Rekindling Reform—How Goes Business?

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GIVEN THE DIFFICULTY

Lyndon Johnson met with in passing Medicare under the most favorable political circumstances, and the more recent experiences surrounding the failure of the Health Security Bill (or Clinton Plan) in 1993 and 1994, future health reformers would be well advised to minimize unnecessary opponents. This article outlines the role I would expect the business community to play in a new effort to enact universal health coverage, and steps that might be taken to minimize business opposition and perhaps even garner some business support. An assessment of what motivated business’s response to the Clinton Plan offers an instructive starting point.

THE HEALTH SECURITY BILL

Business opinion was not monolithic during the debate over the Health Security Bill. There were 3 key groups: employers who provided health benefits, those who did not, and those whose business was health care. From a strategic point of view, it is important to understand that all 3 groups were represented on the policymaking bodies of the country’s major business organizations—the US Chamber of Commerce, the Business Roundtable, and the National Association of Manufacturers (NAM).

Employers Go to School

In the late 1980s, employers sponsoring health benefit plans faced enormous bottom-line pressures from skyrocketing health costs. The problem was compounded by the economic difficulties then facing the country. As a result, the Chamber of Commerce, the Business Roundtable, and NAM all formed committees to discuss health reform. Many employers had found that there were limits to what they alone could do to counter this cost trend other than manage their benefit plans as effectively as possible. They had learned that the best managed care plan remained exposed to government cost shifting and to cost shifting from employers not offering coverage. Hence, these health policy discussions were well attended. As Chrysler’s health policy director, I was personally involved in the deliberations of each of these 3 business groups.

Over the next few years, many employers came to understand the merits of achieving universal coverage and developing a coordinated health policy for the public and private sectors. All 3 groups debated reform alternatives in an atmosphere largely devoid of political considerations. This was prior to the presidential election of 1992.

Given the limited options available for achieving universal coverage, the fact that most businesses were unwilling to support a tax-financed national health plan, and the understandable bias that many employers had toward retaining employer-sponsored health plans, it is not surprising that serious discussions ensued within all 3 business groups relative to the merits of an employer mandate.

NAM focused on this issue for a number of reasons. Not only did all of its larger members offer health benefits, but it had a significant small business component, over 90% of whom also provided coverage. After much committee work, a survey of NAM members published in late 1992 found that a majority approved of an employer mandate so long as it was part of a comprehensive reform plan. This response was in part motivated by the results of a cost-shifting study commissioned by NAM that indicated that fully 28% of manufacturers’ health costs were the result of costs shifted from others, the major source of these costs being other employers who failed to provide coverage. NAM’s board of directors subsequently issued, in October 1993, a policy statement supportive of an employer mandate, and they ratified it on February 5, 1994.

Likewise, in 1993 the Chamber of Commerce, after considerable policy debate, endorsed comprehensive health reform, calling for universal coverage with shared employer/employee financing responsibility. The Chamber of Commerce maintained this position until early February 1994.

The Business Roundtable’s health committee, chaired at the time by a representative of the insurance industry, never embraced an employer mandate.

While the above discussions were proceeding, the National Federation of Independent Business, a major voice for small business, was unalterably opposed to an employer mandate,
for reasons quite similar to their opposition to increases in the minimum wage—it was unaffordable and would lead to job losses.

Enter Politics

The presidential election of 1992, which focused much attention on the nation’s health care crisis, saw Bill Clinton elected with only 43% of the popular vote and in the process incurring the wrath of a powerful cohort of the Republican Party. The inherited deficits deepened, and the administration’s first order of business was not its health plan but a budget/tax bill designed to stem the deficit, which passed by 1 vote in both the House and Senate in August 1993.

All of this contributed to a movement led by Newt Gingrich to recover both the White House and Congress for Republicans, a central component of which was to deny the administration any form of victory in the health care reform debate.1 Gingrich got some unintended help from the fact that the Clinton Plan as ultimately proposed in September 1993 was a far from perfect document.

