

Business Opposition to Nationalized Healthcare

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Abstract: This paper examines the historic failure of business to support nationalized healthcare, despite the fact that employers have to come shoulder much of the burden of providing increasingly expensive health insurance. The paper examines the numerous hypotheses proposed in the existing literature and builds on them to provide a comprehensive analysis of business' position. Although many reasons have been given for business' absence from the debate and failure to support government backed health care reform throughout the century, they have not been examined in one cohesive work. This paper fills that gap.

Introduction

Throughout the last century, various health care reform bills have been proposed and debated by the United States federal government, but until recently, none passed. During this period, employers have come to shoulder much of the burden of providing increasingly expensive health insurance. Starting in the 1970s, the Nixon administration began calling for business to become involved in the debate over health care legislation, hoping that the interests of the group increasingly responsible for providing health care coverage would align with those of the administration,¹ particularly given the skyrocketing costs of health care. Indeed, between 1965 and 1982, hospital costs per admission rose approximately 690 percent.² In addition, “between 1970 and 1989 employer spending (in constant 1989 dollars) rose 1 percent for wages and salaries, 32 percent for retirement benefits, but 163 percent for health benefits.”³ And by 1989, business was the second largest payer of healthcare.⁴ Given these numbers, it would seem natural for business lobbies to support government health care reform plans. And yet, throughout the last century, business has either remained silent or opposed government efforts to overhaul the healthcare system. The question, then, naturally arises: Why hasn’t business supported government run healthcare plans?

Surprisingly, the reasons for business’ absence from the debate or failure to support government backed health care reform throughout the century have not been examined in one cohesive work. This paper, therefore, aims to fill that gap. Because the role of business in the failure of the Clinton Health Care plan has been examined in detail by various researchers, including but not limited to Gottschalk 1999,⁵ Gordon,⁶ Greer and Swenson 2000,⁷ Hacker 1997,⁸ Johnson and Broder 1996,⁹ and Skocpol 1996,¹⁰ that era will not be included in the scope

of this paper. Rather, this paper will cover the beginning of the century until the early 1980s.

I shall begin by enumerating the various hypotheses that have been examined in the existing literature. I shall then posit my own hypothesis and, in order to support it, examine the history of business and healthcare reform chronologically, beginning with the American Association for Labor Legislation (AALL) state bill (first proposed in 1914) and ending with the Reagan era.

The Business of Business Involvement in Health Care

One commonly cited explanation for business' lack of support for government sponsored health care reform is business' philosophical opposition to government intervention.¹¹ The logic behind this hypothesis is that business leaders have a knee-jerk reaction in opposition to government intervention in any sector of business, including the health care sector. Indeed, business leaders may have feared that government intervention in the insurance industry (itself a member of the business community) could be the precursor to increased involvement of government in all sectors of business. Or they may have feared that government intervention could ultimately increase the health care burden carried by employers. But it is not convincing that business leaders would oppose government intervention exclusively for philosophical reasons if they believed it would decrease their costs.¹² In reality, as health care costs increased through the 1970s and 80s, businesses that had high healthcare burdens sought out government help in reducing costs.¹³ Therefore, further hypotheses must be considered.

Another commonly cited reason for business' willingness to provide health benefits is the legacy created by tax laws initiated by the War Labor Board during World War II.

Specifically, the Revenue Act of 1942 allowed employers but not individuals or employees to deduct their health insurance costs.¹⁴ As a result, both businesses and employees benefited when employers provided health insurance. Although this policy may have institutionalized employer provision of health insurance, it alone cannot explain the unwillingness of the business community to support government healthcare reform. The business community's attitude can be better understood, however, if we concurrently consider the hypothesis that employers considered business' provision of fringe benefits, including health care, beneficial to the company. Indeed, beginning in the 1940s, industrial psychology taught employers that instilling goodwill in employees towards the company would increase worker productivity and reduce turnover by increasing loyalty to the company.¹⁵ Nevertheless, had costs been too high, employers would have sought out other means of placating employees.

We must consider, therefore, whether health care did, in fact, impose a serious cost burden on employers. Klein argues quite convincingly that, at least initially, insurance companies successfully marketed private group policies to businesses at a relatively low cost to employers.¹⁶ According to Klein, insurance companies not only lobbied the government but also spent considerable time and money convincing other business groups that government regulation of the insurance industry would be detrimental to them in the long run. Thus, a plausible hypothesis is that for decades, health insurance was not a major business expense and therefore not a major business priority. In addition, businesses wanted to avoid government regulation of the insurance industry for fear that government incursion into other business sectors might one day follow.

