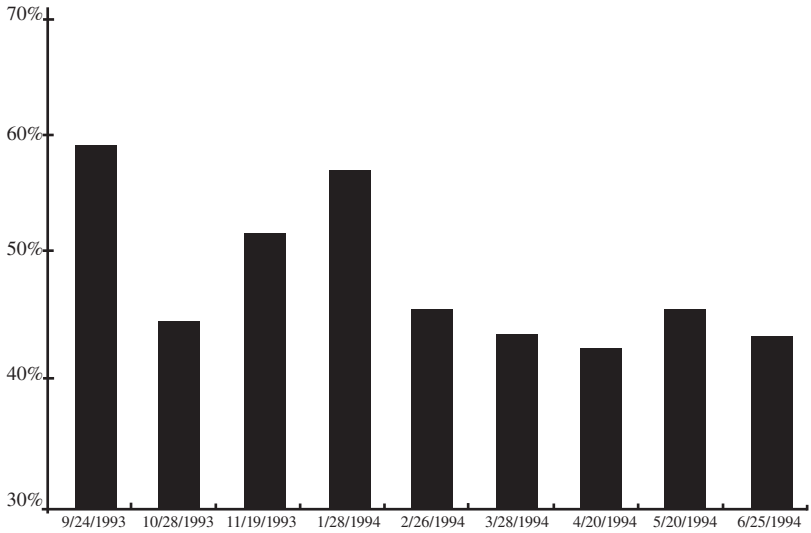
Even many Fortune 500 companies with more than 5,000 employees and thus exempt from joining the regional purchasing alliances adamantly opposed the plan. Exemption, the Clinton administration thought, would

allow them to forge ahead with their own solutions. But most, it seems, anticipated being compelled to join and thus "would end up ceding control of their health-benefits programs . . . reducing their role to simply writing checks" (ibid.). They dreaded that the big regional alliances would exercise so much market muscle in wresting discounts that providers would shift their losses from the discounts onto the independent firms. Once sheltered in an alliance from such cost shifting, they could no longer legally opt out. That would prove damaging in the long run, for they feared that the politicized government bodies would lose their ability to control overall growth in health costs in the face of political pressures against managed care (interview with Boress, June 2001). In short, they thought "they could control costs much better than the Government could, and they feared that under the Clinton plan they would lose the right to tailor health benefits to their employees' needs" (Clymer, Pear, and Toner 1994: A1).

As General Electric's celebrated chairman Jack Welch put it in the spring of 1994, when the Clinton plan was staggering battle-scarred through Congress, "the system is now getting under better control." Continuing, he said that the administration "could declare victory" and move on to other things (Rogers 1994). Welch forgot that cost control was not the only reform objective. Dropping universal coverage would mean Clinton's defeat, not victory.

Death by Disinterest

Although public support for Clinton's efforts softened throughout 1993 and 1994, there was never a strong rejection of reform in principle (Rushefsky and Patel 1998: 234–242; Blendon, Hyams, and Benson 1993; Blendon et al. 1994). Therefore it makes sense to puzzle over, as does Theodore Marmor (1999: 458), "why all the health care reform plans died in 1994 when the Clinton Plan disappeared from American politics." If big business interest played an important part in propelling the issue onto the national agenda and if the loss of interest helps explain the collapse of the Clinton plan, then Marmor's puzzle may be solved. Had big business remained interested, negotiated adjustment of the Clinton plan's details may not have run aground. Perhaps big employers would have helped finance a counteroffensive in the battle over public opinion, which opponents increasingly dominated as time went on. Perhaps we would not have seen the precipitous drop in public support—from 57 percent in late January 1993 to 46 percent by late February



Percent responding favorably to question: "From everything you have heard or read about the plan so far, do you favor or oppose President Clinton's plan to reform health care?"

Figure 2 Public Support for the Clinton Plan. *Source*: Jacobs and Shapiro 1995: 418.

1994—shortly after the news media trumpeted the three big business organizations' seemingly concerted rejection of the Clinton plan. (For three months before then, support had been recovering after an earlier decline. Thereafter it remained in the doldrums.) Existing public opinion studies do not mention the simultaneity of business and voter rejection and examine the possible connection (Jacobs and Shapiro 1995: 418; 2000: 228–229; Blendon, Brodie, and Benson 1995) (see Figure 2).[2]

Although businesspeople were key activists in contemplating legislative initiatives—various members of the NLCHCR, for example—there were no corporate initiatives after 1994. Activist firms retreated from the debates, and even Bethlehem Steel, which remained a supporter of the Clinton plan until the end, never bothered to contact politicians on the

2. Note that polling data for December 1993 are not available. The high point in September 1993 registered two days after Clinton's televised speech on the plan to a joint session of Congress. Older citizens' worries about the cut in Medicare benefits to partially finance the plan possibly explain the initial dip; in any case the elderly seem to account for much of the drop between September 1993 and February 1994 according to Blendon's 1995 analysis. The relatively long three-month period of rising support has not been analyzed; Hacker (1997: 147), for example, only mentions and tries to explain the "hemorrhaging of public support" after Clinton's September address.

issue, all the while lobbying them on other issues like shipbuilding or steel imports (Pearlstein 1994). By the end of the decade, most of the big corporate members of the NLCHCR had dropped out of the organization.