Donna Shalala, secretary of Health and Human Services during the Clinton years, discussed one major problem in a wide-ranging interview with Princeton health economist Uwe Reinhardt.2 Shalala noted that many stakeholders were threatened by the proposal because they foresaw a loss of profits. I put in that category employers whose primary attraction to health reform was the potential to eliminate cost shifting. She quite correctly observed that if in the future there was an effort to change the system, “you’d better have some money to put in, so that you can buy the change rather than redistributing the existing pot of money.”2(p51)

The Clinton Plan did not do that. Having just signed a major tax increase, one must assume President Clinton was reluctant to call for even more taxes to finance coverage for the uninsured, including the subsidies necessary to make an employer mandate affordable. Instead, the subsidies had to be extracted from inflated premiums charged to other payers. (Subsidies were required not only to make an employer mandate affordable but also to help cover the cost of other subsidized groups, including retirees not yet eligible for Medicare.) From the perspective of employers seeking relief from cost shifting, such explicit cross subsidies were seen as simply codifying into law the then-current informal process of cost shifting. However, the alternative—seeking new broad-based tax revenues—was equally abhorrent to many in the business community at that time.

The cross-subsidy problem was aggravated by small business’s reaction to the Clinton Plan. The plan as introduced limited an employer’s cost to a maximum of 7.9% of payroll (a little over 30 cents per hour for a minimum wage worker at the time). For many small employers, the maximum was 3.5%. Despite this generous subsidy, small business rebelled. Congressional committees countered with even greater subsidies, ultimately bringing the maximum for small employers down to 1%, and got the same response. Worse, once small business subsidies reached such extraordinary levels, and revenue raisers targeting larger employers were added, many larger employers concluded that the proposed reforms would actually increase their health costs. To say that this lessened the zeal of many business health reform proponents is an understatement.

Business Flip-Flops

Meanwhile, the political tug-of-war had begun. While the administration worked to gain the support of large employers, Republicans worked hard to keep the major business groups from supporting the Clinton Plan. The most startling flip-flop involved the Chamber of Commerce. Following a lengthy process, it had developed a policy in support of an employer mandate and was prepared to advance it before the House Ways and Means Committee in February 1994. After the testimony had already been delivered, but prior to the actual hearing, the Chamber of Commerce suddenly reversed course and totally rejected the Clinton Plan.

Similarly, NAM had developed a policy in support of an employer mandate, had had it approved by its board in October 1993, and had ratified it again in early February 1994, only to have the NAM executive committee suddenly reverse this policy 6 weeks later and oppose the mandate.

The Business Roundtable, while never supportive of an employer mandate, was at least prepared not to oppose it. However, it too was being encouraged by Clinton Plan opponents to support a less comprehensive plan sponsored by Rep Jim Cooper of Tennessee that did not contain an employer mandate. Despite the fact that the Business Roundtable was staunchly opposed to a key financing provision of the Cooper bill, denying the deductibility of business health costs for more generous health plans, it announced it was opposing the Clinton Plan and supporting the Cooper bill as “a starting point.”

By rejecting the Clinton Plan’s key financing mechanism—the employer mandate—the country’s major business organizations effectively killed the bill. There remained no significant push by employers providing benefits to counter the massive pressure from those businesses that preferred the status quo—that is, paying nothing.

One reason the small business opposition to the employer mandate was so effective was that it had the support of some very large businesses (e.g., Pepsi and General Mills) that were heavily invested in fast food operations with many uncovered workers. These large companies not only provided support for the small business community, they also worked to keep the large employer community from coalescing. If anything, this segment of the large business community has grown.3

THE NEXT TIME

Some future president will make it his or her business to achieve universal health coverage. I continue to believe there is hope that the business community (that is, those providing health benefits) will become allied with this cause.

First, health costs and cost shifting continue to plague business. Premium increases far outpace both overall inflation and profit growth. Further, health costs continue to be unfairly distributed throughout the economy as the number of working uninsured remains alarmingly high.
There are many low-wage-paying industries that can tolerate high turnover and have little incentive to provide health benefits. This will not change absent legislation.

Further, many of the “silver bullets” advanced by some in the business community as alternatives to more comprehensive reform measures have proven inadequate to address either the cost or the access problem. I refer specifically to managed care, medical savings accounts, and insurance reforms. Likewise, neither incremental government initiatives nor charity care have adequately filled the void.

Politics aside, business attitudes regarding any universal coverage initiative will be determined by the specifics of the proposed reforms. The list of likely reform options, however, is not a lengthy one.