All of the discussion thus far has assumed that the business community, or at least a

substantial segment of it, was capable of speaking with one voice on the health care issue. Consequently, the last hypothesis that needs to be considered is that “business” was unable to present a united front because of the high level of fragmentation in the sector.¹⁷ For example, although some companies had high healthcare costs, many others had little or no health care expenses. These same companies opposed any government policies that implied that businesses were responsible for providing employee health coverage, which most of the government backed health reform plans, to one degree or another, did.¹⁸

Given these facts, in this paper I shall argue that successful marketing of group policies to business by the insurance industry combined with favorable tax status due to WWII wage restrictions led many companies to provide health insurance to employees as part of a larger set of “fringe benefits” aimed at generating goodwill towards the employer and tying employees to the company. As healthcare costs increased, businesses looked first at ways of reducing costs and only as a last resort did they consider government involvement. Even then, many businesses opposed government intervention, either because they did not provide health insurance for their employees and therefore were not subject to cost increases, or because they feared that government regulation of the insurance industry could serve as an opening for increased government regulation of other industries.

1914 – 1920s: Welfare Capitalism and the American Association for Labor Legislation (AALL)

State Bill

Widespread employer provision of health care began shortly after World War I, when Standard Oil of New Jersey began offering workers a bevy of fringe benefits, including health and

accident insurance.¹⁹ Concurrently, labor shortages and increasing unionization led employers, especially at large companies, to increase employee representation and support for personnel departments in an attempt to improve worker morale.²⁰ Welfare capitalism, or “any service provided for the comfort or improvement of employees which was neither a necessity of the industry nor required by law,”²¹ was seen to benefit employers in multiple ways. First, companies considered welfare programs good publicity and hoped that public sympathy towards companies would undermine political support for antitrust litigation, restrictive legislation, or strikes.²² Second, by providing fringe benefits voluntarily, employers were able to control the terms of employment rather than allowing them to be determined through bargaining with unions.²³ At the same time, WWI war profits allowed employers to fund welfare programs easily.²⁴

During the same period that some employers began providing health insurance to employees, the American Association for Labor Legislation (AALL) was promoting a model state bill for employment-based sickness insurance. The bill proposed insuring wages lost due to illness, not costs of care, and was confined to industrial employees earning less than \$1200 a year.²⁵ Employers were not yet systematically involved in health care provision at this point, but neither did they support the AALL plan.²⁶ Although opposition was not universal, the majority of the business community felt that the AALL bill tied health care too closely to employment, placing “the burden on the employer of things which are not his fault.”²⁷ Thus, although it was during this era that some employers began providing health insurance for their workers, business leaders resented the implication that they should be the ones responsible for providing this coverage.²⁸

At the same time, insurers began aggressively marketing private group plans to employers. One method that insurance companies used to sell policies was experience rating, a system in which lower risk groups pay lower premiums.²⁹ Under this system, employer-paid health costs were lower than any other in the nation because employers could cherry pick the healthiest members of the population. As a result of their ability to keep costs low, employers were not worried about unloading the burden of health care coverage onto the state.³⁰

Moreover, large insurers such as Metropolitan not only sold policies to companies; they considered it equally important to sell the idea of social welfare partnership between the insurance company and the employer.³¹ Metropolitan told large firms that “group insurance enables the employer to reestablish that personal contact with [its] employees and that sympathetic interest in the welfare of the employees’ home folks, which tends to become lost in this age of machinery.” Companies facing public scrutiny were told, “group insurance gives the employer excellent publicity of the right sort.” In an age in which worker morale was of increasing importance, Metropolitan promised that “The certificate of insurance and the Metropolitan Service go into the worker’s home and create there appreciation of the employer’s generosity and thoughtfulness, thus winning over to him many a fireside ally back in the home.”³² In order to facilitate the turn towards welfare capitalism on the part of employers, Metropolitan had a management consulting service to help companies install new managerial practices, facilitating the reduction of safety problems and job turnover which, in turn, improved companies’ experience rating and lowered their group insurance premiums.³³

Finally, employers did not support regulation of the health care industry because they recognized that the health care industry was part of the commercial sector and feared that

government regulation of health care could eventually be extended to their own companies.

