

Back to the Future? Health Benefits, Organized Labor, and Universal Health Care

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Abstract The umbrella of employment-based health benefits is growing increasingly threadbare. As a result, health benefits are once again a major arena of labor-management strife, and once again calls for universal health care by many labor leaders mask important differences between them over health care reform. Some labor leaders advocate a bottom-up mobilization in support of a single-payer solution that would dismantle the system of job-based benefits rooted in private insurance. Others stake their health care strategy on wooing key business leaders to be constructive partners in some kind of unspecified comprehensive reform of the health system.

Organized labor faces enormous obstacles, both institutional and ideological, to forging an effective united front to fight for comprehensive, high-quality, affordable health care for all. Two entrenched features of the shadow welfare state of job-based benefits, notably the Employee Retirement Income Security Act (ERISA) of 1974 and the union-run health and welfare funds created under the Taft-Hartley Act, remain daunting barriers on the road to reform, exacerbating tensions and differences within organized labor. Moreover, a dramatic ideological schism in the labor movement about its future direction vexes its stance on health care reform. These ideological differences fuel vastly different views within organized labor about how best to confront the unraveling of job-based health benefits and the growing popularity among business leaders, insurers, and public officials of the “individual-mandate” solution, which would penalize people who do not have adequate health insurance.

The umbrella of employment-based health benefits is growing increasingly threadbare. As Andrew Stern, president of the Service Employees International Union (SEIU), declared last year: “We have to recognize that employer-based health care is ending. It is dying in front of our very

eyes” (Brookings Institution 2006: 12). Health benefits are once again a major arena of labor-management strife (Bureau of National Affairs 2004). Once again, calls for universal health care by many labor leaders mask important differences between them over health care reform. Some labor leaders advocate a bottom-up mobilization in support of a single-payer solution that would dismantle the system of job-based benefits rooted in private insurance. Others stake their health care strategy on wooing key business leaders to be constructive partners in some kind of private sector–led reform of the health system.

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In the early 1990s, as health care reform moved to the top of the national agenda, organized labor was unable to forge an effective united front. The health care committee of the American Federation of Labor and Congress of Industrial Organizations (AFL-CIO) divided sharply over whether to support a single-payer approach, which was popular with some labor leaders and with the more politically active members of labor’s rank and file. Instead, the labor federation initially backed an open-ended, let-a-hundred-flowers-bloom position on health reform that failed to ignite the grass roots. As the rough outlines of Clinton’s Health Security Act became clearer, the national leadership of organized labor closely sided with the White House. Labor leaders also courted the business sector, pursuing what turned out to be a false hope—that business would be a reliable ally in satisfactorily resolving the nation’s health care crisis. At the time, the AFL-CIO concentrated its efforts at the national level. It eschewed promising state-level initiatives for comprehensive health reform, viewing them as dead ends and a drag on the national push to find a solution.

As speculation grows that we may be at the brink of another major

attempt to overhaul the U.S. health system, organized labor is once again divided. However, the cleavages are not identical to those of fifteen years ago. Ironically, Andrew Stern of the SEIU, who split with the AFL-CIO in 2005 and founded a rival federation with seven disgruntled unions, is stridently staking out a position on health care reform remarkably similar in some ways to the pro-business stance the AFL-CIO pursued in the early 1990s. Stern has embedded his health care stance in a highly controversial vision of how best to revitalize organized labor in a globalized economy. Meanwhile, the AFL-CIO has not shut out the single-payer option. In March 2007, the federation's executive committee unanimously endorsed "Medicare for all." Even though the AFL-CIO did not use the words "single payer," some single-payer advocates praised the federation's new stance. Furthermore, this time around, the AFL-CIO has not been aggressively promoting business and employers as the key players in health care reform. The federation has also been more supportive of state-level initiatives in health care reform.