One option, a tax-financed system, would carry much baggage. For ideological reasons alone, one might expect serious political resistance as well as resistance from employers, even though this option would relieve them of managing health plans. More daunting would be the task of convincing legislators to raise through the tax system not only the funds required to cover the uninsured but also the funds currently paid voluntarily by employers. One irony: the Federal Employees Health Benefit Plan, which has often been cited by both Republicans and Democrats as a model plan, is itself financed through taxes.

Another option is to adopt an individual mandate, with subsidies provided for those who cannot afford it. On balance, I believe most employers would support this concept, or at least not oppose it, since they would find such a system compatible with employers remaining able to provide health benefits. Over time, however, I believe this reform model would erode employer-provided coverage, as many new employers would have little incentive to offer health benefits. This, in turn, would significantly increase the cost of public subsidies, posing a major obstacle to its enactment.

Further, proponents would have the serious political burden of persuading a large percentage of employed, insured, voting Americans to abandon the current employer-based system that they are comfortable with in return for a system in which they ultimately may be required to pay premiums that may or may not be subsidized.

**Employer Mandate Redux**

The remaining option is to build on the current system, much as the Clinton Plan did. Inherent in this option is some form of employer mandate. What will it take to give this reform option a reasonable chance of gaining employer support?

First, it must be recognized that the vast majority of businesses that get engaged in this issue will do so solely on the basis of their economic self-interest. A reform proposal that adds to the costs of employers already providing benefits will be a nonstarter.

Second, employers providing health benefits must recognize that the current system of cost shifting represents a de facto tax paid only by them. They must also recognize that legislators are unlikely to eliminate this politically risk-free form of raising revenue unless those paying this unfair “tax” both strenuously object to it and lend their support to a fairer, broad-based form of taxation adequate to subsidize coverage for the uninsured.

Third, managed care is here to stay and should play a major role in a reformed system. A reform strategy seeking to eliminate the insurance industry would make that industry and many other businesses instant and unnecessary opponents.

Employers not providing health benefits can of course be expected to staunchly oppose an employer mandate. Ironically, after the Republicans assumed control of Congress in 1995, Congress increased the minimum wage by an amount far greater than the cost of the heavily subsidized Clinton Plan premium for minimum wage workers that small employers had objected to paying. The reality is that for many low-wage-paying employers and their employees, an employer mandate is a de facto increase in the minimum wage. As such, I believe any future mandate proposal should be linked with a moratorium on minimum wage increases for a certain period of time.

**The Business of Health Care**

Those businesses whose business is health care could pose a significant obstacle to reform. This is because any proposal to ensure coverage for all Americans must likewise ensure that health costs do not bankrupt the nation. Any proposal designed to limit the growth of health care spending will get the attention not only of family physicians but of major teaching hospitals and giant firms in the pharmaceutical, biotech, and medical equipment business as well. They can all be expected to weigh in—expressing concerns relative to quality of care—and have a very real potential to spread fear among the currently well-insured public. Further, talk of “price controls” will also strike a negative chord, not only among those in the business of health care but among the overall business community as well.

The cost issue, never truly addressed during the Clinton Plan debate given the stalemate over the employer mandate, will pose a major challenge to reform. Reform proponents may wish to consider the comments of Arnold S. Relman, MD, former editor of *The New England Journal of Medicine*, concerning entrepreneurial medicine:

> The American health care system operates like a business (or, more accurately, many businesses), with all the incentives of private enterprise to expand the market but with few of the risks. . . . [T]he industrialization of medical care [has] contributed greatly to cost inflation by introducing aggressive marketing and other competitive business methods aimed primarily at increasing the revenue and market share of providers. . . . Commercialized health care, like any other commercial activity, generates increased consumption, thereby adding to total expenditures. . . . If we are going to allow the continued industrialization of medical care, there will be no way to control its costs except through much firmer regulation.

In conclusion, there are sound reasons for employers who provide health benefits to welcome another opportunity for comprehensive health reform. There are also important lessons that can be learned from the Clinton Plan debate. If they are heeded by both employers and health reform advocates, there remains hope that key elements of the business community will play a positive role in the next comprehensive health reform effort.
Labor Rekindles Reform

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