Following WWI, business worried that if the government exercised significant control over one industry, “state control over other professions and industries was sure to follow.”³⁴

The real opposition to nationalized health care, however, came from the American Medical Association (AMA), one of the first and most powerful lobbies in the nation. Gordon explains that “through the 1920s and early 1930s, organized medicine emerged as the most important and influential opponent of both public health insurance proposals and private experiments in group medicine.”³⁵ And because the direct cost of medical care born by business was not significant at that point, business generally supported the AMA.³⁶

1930s & 1940s: Institutionalizing Employer Provided Health Care

Although the Great Depression caused a steep decline in fringe benefits, the labor shortages of World War II brought not only a resurgence of welfare capitalism, but also the beginning of the institutionalization of employer provided health care. Two primary factors led employers into the business of providing health care: the exclusion of fringe benefits from payroll taxes and World War II wage restrictions.

Until 1939, the law said nothing about whether payroll taxes had to be paid on fringe benefits. Seeing this opening, Marion Folsom, Kodak’s treasurer from 1935 to 1958 and one of the few businessmen to lobby for social security, fought to exclude fringe benefits from payroll taxes. He argued that not taxing them was in workers’ interest, saying, “We wanted to do everything we could to encourage fringe benefits . . . and if you started to tax them, you’d discourage them.” Indeed, “when he helped the Social Security Board set up its record system,

he tried to prevent the inclusion of fringe benefits in the government's payroll data."³⁷ In the end, Congress specified that fringe benefits were exempted from payroll taxes.³⁸ Thus, the Revenue Act of 1942 allowed employers but not individuals or employees to deduct their health insurance costs.³⁹

Although Folsom supported social security and argued for the exclusion of fringe benefits from payroll taxes, he did not support government provided health benefits. This position had two bases: first, Kodak provided few health benefits and therefore did not see a need for government intervention; second, like many business leaders of the time, Folsom thought a completely voluntary approach to health benefit provision was preferable.⁴⁰

The institutionalization of employer provided benefits stems largely from their exclusion from payroll taxes, but the proliferation of these benefits can be traced to WWII wage restrictions. Although increases in the hourly rate of pay were not allowed during WWII, increases in fringe benefits were.⁴¹ Specifically, the National War Labor Board (NWLB) "policy held that the board would approve group insurance or other benefit plans voluntarily agreed upon by unions and management as long as they did not exceed 5 percent of payroll."⁴² Because labor was scarce, employers seized on the provision of fringe benefits in their struggle to attract and retain workers.⁴³

Additionally, both labor and management realized that because fringe benefits were exempted from payroll taxes, "A dollar contributed by the employer will buy more in the way of benefits than a dollar given to the worker and then checked off . . . because the worker pays an income tax on his dollar while the employer receives a tax deduction for his."⁴⁴ One employer argued that health insurance was an inexpensive means of "persuading workers to stay on the

job” because “it was a case of paying the money for insurance for their employees or to Uncle Sam in taxes.”⁴⁵ An analysis of employee benefits explains why companies were expanding corporate welfare plans in this era:

The benefits available under a group insurance plan give employees a sense of security and freedom from worry, which in turn contributes toward their work and the company. Contented and satisfied workers are usually loyal employees. More cordial relations with employees, better morale, employee good will and satisfaction were listed by cooperating companies as the outstanding advantages of their group insurance plans.⁴⁶

Furthermore, during the era of wage restrictions, unions seized on fringe benefits as a bargaining point: they could not bargain for wage increases, so they bargained for non-wage benefits instead.⁴⁷ Some union leaders believed that rather than hurting the cause of nationalized health care, employer provision of benefits would help because, the reasoning went, once employers had to shoulder the burden of health coverage, their opposition to nationalized health insurance would dissipate.⁴⁸

Once the war ended, continuing prosperity and full employment led to the persistence of fringe benefits: “The postwar period of prosperity was sufficiently long and sufficiently great to support not only a higher economic standard of living but also a higher standard of social welfare.”⁴⁹ In this way, employer provided health care became institutionalized in the US: in 1926, surveys found only fourteen employment-based health plans, and in 1939 only forty-eight, whereas “by the late 1940s over half of firms employing under 250 persons and over two-thirds of firms employing over 250 offered some form of health insurance.”⁵⁰ In addition, approximately 75 million Americans had hospital insurance in 1950, whereas only about one in eleven had it in 1940.⁵¹

Once again, however, the insurance companies and the AMA played a role in the persistence of employer provided insurance. Both doctors and insurers warned employers that state intervention in health care could have larger regulatory ramifications for the business community and argued that the rapid spread of private provision was the key to thwarting national health insurance.⁵² As a result, when Truman attempted to enact health care reform, business once again failed to support his plan.