Divided and hemorrhaging members,¹ unions nonetheless remain pivotal players in the politics of health care. For well over a century now, labor has been instrumental in the development of the U.S. health system. It established some of the first prepaid group practices and health maintenance organizations, was the leading voice for national health insurance up until the mid-1970s, and was decisive in the establishment of Medicare and in the expansion of other major social programs, like Social Security and the Great Society. The employment-based system of health benefits is largely the product of a collective-bargaining regime established during and immediately after World War II. That system is under siege today. Without unions to act as a brake, today's downward spiral in health benefits for union and nonunion workers would be even faster.

Despite its dwindling ranks, organized labor still has formidable resources to influence the course of health care reform.² The membership rolls and resources of the major unions continue to dwarf those of most public interest groups. Labor's lobbying capacity has expanded dramatically as the AFL-CIO, other labor groups, and individual unions have invested more heavily in lobbyists, enlarged their research departments, and developed grassroots lobbying networks (Dark 1996: 91–92; Francia 2006: 71–72). With the recent assaults on Social Security and retiree

1. In 2006, just 12 percent of the work force was unionized (U.S. Department of Labor, Bureau of Labor Statistics 2007).

2. For more on labor's political potential, see Levi (2003) and Gottschalk (2000), especially chapter 2.

health benefits, retired unionists have become a force to be reckoned with in local, state, and national politics. The mobilization of these retirees has helped to offset some of the political losses associated with the shrinking size of the unionized work force. Labor's financial resources have not contracted significantly despite its dwindling membership base (Masters 1998). Unlike many other organizations that fund political campaigns, unions provide not only cash but also other important resources such as phone banks and nonpartisan get-out-the-vote drives. The Democratic Party has become increasingly dependent on labor's money, votes, and electoral apparatus. About one-quarter of delegates and alternates to the Democratic National Convention are affiliated with labor organizations (Sack 1996). One major sign of labor's influence and importance is that seven of the major Democratic contenders for the White House agreed to appear at a labor-sponsored debate on health care in March 2007, the first of its kind in the 2008 presidential race.

Certainly the size of the labor movement and its resources are important factors in determining the course of health care reform in the United States. However, the political influence of unions depends on far more than just money and members. As Douglas Fraser (1991: 413), the former president of the United Automobile Workers union (UAW), reminds us, the strength of the union movement also depends "on the agenda, the sense of commitment and the manner in which the labor movement allocates resources."

For the past few years, the private safety net of employer-sponsored benefits has been steadily unraveling. Benefits for unionized workers are ground zero in the attack on employee benefits. The growing threats to health care and other benefits are reconfiguring the politics of health care reform. Understanding the specific institutional and ideological pulls on labor leaders and labor organizations today and the varied ways in which they respond to those pulls is key to understanding labor's political capacity in health care reform and the fate of universal health care in the United States.

The Unraveling of the Shadow Welfare State

For decades, employment-based benefits anchored in the private sector but backed by government policy have been a major feature of the U.S. health care system. Consequently, the private sector has been a key battlefield where business, labor, the state, and employees hotly contest the contours

of social provision in the United States.³ The proliferation of job-based union benefits had important positive spillover effects on the nonunionized sector. Many employers began offering comparable benefits as a way to retain the best workers and keep unions at bay after World War II (Jacoby 1997).

Since the demise of the Clinton health plan almost fifteen years ago, the benefits of unionized workers have come under attack from many directions. The erosion of benefits in unionized jobs has hastened the erosion of benefits for workers in nonunion jobs. Employers are now shifting more of the health care burden onto their employees. Some are eliminating benefits altogether; others are whittling away at them. Companies are creatively using bankruptcy proceedings to wiggle out of contract obligations to unionized workers. They also are suing their retirees in an effort to renege on earlier promises made to retired workers. New national accounting standards for private and public employers threaten to hollow out retiree benefits further. In the public sector, the new standards pit taxpayers against state and municipal employees.

While employers have been offloading more of their health care costs onto their workers, they have been coalescing around a powerful new idea that has rapidly insinuated itself into the health care debate—the idea of an individual mandate. Instead of penalizing employers who do not provide health insurance coverage for their employees, the focus of the debate is rapidly shifting toward penalizing individuals who do not secure a minimal level of health insurance coverage. This ideological shift is helping to legitimize the steady retreat of employers in the provision of social welfare.