Promising health reform efforts at the state level, in which businesspeople played an important role, faltered at the same time as the Clinton plan did. Massachusetts and Oregon both passed legislation with employer mandates but delayed their implementation until 1995, and ultimately abandoned them before then (McDonough 1992: 61–62; Paul-Shaheen 1998). Enthusiasm for the private solution took over completely. Large firms continued moving large numbers of employees out of traditional insurance into managed care in the aftermath of the national legislative struggle (Marquis and Long 1999: 81). Exuberance for the private remedy even upset existing regulatory practices that had previously enjoyed business support. For example, deregulation occupied the 1996 legislative agendas in Massachusetts and New York, pioneers in regulatory control once favored by big business groups. Legislatively imposed rates, payment or funding caps, or other intrusive regulation were abolished or severely weakened (Hackey 1998: 90, 133).

Of course, as many analysts pointed out, managed care could not guarantee much more than a one-time reduction in costs. At best, perhaps, it could lean against strong underlying demographic and technological factors pushing health care costs upward. Suspicions that reductions in the mid-1990s were at least in part the result of an underwriting cycle were confirmed. Managed care companies and insurers competed voraciously over market shares of "lives" delivered by employers into their hands with unsustainably low prices. Subnormal profits and a punitive stock market later forced charges to employers and workers up again. Indeed, the eerie calm that settled over employer health costs around 1994 was rudely disrupted by 1999. Soon health cost inflation galloped ahead once again, by a factor of three, of general inflation (Mercer 1999b; Miller 2000; Reese 2001).

Also, the surge into managed care subsided, having reached a saturation point. Enrollment by 2000 was actually dropping. To the consternation of big employers, the political attack on managed care in the form of patients' rights bills in state legislatures and Congress pressured the health care industry to relax some of its more stringent practices for holding down costs. By joining the campaign for patients' rights, organized labor, in a gradual historic turnaround, shifted sides fully from being an early advocate of managed care to being an ally of physicians and other provider professionals against it. Meanwhile, aside from polit-

ical efforts to defend managed care, employers found little left in their arsenal of private solutions to hold the line on costs. Passing more costs on to workers proved difficult, at least for a while, given labor shortages in the late 1990s until 2001. Expansion and improvement of employee "health and well-being" programs was not going to help, its saturation point having been reached. In 2000, 90 percent of all worksites in the United States already sponsored at least one health-promoting activity, with virtually all senior managers citing health care costs as the reason (Mercer 1999a, 2000).

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

By the end of the 1990s, however, none of these three assumptions appeared to hold any longer. A truly revolutionary transformation of the system, incorporating far-ranging and ruthlessly competitive processes, had been carried out without government compulsion. A great deal of retaliatory cost shifting was accomplished through private competitive mechanisms. Then as costs started to rise again, the prospect of government imposing an even more rigorous system of competitive mechanisms seemed increasingly remote and implausible. If anything, politicians across the political spectrum appeared to employers to be overly solicitous of a broad-based alliance of political forces for costly patients' rights legislation. Government intervention was, if anything, going to undermine, not reinforce, new private market controls.

Thus the chances of a cross-class coalition brokered by liberal and centrist reformers in favor of universal health care on the Clinton model became effectively nil. Now, without a convincing model for cost con-

tainment that requires government and universalism, firms will continue to favor private mechanisms, especially in tight labor markets, that make recruitment and retention difficult. Recession, of course, makes shedding benefits and shifting their costs on workers easier. Demonstrably cost-effective single-payer systems face powerful political opposition from the business community, not just the AMA. American businesspeople regard democratically elected politicians as too weak and unreliable to withstand political pressure for benefit mandates that will raise costs. By delaying passage and therefore ensuring the death of the Clinton plan, opponents of reform closed a window on an unusual opportunity to establish a universal health care system in the United States. It also closed the book on that model of business-government cooperation in health care.

Conclusion

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

Institutional conditions no doubt endowed reform's opponents with enormous and perhaps fatal stalling power in the 1990s. However, it must be remembered that other major welfare reforms have passed in this country despite the same institutional obstacles. Looking at the events of the 1990s in historical perspective as we have done makes it all the more plausible to believe that reform might have passed with a mix of big busi-

ness support and tolerance despite institutional obstacles—had employers continued to feel powerless to control health markets on their own. The analysis suggests that the opportunity will not arise again except under unusual economic and political conditions. History suggests that these conditions might involve long-term economic adversity, further reductions in coverage hitting large parts of the politically efficacious middle-class population, and highly skillful political entrepreneurship. Executive and congressional leadership will need to be innovative in designing reform that somehow helps employers cope with the crisis while also expanding coverage to the uninsured. History also suggests there will be a need for a "cautious reformer," too, like Edwin Witte, whom FDR brought in to direct legislative drafting efforts for the SSA. Were he alive today, Witte, schooled in the matter by the dean of American reform intellectuals, John R. Commons, would advise taking extra care to satisfy the interests of big business (Witte 1935: 8; Schlabach 1969: 123; Swenson 2002: 13–14, 206). For all the criticism that Ira Magaziner and the Clintons received after their failure, they did in fact make efforts in that direction (Pearlstein and Priest 1993). Some of their efforts may have been clumsy and ill-advised, but probably their chief problem was bad timing.

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