Wagner-Murray-Dingell Bill

Calls for universal health care date back to the Truman administration, when, on November 19, 1945, the president declared, “Our new economic bill of rights should mean health security for all, regardless of residence, station or race – everywhere in the United States.”⁵³ The result of Truman’s work was the Wagner-Murray-Dingell Bill, which both fell short of the President’s aspirations and failed to garner sufficient support to pass. This bill proposed a “single unified system of national social insurance” which would be funded by one payroll tax, 6 percent from workers and 6 percent from employers.⁵⁴

Despite business’ increased involvement in healthcare provision, a number of factors led to the failure of the business community to support this bill. First, as in previous years, the AMA fought to convince the business community that government involvement in healthcare was the first step down a slippery slope:

Let the people of our country realize that the movement for the placing of American medicine under the control of the federal government through a system of federal compulsory sickness insurance is the first step toward a regimentation of utilities, of industries, of finance and eventually of labor itself. This is the kind of regimentation that led to totalitarianism in Germany and the downfall of that nation.⁵⁵

Further, R. S. Senserich, the chairman of the AMA board of trustees, told senators that voluntary insurance would “accomplish all the objects of this bill with far less expense.”⁵⁶

Second, employers still reaped many benefits from welfare capitalism. On a basic level, the provision of health care tied workers to their employers. Businesses thus used fringe benefits such as health insurance to make workers dependent on their employers rather than on the state for the provision of basic services.⁵⁷ By tying social welfare to employment, companies tied the workers themselves to the firm. Moreover, by avoiding government control of social welfare, employers were able to offer the social benefits that workers demanded without allowing the benefits to become rights.⁵⁸

In addition, after WWII, businesses commonly used fringe benefits, health insurance in particular, to stave off unionization and to moderate union demands. Even in unionized plants, employers often made decisions about health care plans unilaterally, even when unions demanded a negotiated plan. Furthermore, “when unions brought grievances over fringe benefits to the NLRB, the board rarely ruled in the union’s favor if the plan had already been unilaterally implemented by the employer.”⁵⁹ And as employer provided social benefits expanded, unions had an increasingly difficult time pushing for public social welfare programs, which suited the ideological interests of businesses.⁶⁰

Finally, the cost to employers of health care provision remained low. On the one hand, fringe benefits were profits that were not taxed: “From the employer’s viewpoint, in the prosperous postwar period of rising productivity, putting additional profits into labor costs, which would then be deductible as business expenses, was economically wiser than having it

taxed as income.”⁶¹ On the other hand, insurance companies worked hard to keep group plan costs low for businesses. They did this in part by providing dividends to the employers:

All mutual insurance companies purposely overcharged at the front end to make up for any possible miscalculations in “risk,” or actual use of services. After covering administrative and other charges, insurers returned any extra premium money as a year-end dividend. Since the corporation was the legal policy holder, such dividends belonged solely to management.⁶²

Although workers contributed to the cost of plans, they were not eligible for dividends. As a result, insurers used the dividend system to ensure that the cost of group insurance plans was born more by the worker than by the employer. In addition, neither the initial employer contribution nor the dividends were taxed. Consequently, money contributed to group insurance policies by employers often became untaxed profits. Martin Segal, who ran a pension and health insurance consulting firms for unions, explained that

The employer’s contribution to the cost of the group insurance is deductible from his taxes as a necessary “business expense.” . . . Furthermore, after tax deductions, the remainder of the employer’s contribution is wholly or in part wiped out by the dividends or rate refunds which are returned to him by the insurance company. . . . As a rule, therefore, after tax deductions and insurance company dividends or rate deductions, the employer’s contribution is only nominal.⁶³