Despite five years of consecutive economic growth, employers' role in providing health insurance has continued to contract. The bluntest indicator of this is the rise in the number of Americans who are uninsured. In 2005, 46.6 million, or about 16 percent of the population, was uninsured, up from about 14 percent in the early 1990s (DeNavas-Walt, Proctor, and Lee 2006: 68, table C-2). About 82 million people—or nearly one-third of the population under age sixty-five—face a spell of uninsurance in any two-year period (Dorn 2004: 1). The percentage of firms offering health benefits, after increasing slightly in the late 1990s, has eroded steadily in the past few years, falling from 69 percent in 2000 to 61 percent in 2006 (Kaiser Family Foundation and the Health Research and Educational Trust [KFF/HRET] 2006: 34, exhibit 2.1). Between 1991 and 2003, the propor-

3. For more on the development of private-sector benefits, see Hacker (2000), Martin (1998, 2000), Howard (1997), Gottschalk (2000), and Rosner and Markowitz (2003).

tion of full-time employees participating in employer-sponsored health plans at medium-sized and large firms plummeted from 83 percent to 65 percent. In 1980, the figure was 97 percent (Employee Benefit Research Institute [EBRI] 2006: table 4.1a). For workers at small firms, the contraction was even more severe, from 69 percent in 1990 to just 42 percent in 2003 (*ibid.*: table 4.1b). Last year, just over one-half of workers employed in the private sector participated in employment-based health plans.⁴ Several factors explain the drop in participation. Fewer firms are sponsoring health plans, eligibility rules have tightened, and more employees are declining to join their employers' health plans, often because they cannot afford them (Clemans-Cope, Garrett, and Hoffman 2006).

The extensive cost-shifting onto the backs of employees is further evidence of the rapid deterioration of job-based benefits. By 2003, employers at large firms paid, on average, 70 percent of employees' total health care costs, down from 75 percent five years earlier, according to a survey by Hewitt Associates.⁵ Employees now pay more money for less coverage because of escalating premium costs and dramatic rises in deductibles, co-payments, and out-of-pocket expenses for medical care.⁶ By 2001, medical expenses comprised on average 18.2 percent of personal consumption expenditures compared to about 15 percent a decade earlier and barely 10 percent in 1970 (Reinhardt, Hussey, and Anderson 2004: 20, exhibit 4). A recent study suggests that more than one-half of the nearly 1.5 million American families who file for bankruptcy annually are forced to do so because of mounting debts for medical expenses. Many of these families come from middle-class, educated backgrounds and have health insurance or at least had it at the start of the illnesses that plunged them into debt.⁷

Health benefits for retired workers are at the epicenter of the assault on the shadow welfare state.⁸ Today only about one-third of large firms offer

4. These figures include workers covered but not yet participating in such plans due to the employer's minimum service requirements. They do not include workers who were offered but chose not to participate in contributory health plans (U.S. Department of Labor, Bureau of Labor Statistics 2005: table 2).

5. During that time, annual out-of-pocket expenses for employees at large firms more than doubled to about \$2,100 (Freudenheim 2003).

6. For rising cost trends for health insurance premiums and deductibles, see Kaiser Family Foundation and the Health Research and Educational Trust (KFF/HRET 2005: 1; 65, exhibit 6.7; 79, exhibit 7.2).

7. This is about a sixfold increase in the proportion of families filing for medical bankruptcy since 1981 (Himmelstein et al. 2005: 6).

8. Nearly all U.S. citizens age sixty-five and older qualify for Medicare, the federal health care program for older Americans. Those who retire before age sixty-five are usually ineligible. Some employers provide health insurance to retired workers until they qualify for Medicare and/or provide so-called Medigap coverage to retirees aged sixty-five and above to cover items or expenses not included in Medicare.

health benefits for their retirees, down from 46 percent in 1991, and a more rapid drop is likely in the near future. In a recent poll of mostly Fortune 500 companies, 95 percent said they would scale back their retiree health plans over the next five years, and 14 percent expect to stop providing coverage altogether (Dixon 2006). More brazen efforts by employers to disavow promised benefits coupled with changes in national accounting standards for employee benefits are two of the main culprits in shrinking retiree coverage. During recent contract negotiations with the Professional Staff Congress (PSC) at the City University of New York (CUNY), which represents twenty thousand CUNY employees, management bluntly told PSC president Barbara Bowen, “Why don’t you cut retirement benefits? They don’t vote on the contract.”⁹

Until recently, employers generally did not attempt to slash retiree health benefits covered by union contracts, even as they cut the benefits of their nonunion workers.¹⁰ But employers are now aggressively targeting retiree benefits. A few years ago, unionized firms began suing their retirees, arguing that the guarantee of “lifetime” health benefits meant coverage for the life of the contract, not the life of the retiree. This has been a win-win situation for firms that have stopped paying the cost of their retirees’ health plans. While these cases drag on in the legal system, employers have saved money as retirees, “who have to pay growing portions of their health care costs, forgo costly care, drop out of the plans or die” (Schultz 2004). Should they lose in court, employers do not have to pay punitive damages or penalties. They merely have to resume paying their retirees’ health plans, and they may not have to resume providing benefits for those retirees who dropped out of the health plans during the legal struggle. In the meantime, firms also get a boost in their earnings because they are permitted to reduce the liabilities on their books after announcing cuts in retiree benefits. Many retirees have been unable to afford legal representation to fight for a restoration of their benefits. Some labor contracts even stipulate that the union is not permitted to represent retirees in future lawsuits. The U.S. Labor Department has not taken up the cause of these retired workers denied health benefits, arguing that they “aren’t our constituents anymore” (Schultz 2004).¹¹

9. Quoted in remarks given by Barbara Bowen at the “Our Health Care Benefits: What Does the Future Have in Store? What’s at Risk?” symposium, Hunter College School of Social Work, New York City, December 2, 2006.

10. Large firms with at least some unionized workers are more than twice as likely as non-union ones to provide retirees with health benefits (49 percent compared to 24 percent; KFF/HRET 2005: 117, exhibit 11.3). See also Fronstin (2005).

11. This paragraph is based on Schultz (2004).

The government has been an accomplice in this assault on retiree benefits in other ways. In a three-to-one decision in April 2004, the Equal Employment Opportunity Commission (EEOC) voted to permit employers to decrease or eliminate health benefits for retirees when they become eligible for Medicare at age sixty-five. The decision essentially created an explicit exemption to the Age Discrimination in Employment Act of 1967 and jeopardized the health benefits of the 12 million Medicare recipients then receiving coverage from their former employers (Pear 2004). Four years earlier, a federal appeals court had ruled that such age-based discrimination was illegal. The new EEOC position reversed the stance the commission took in the earlier court case and in its previous policy statements. The AARP, the largest advocacy organization for senior citizens, is involved in several lawsuits challenging cutbacks in retiree health care, including a suit to block the EEOC from exempting retiree health plans from federal age discrimination law (Powell 2006).

Employers are increasingly turning to bankruptcy proceedings to slash benefits, most notably in the airline and automobile industries, but in many other sectors as well. Dumping their pension obligations onto the Pension Benefit Guaranty Corporation, the government agency that insures private pensions, has become an attractive option for employers. Workers at United Airlines stood to lose \$3.4 billion in retirement benefits after the airline's pension fund went belly up in 2005, in large part because of the high-risk, unregulated investments favored by money managers and pension consultants who reap enormous fees and commissions from such investments (Walsh 2005a, 2005b; *New York Times* 2005; Biddle 2005: 1). As pensions shrink, retired workers will have fewer resources to pay for health care. Fidelity Investments (2007) recently estimated that the average couple retiring at age sixty-five without employer-sponsored health benefits would need more than \$200,000 just to cover medical costs in their remaining years. Some experts consider the Fidelity estimate, which excludes the cost of over-the-counter medications, most dental services, and long-term care, to be too low (Powell 2006).