In addition, large insurance firms provided consultants to advise employers on how to select and manage insurance policies and even on how to meet NWLB requirements: “Metropolitan’s PSB offered to conduct labor turnover analyses, set up internal health and safety programs, establish standardized hiring and firing procedures, and help with personnel recordkeeping for any group client.”⁶⁴ Insurers also made it as easy as possible for employers to keep health care costs low by allowing employers to mold health insurance policies to the needs of their company.⁶⁵ One Equitable promotion piece stated, “Every Equitable Group plan is specifically

tailored to meet your company's individual needs, eliminating the cost of superfluous coverage while protecting you from the danger of inadequate coverage." Metropolitan's Group Division even published a booklet called, "Tailored to Fit: A Group Insurance Plan Designed for the Employees of Your Company."⁶⁶ In this way, insurers were able to enlist employers in their battle against the regulatory welfare state. For the AMA, the ever expanding private social welfare network was evidence that a public social welfare system was unnecessary, and the AMA used this information to convince senators that Truman's healthcare reform was superfluous.⁶⁷

1950-1970: The Specter of Higher Costs

In the 1950s, the honeymoon between insurers and employers waned. Employers became less enthusiastic about providing health benefits because, at the same time that employers faced constant pressure for more inclusive plans, the cost of health care was increasing at an alarming rate. Some resented that employers had become the "cash cow" for private insurance. Others blamed doctors and insurers for health inflation.⁶⁸ Nevertheless, many firms still opposed expanding the public-sector welfare state and used private welfare benefits as a means of avoiding it. The National Association of Manufacturers (NAM), for example, "implored its members to make health insurance widely available to retiring employees to thwart the push for Medicare."⁶⁹ The focus of health politics had shifted, however, from providing universal, government run coverage to slowing health inflation.⁷⁰

And despite increasing costs, many employers still saw benefits from providing health coverage to their workers. One General Electric executive explained that welfare capitalism

programs “pay a return to the owners of the business on the money invested in the program by improving productivity, raising morale, reducing turnover and increasing loyalty.”⁷¹ As a result, businesses focused their lobbying efforts on pushing for cost control mechanisms.

At the same time, the passage of Medicare in 1965 helped private industry control costs by removing the people from the private insurance pool who, by insurance standards, were the worst risks. In effect, Medicare subsidized the private health industry. Indeed, one person commented that the “result will not be so much the subsidizing of needy people as the subsidizing of an industry.”⁷² Even so, many members of the business community fought to prevent Medicare from expanding beyond its limited mandate. Health care costs continued to rise, however, leading the business community to increase its involvement in health politics.

1970s Onward: Cost Control at the Forefront

Until the 1970s, business had been largely uninvolved in the politics of health care, and so when Nixon proposed a health care reform plan, Robert Finch, Nixon’s secretary of health, education, and welfare declared, “We will ask and challenge American business to involve itself in the health care industry, including the creation of new and competitive forms of organization to deliver comprehensive health services on a large scale.”⁷³ In the ensuing years, the business community did involve itself in the politics of health care, though not necessarily in the way envisioned by the Nixon administration. Rising health costs had made health care a higher priority for business, but businesses’ focus was on cost mediation rather than systemic reform.

The rising cost of health care for businesses can be illustrated with a simple comparison: “Between 1970 and 1989 employer spending (in constant 1989 dollars) rose 1 percent for

wages and salaries, 32 percent for retirement benefits, but 163 percent for health benefits.”⁷⁴

In 1970, top business leaders began speaking to the national press about the health care cost “crisis.” In addition, new associations such as the Washington Business Group on Health (WBGH) were created to represent the interests of America’s largest corporations in the shaping of health care policy. Concurrently, dozens of state-level commissions aimed at solving the “health care cost crisis” were formed with heavy leadership from the business community.⁷⁵ The explosion of coalitions and task forces charged with tackling the health care crisis was indicative of the increase in business organization around the issue,⁷⁶ and, for the first time, business leaders became involved in the writing of health care legislation, both at the state and national level.⁷⁷

Although business leaders advocated for reductions in health care costs, they were uninterested in increased government regulation of the health care industry. Rather, many business leaders argued in favor of using market based solutions to combat the fast rate of inflation in the health care industry. For example,

three businessmen, representing large banking and manufacturing firms . . . pleaded for both the creation of a “true market” with patient choice among competing modes of delivery and a “major role for private capital and management paralleling the rest of the nation’s industrial system.” They concluded, “Our health-care industry is the only major industry that has not had to submit to the discipline either of the marketplace or of public regulation.”⁷⁸

Largely as a result of business involvement in the health care debate, the focus shifted from reform based on national health insurance and industry regulation to market based approaches that would lower costs.⁷⁹ Business interests thus encouraged “competitive” reforms while fighting regulation and nationalization of the health care industry.⁸⁰

Even when businesses did support government efforts at health care reform, moreover, they did not support all of the consequences. For example, many companies do not want to lose the ERISA (Employee Retirement Income Security Act of 1974) preemptions that allow them to self-insure and thereby avoid state regulations, including mandated benefits.⁸¹

Specifically,

Section 514 of ERISA preempts state laws that “relate to any employee benefit plan.” The courts have interpreted this clause to mean that self-insured employers and Taft-Hartley funds, which essentially execute the same underwriting functions as the commercial insurers, are preempted from state-level insurance regulations regarding such items as benefits, coverage, and quality standards for medical care. States also are not permitted to tax self-insured plans or subject them to state insurance regulations regarding, for example, licensing or the posting of reserves to ensure the financial integrity of such plans.⁸²

As Gottschalk explained, the courts’ liberal interpretation of this provision has exempted “more and more categories of employers’ health-insurance plans, many of which . . . bear no resemblance to self-insured plans.”⁸³ Any attempts at reform, therefore, must contend with the aspects of the current system that businesses want to maintain.

Thus, as health care costs became increasingly burdensome for employers, the business community sought not to unload the costs onto the government but rather to create market mechanisms to reduce the rate of inflation in the health care industry. In the meantime, the system of experience rated health care became so entrenched that it precluded the possibility of shifting to community rating. In the late 1980s a NAM spokesperson explained, “we arrived at a social contract that if government would take care of the old and the poor, the private sector would take care of the working.”⁸⁴

Why business isn’t as worried as we think it should be

Although the business community has become much more involved in health care politics in the last few decades than it was prior to the 1970s, its voice in the debate is still not as strong as many would expect it to be. This seeming anomaly stems from a few root causes. First, despite increases in the costs of health care, they do still not overwhelm businesses, as a result of which, health care remains low on the list of priorities for businesses. Second, health care is itself very big business, and thus has a voice in the business community. Third, the business community lacks unity on this issue and therefore does not speak with one, powerful voice as many had hoped it would. Finally, many of the health care reform plans have involved mandating employment-based care, which inspires widespread opposition in the business community.

Although the burden of health care costs on employers is widely discussed, in many cases the costs are not as high as they seem. For example, though health care costs are often cited as hindering the competitiveness of US firms in the international market, Brown argues that “the business sector’s ability to compete in international markets turns not on health spending per se but rather on the total compensation package that firms offer.”⁸⁵ Therefore, by reducing worker compensation in some areas, employers are able to mitigate the increases in health care costs. Furthermore, businesses have a number of ways of dealing with increases in health care costs: they can pass them on to consumers, reduce shareholders’ returns, or, most common, slow wage growth. Consequently, workers, and not employers, often bear the brunt of increases in health costs: “presumably the 163 percent rise in health benefits between 1970 and 1989 has something to do with the measly 1 percent growth in real wages over those years.”⁸⁶

Perhaps as a result of business' ability to pass health care cost increases on to workers, in most cases, health care costs are not a priority for businesses. That is to say, although business leaders may have opinions regarding the health care debate, they spend their time and energy on the legislative issues that they consider of greater importance and "save their political capital for battles that count more heavily."⁸⁷ Evidence of this trend was found by Mizruchi (2002) who "counted the cases in which two or more of a sample of fifty-seven manufacturing firms in the Fortune 500 testified before congressional committees on various issues between 1980 and 1987." He found that

Energy was the subject in forty-three hearings; automobile and transportation issues in thirty-five; government regulation and taxes, thirty-one; environmental protection issues, thirty; industrial health and structure, twenty-two; public works and government budget concerns, twenty-two; science, technology, and education, twenty-two; foreign trade, eighteen – and health care, just one.⁸⁸

Furthermore, in a poll conducted by the Robert Wood Johnson Foundation in 1989, "although 60 percent of the corporate chiefs who responded labeled health care costs as a major concern, only 35 percent called them a 'top' concern."⁸⁹ In addition, although the corporate leaders considered health care costs a concern, they did not consider continued provision of health care by employers to be a problem.

Moreover, some business leaders did not believe that government involvement would reduce cost inflation. One executive interviewed by *Business Week* explained, "My snap opinion is that a national plan would involve constantly escalating costs. But more important, a national plan would take away an item worth up to a cent an hour that you can now stack on the bargaining table."⁹⁰ Thus, although the business community wanted a reduction in health care cost inflation, many companies that provided health care still saw this fringe benefit as a

useful tool in dealing with employees. At the end of the day, they neither wanted to cede health care provision to government nor to be required to provide it.