Just as the automobile industry was the bellwether for the expansion of health benefits in the 1940s and 1950s, today it is the bellwether for the contraction of the shadow welfare state. In October 2005, Delphi, a leading automobile parts supplier spun off from General Motors in 1999, declared bankruptcy on its U.S. operations, omitting its profitable plants abroad. It sought to slash wages by two-thirds and drastically cut health care and pension benefits (Moberg 2006). The UAW rejected Delphi's initial proposals and periodically threatened to strike the company if Delphi

succeeded in convincing the bankruptcy court to void its contracts (Peters 2006; Aguilar and Shepardson 2007). Hoping to avoid a strike at Delphi, which would cripple GM, the automobile giant agreed in 2006 to help pay for buyouts for Delphi workers and hire back some of them (Maynard 2006a, 2006b). As the contentious talks between Delphi, GM, and the UAW dragged on, GM indicated in May 2007 that it might contribute additional money to cover retirement costs at Delphi and end the stalemate (Green and Bennett 2007; Bunkley 2007b). In late June 2007, the UAW leadership, Delphi, and GM finally reached a tentative agreement after twenty months of torturous negotiations that would drastically cut hourly wages (by at least one-third) and scale back health benefits for Delphi workers (Terlep 2007). This agreement could open the way for massive cuts across the automobile industry, because the company has been part of the UAW's practice of pattern bargaining (O'Dell 2006). The Delphi agreement came on the eve of negotiations over the new master contract for the Big Three automakers and the UAW, which expired in September 2007. Some business analysts speculated that the Delphi pact would embolden the automakers to demand significant wage and benefit cuts in the negotiations for a new master contract with the UAW (Stoll 2007).

The same month that Delphi filed for bankruptcy, GM prevailed in forcing the UAW to reopen its contract. In October 2005, the union agreed to an unprecedented cut in health benefits for its active and retired workers that could save GM \$1 billion and Ford \$750 million annually. Retirees and their dependents account for about three-quarters of GM's health care costs, which totaled about \$6 billion a year prior to the concessions (French 2006a).¹² Detroit automakers have approximately 1 million union retirees and dependents (McCracken 2007a). The agreement the UAW reached with GM and Ford requires their retirees to pay monthly insurance premiums, annual deductibles, and co-payments for some medical services for the first time. Current workers also agreed to relinquish a promised dollar per hour raise in 2006 to help cover retiree medical costs.¹³ Ford and GM have also offered more generous lump-sum buyouts to workers who consent to relinquish their retirement health benefits (Freudenheim 2006a). A federal judge rejected claims from retired automobile workers that the settlement between the automakers and the UAW violated their contracts.

12. This is part of a series of articles by Ron French examining the effects of rising health care costs on GM and its employees that appeared in the *Detroit News*, September 26–29, 2006; see also McCracken (2007b).

13. While 60 percent of GM workers voted for the plan, workers at Ford barely approved the deal, which shocked UAW officials (Maynard 2006c; Peters 2005).

Retirees brought a class-action suit against GM and Ford (O'Dell 2006; Powell 2006).

Roy Gettelfinger, UAW president, described the concessions as “probably the most difficult backward step for us to take in the history of our union” (Fonda 2006). Jerry Tucker, founder of the UAW’s New Directions rank-and-file dissident movement, suggested that the cutbacks in retiree benefits may wake “a sleeping power—the older current UAW workers who, over the years, have avoided militancy because of the ‘holy grail’—the pension with generous, mostly paid health care coverage” (Slaughter 2005: 4). These cuts challenge the contractual glue that secured relative labor peace over the past couple of decades in the automobile industry and elsewhere as the UAW and other unions acquiesced to lower, two-tier pay scales for new workers in exchange for contracts protecting the wages, benefits, and jobs of older workers. Not surprisingly, Gettelfinger faced considerable rumblings in the ranks over the concessions (Ten Eyck 2006; Maynard 2006c). In the run-up to the start of the 2007 contract negotiations, he vowed that the UAW would not accede to further health care cutbacks in the new contract (Bunkley 2007a).