At the same time that health care costs were rising, the size of the health care industry was increasing. For example, in the 1980s, health care accounted for one-fourth of the net job growth in New York State, and health services are the state's top source of employment.⁹¹ In the national economy, moreover, health care is the leading growth sector.⁹² As health care has come to be an increasingly large segment of the business community, it has come to have an increasingly powerful voice in the debate. Furthermore, given the complexity of the health care system and the potential options for change, most corporate CEOs find the topic beyond their expertise.⁹³ This situation creates room for those in the health care industry, who are intimately familiar with the workings of the health care system, to exert more influence.

The health care sector is not the only segment of the business community that has diverging interests and views. In fact, the business "community" is not a community at all. Each company acts in its own interests, and it is rare for large segments of the business community to be united on any one issue, particularly when it comes to social welfare.⁹⁴ As Bergthold illustrates,

Businesses are split in their policy preferences by their size, by whether or not the business has substantial supplier or provider interests or is mainly a purchaser of coverage, and by region of the country in which they are located. Big business is tired of paying cost shifts perpetuated by small businesses who do not cover their employees. Manufacturers feel differently about reform than do companies that produce medical supplies. Business headquartered in California or Minnesota, where managed care is prevalent and acceptable, have different views about reform possibilities than do businesses located in the East or South.⁹⁵

Consequently, coming to an agreement about the proper government action regarding healthcare is next to impossible.

For example, although many large businesses would like their health care costs to be reduced, small businesses, many of which do not provide health insurance for their employees, are staunch opponents of any plan that would increase their health care burden. Small business executives, moreover, often argue that regulations in the health and safety fields impose excessive burdens on them.⁹⁶ Any new regulations of employer provision of health care fall under this umbrella. On the other hand, "If a company's health care costs were more than 10% of a company's payroll, health care reform was that company's top priority."⁹⁷ For most businesses, however, this is not the case, and those businesses want to avoid being forced to cover the healthcare costs of their employees. Consequently, although some employers support universal access to health care and cost containment, achieving this goal would require mandatory participation, which many smaller employers vehemently oppose.⁹⁸

Accordingly, any reform of the health care system would benefit some sectors of business while hurting others because controlling costs for some firms would likely require imposing those costs on others. Such divisions in the business community were visible in businesses' response to the Nixon health plan:

Major organizations representing big business were more favorably inclined toward the Nixon approach. Representatives of the NAM and the US Chamber of commerce offered their qualified support for the Nixon Plan, but argued for a reduction in the percentage of employee health insurance costs employers would have to assume. Organizations catering to the small business community were more reticent about the Nixon plan. The National Federation of Independent Business went on record opposing the president's proposal, saying that many small businesses could ill afford the requirement that they pay for a portion of their workers' health insurance premiums. Under questioning by

Representative Griffiths, the legislative director of the 239,000-member NFIB conceded that the administration's plan would be much worse for small businesses than the Kennedy-Griffiths proposal for national health insurance.⁹⁹

Thus, the entrance of business in the health care debate ultimately has resulted in increased confusion about the proper course of action.¹⁰⁰

Consequently, though supporting nationalized health care would seem to be the natural stance for the business community to take in an age of increasing health care costs, the fragmentation of the business community has largely prevented employers, even those in support of such reform, from exerting significant influence in government. Such fissures reappeared during the debate about the Clinton Health Care Plan, and are considered one of the major causes for the failure of that proposal. Furthermore, any support that businesses have for health care reform is hindered by discussion of mandated employment-based care. Employers simply do not believe that covering employees is their responsibility, and they have opposed any plan that assumes that it is.¹⁰¹ Finally, employers that do provide health care are often able to pass the costs on to workers. Accordingly, these costs often do not have enough of an impact on firms for them to be a top priority.

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⁴ "In 1989, business was the second largest payor of health care, contributing 30% of total expenditures for health services and supplies (excluding research and construction). Households accounted for the largest segment of expenditures at 37%" (Bergthold, Linda. "American Business and health Care Reform." *American Behavioral Scientist* 36.6 (July 1993): 802).

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- ¹¹ Brown 339.
- ¹² See Mares, Isabela. 2003. The Politics of Social Risk: Business and Welfare State Development. New York: Cambridge University Press, 2003.
- ¹³ Bergthold (1990): 129; Gottschalk 694.
- ¹⁴ Gordon 58.
- ¹⁵ See Jacoby, Sanford. 1997. Modern Manors. Princeton, NJ: Princeton University Press.
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- ¹⁷ See Mares, 2003.
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- ¹⁹ Jacoby 18.
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- ²¹ Brandes, Stuart D. 1976. *American Welfare Capitalism, 1880-1940*. Chicago: University of Chicago Press: 5-6.
- ²² Brandes 32.
- ²³ Klein 17.
- ²⁴ Brandes 26.
- ²⁵ Gordon 12.
- ²⁶ Gordon 211.
- ²⁷ Gordon 212.
- ²⁸ Gordon 110.

²⁹ This system is in contrast to community rating, in which “all subscribers paid the same rate, regardless of the amount of medical care services she or he might need or consume. Therefore, the healthier members of the community helped subsidize the less healthy members” (Klein 118).

³⁰ Gordon 104.

³¹ Klein 34.

³² Klein 37.

³³ Klein 49.

³⁴ Gordon 142.

³⁵ Gordon 215.

³⁶ Gordon 218.

³⁷ Jacoby 215.

³⁸ Jacoby 215.

³⁹ Gordon 58.

⁴⁰ Jacoby 219.

⁴¹ Allen, Donna. 1964. Fringe Benefits: Wages or Social Obligation? Ithaca: Cornell University Press: 8.

⁴² Klein 185.

⁴³ Allen 39; Jacoby 216.

⁴⁴ Unionist quoted in Gordon, 58.

⁴⁵ Gordon 58.

⁴⁶ Derickson 118

⁴⁷ Allen 25, Jacoby 216

⁴⁸ Derickson, Alan. 2005. Health Security for All: Dreams of Universal Health Care in America. Baltimore: The Johns Hopkins University Press: 121.

⁴⁹ Allen 26.

⁵⁰ Gordon 21.

⁵¹ Derickson 114.

⁵² Gordon 219.

⁵³ President Truman quoted in Derickson 93.

⁵⁴ Klein 175.

⁵⁵ The *Journal of the American Medical Association* quoted in Derickson 94.

⁵⁶ R. L. Senserich quoted in Derickson 96.

⁵⁷ Klein 205, 224.

⁵⁸ Klein 206.

⁵⁹ Klein 211.

⁶⁰ Gottschalk 2.

⁶¹ Allen 39.

⁶² Klein 225.

⁶³ Martin Segal quoted in Klein 226.

⁶⁴ Klein 211.

⁶⁵ Klein 223.

⁶⁶ Klein 223.

⁶⁷ Beland, Daniel, and Jacob S. Hacker. 2004. "Ideas, private institutions and American welfare state 'exceptionalism': the health of health and old-age insurance, 1915-1965." *International Journal of Social Welfare*, 13: 52.

⁶⁸ Gordon 229-231.

⁶⁹ Gottschalk 48.

⁷⁰ Gordon 243.

⁷¹ Quoted in Gordon 68.

⁷² Anonymous source quoted in Gordon 234.

⁷³ Robert Finch quoted in Bergthold 22.

⁷⁴ Brown 340.

⁷⁵ Bergthold (1993).

⁷⁶ Gordon 244-245.

⁷⁷ Bergthold (1993).

⁷⁸ Bergthold (1990): 32.

⁷⁹ Bergthold (1990): 59.

⁸⁰ Gordon 169.

⁸¹ Brown 344.

⁸² Gottschalk 54.

⁸³ Gottschalk 55.

⁸⁴ Gordon 126.

⁸⁵ Brown 343.

⁸⁶ Brown 343.

⁸⁷ Brown 344.

⁸⁸ Brown 344.

⁸⁹ Brown 342.

⁹⁰ Bergthold (1990): 30.

⁹¹ Brown 343.

⁹² Brown 343-344.

⁹³ Brown 345-346.

⁹⁴ See Mares (2003).

⁹⁵ Bergthold (1993).

⁹⁶ Levitan and Cooper 40.

⁹⁷ Bergthold (1993).

⁹⁸ Bergthold (1993).

⁹⁹ Gottschalk 69.

¹⁰⁰ Gordon 244.

¹⁰¹ Gordon 247-248.