Fear of more health care concessions in the automobile industry heightened in May 2007 with Daimler-Benz’s announcement that it planned to sever its nine-year-old merger with Chrysler. Under the proposed deal, the German firm would essentially pay Cerberus Capital Management, a private equity firm, to take Chrysler (and its estimated \$16–\$18 billion in unfunded retiree health care obligations) off its hands. The UAW previously had expressed strong objections to selling the company to a private equity firm, but Gettelfinger quickly threw his support behind the deal when it was announced (Schuman 2007; Maynard 2007).

This agreement could have seismic consequences for health care benefits in the automobile industry and for the future of health care reform. The surprise sale of Chrysler to Cerberus likely weakened the hand of the UAW to resist further health care concessions on the eve of the 2007 contraction negotiations between the Detroit automakers and the UAW (Kutalik and Ten Eyck 2007). In 2005, the UAW had refused to grant Chrysler the same concessions on health care costs that it gave to Ford and GM, which it considered in far worse financial shape. The union also helped to scuttle an earlier plan to sell Delphi to Cerberus by refusing to permit deep wage and benefit cuts at GM’s former parts subsidiary (Maynard 2007).

Labor issues are a key hurdle in finalizing the deal between Daimler-Benz and Cerberus (McClatchy-Tribune 2007). Many expect the private equity firm to press the UAW to agree to the creation of a new union-run

trust fund for health benefits that would essentially absolve Chrysler of many of its health care obligations (*Economist* 2007). Such a trust would likely put the union in the unenviable position of having to directly impose health care concessions on its own members. If the UAW and Chrysler agree to a union-run trust fund, GM and Ford would probably press for similar arrangements (*Economist* 2007). As the history of union-run Taft-Hartley funds shows, once unions establish health care trust funds under their control, they are extremely reluctant to give them up for some kind of universal health insurance program (Gottschalk 2000: 44–53, 149–151, 173–174).

For some time now, automakers and the UAW reportedly have been exploring ways to transfer the responsibility of retiree health care from the Big Three automakers to the union. The trust fund idea gained traction after the 2006 settlement of a strike with the United Steelworkers at Goodyear Tire and Rubber Company in which the tire company consented to create a billion-dollar, union-run trust fund, or about \$0.77 on the dollar, to cover health benefits promised to retired workers (*New Zealand Herald* 2007). Steelworkers agreed to the plan partly out of fear that, if Goodyear went bankrupt, all bets were off on getting anything for their retirees. Several years ago, thousands of retired steelworkers and their spouses lost their health benefits after a rash of bankruptcies in the steel industry (Maher 2007; McCracken 2007a). The obstacles to creating an adequate union-run health trust fund in the automobile industry are enormous because its retiree health care liabilities are so enormous. With more than \$50 billion in retiree health care obligations, GM does not have the resources to create a trust fund that gives the UAW even \$0.60 on the dollar, according to some financial analysts. Moreover, dissident groups within the UAW are wary of trust fund proposals, seeing them as yet another unwise giveback, especially now that the Democrats have retaken Congress and health care reform is a leading national issue again (Hoffman 2007b).

New Accounting Standards

Retiree health benefits are increasingly vulnerable on other fronts. New accounting standards for states and cities have jeopardized the retiree benefits of public employees. In 2004, the Government Accounting Standards Board (GASB), which sets accounting standards for states and cities, approved a rule change to require public-sector employers to calculate and disclose the future costs of health care for the estimated 24.5 million

active and retired state and local public employees. The new rule will be phased in over three years beginning in fiscal year 2007. Mercer Human Resources Consulting estimates that the current cost to states and cities for retiree health-benefit guarantees is \$1.4 trillion (Walsh 2006b) or about four times Standard and Poor's estimate of the total unfunded public pension debt (Porterfield 2006). States and cities fear that disclosure of their retiree health care liabilities will corrode their bond ratings, making it more expensive for them to borrow money and forcing them to cut spending and raise taxes. State officials in Texas have threatened to ignore the new GASB rule and have been urging other states to join them in seeking to overturn it (Walsh 2007a, 2007c).

The rule change has intensified pressure on states and cities to whittle away at the health benefits promised to retired public employees. State and local governments have begun to challenge health care and pension guarantees that have long been considered sacrosanct. Union contracts and years of favorable court rulings for employees no longer provide the shields they once did for public employees. This is a remarkable shift. Even during New York City's fiscal meltdown three decades ago, no existing pension promises were revoked (Walsh 2006b).

The GASB rule change is just one of the many threats looming over benefits for public-sector employees. The escalating cost of retiree health care is putting some public pension funds at risk. When the stock market was booming in the 1990s, many local and state governments began relying on their pension funds to help pay for retiree health benefits. The subsequent erosion of the stock market and the return of double-digit health care inflation in 2001 have ravaged some public pension funds (Walsh 2006c, 2007b).

Cutbacks in benefits have become a leading issue for public-sector employees. The American Federation of State, County and Municipal Employees (AFSCME), the largest union for public employees with 1.4 million members nationwide, has attacked the GASB rule change. AFSCME charges that GASB's methodology is flawed, leading to excessively alarmist predictions about how future retiree obligations will sink the finances of states and cities.¹⁴ Unions fear the rule change will prompt a taxpayer backlash that will push states and municipalities to shift from funding benefits on a pay-as-you-go basis to prefunding them, which will result in a contraction of public-sector benefits. AFSCME (2006, n.d.) has been invoking this issue to mobilize retired workers.

14. For one such prediction, see Edwards and Gokhale (2006).

The GASB rule change is patterned after a similar rule change promulgated in the private sector two decades ago. Private employers' determination to curtail retiree benefits intensified in the late 1980s due to a rule change by the Financial Accounting Standards Board (FASB), the private organization that sets the rules governing corporate accounting practices. The board recommended that companies be required to disclose the future cost of providing retiree health care for employees expected to retire at a later date.¹⁵ Organized labor initially viewed the new FASB rule on retiree health care liabilities as a welcome catalyst to force firms to finally face up to the extent of their obligations to the private welfare state. Unions hoped this would kindle employers' interest in some comprehensive legislative solution to the health care dilemma. What labor failed to anticipate was the tenuousness of those obligations. Firms cast off their commitments to retiree benefits in quick order and without the public outcry anticipated by labor. Many employers responded to the rule change, which went into effect in late 1992, by shredding the retiree health-benefit packages they had promised to their workers. Some firms eliminated retiree benefits altogether. Many others replaced their defined-benefit programs with new ones based on defined contributions.¹⁶ In less than three years, the portion of large firms offering retiree health benefits shrank from two-thirds to less than one-half (KFF/HRET 2005).

A new FASB rule change promulgated in 2006 is likely to spur a further contraction of pension and retiree health benefits in the private sector. The new accounting standards require that defined-benefit pension, health, and other postretirement plans be explicitly identified as an asset or a liability on a company's balance sheet. The new standards also modify how these obligations are calculated (FASB n.d.; Apostolou and Crumbley 2006). Formerly these plans were relegated to a footnote in a company's annual report. The aim is to make employers' long-term benefit obligations more transparent to investors and shareholders. A study by the Milliman actuarial firm concluded that the proposed rule change could wipe out 8 percent of corporate America's net worth. For companies already in eco-

15. Under the accounting convention that existed, companies were required to count only money actually spent on retiree benefits during a given year—and not future obligations—as a liability on corporate balance sheets. Under the new rule, each year companies would have to report a sufficient amount on their financial statements so that by the time their current employees retire, the full cost of the promised health benefits for the golden years would have been reported. For more on the FASB and this rule change, see Gottschalk (2000: 128–129).

16. Under defined-contribution plans, employers contribute a fixed amount and no longer commit themselves to covering the entire cost of a particular item—such as comprehensive health insurance for early retirees before they qualify for Medicare.

conomic distress and saddled with troubled pension funds, the change could erase their entire net worth (Walsh 2006a). By one calculation, if General Motors were required to show the full costs of its underfunded pension and welfare plans at the end of 2006, its book value would plummet from about \$15 billion to a negative \$43 billion (Reilly 2006). This rule change and the August 2006 enactment of the Pension Plan Act, which tightens pension funding requirements, are expected to propel a seismic contraction of the pension system (Lurie 2006a, 2006b). As one representative of the United Electrical Workers union predicted, "Pressure will build to eliminate the liability by eliminating the retirement plans" (Cohen 2006: 7).

The Idea of an Individual Mandate

The shadow welfare state faces more than just death by a thousand cuts today as employers use new accounting standards, threats of bankruptcy, creative legal challenges, and so forth to disavow health benefits. It is also reeling from a powerful ideological shift that legitimizes the retreat of employers in the provision of social welfare as the individual-mandate solution rapidly eclipses the employer-mandate approach that dominated the health care debate for decades. From the late 1970s onward, the employer mandate played a critical role in defining the strategies and coalitions around which the health care debate was waged. The requirement that employers pay some specified portion of their employees' health insurance costs or face a significant penalty was a central pillar of the Clinton plan.

After the defeat of the Clinton effort, employers faced a "deficit of ideas" on health care reform.¹⁷ Recently, business and conservative interests have begun rallying around the idea of consumer-directed health care and an individual mandate. The goal of this type of health care is to replace what is left of the employment-based benefit system with a new arrangement in which consumers carry around their tax-free health-benefit accounts from one job to another, much as they do now with their 401(k) plans. They would use these accounts to pay for health insurance and other medical expenses as needed. In this model, individuals are seen primarily as consumers of health care, not patients. If they are forced to pay more for health care out of their own pockets, advocates of consumer-driven health plans contend, individuals will be more savvy consumers, shopping

17. On the "deficit of ideas," see Martin (2003: 325).

around for the best deal and holding health care providers more accountable. This, theoretically, will stem medical costs. Savings would also come, supporters argue, from penalizing individuals who do not secure at least a minimal package of health benefits.

In some ways, the individual mandate ratifies what has been happening *de facto* since the 1970s as business, with the help of government, has shifted more of the costs of the shadow welfare state from employers to employees and as job-based benefits morph from comprehensive coverage to catastrophic coverage. Increasingly the problem of the uninsured and underinsured is being redefined as a problem for individuals, not business, the state, or society, and expectations about what kind of benefits employees and others can anticipate have been lowered.

The battle over universal health care in Massachusetts in 2005–2006 underscores just how far and fast we have moved away from the idea of an employer mandate and toward an individual mandate. In late 2005, the Massachusetts House of Representatives approved a payroll tax of 5–7 percent to be levied on employers who have more than ten employees and do not offer health insurance (Krasner 2005). The state's main business associations vehemently opposed this employer mandate based on a modest payroll penalty (Lehigh 2005). In the final version of the health care bill enacted by the legislature in April 2006, certain employers were required to meet only some vague obligation to contribute to their employees' health costs, or they would face a paltry \$295 fee, not penalty, for each employee not covered.¹⁸ Even in this deep blue state, reformers were unable to force employers to make a modest contribution toward paying for their employees' health insurance, as they are required to do in other industrialized countries either through payroll taxes, corporate taxes, higher taxes on personal income, or some combination.

The individual mandate is now all the rage in expert and more popular discussions of health policy. In June 2006, the American Medical Association endorsed the individual mandate (Japsen 2006). At a conference on job-based health benefits sponsored by the Brookings Institution, Len Nichols, director of the Health Policy Program at the New America Foundation, told labor officials, business executives, and health policy experts, "As a person from a think tank that is trying to promulgate a solution around the individual mandate, I am nearly orgasmic with how many times it has been endorsed today" (Brookings Institution 2006: 55). The

18. For a good summary of the Massachusetts plan, see Kaiser Commission on Medicaid and the Uninsured (2006).

Massachusetts plan received broad support and has become a model for other health care reforms at the national and state levels. Requiring the uninsured to purchase health care coverage was a centerpiece of the health plan unveiled by Republican Governor Arnold Schwarzenegger of California in early 2007. Health insurers enthusiastically backed the Massachusetts plan, as did many businesses and conservative groups, including the Heritage Foundation, which has been an ardent champion of consumer-driven health care (see Owcharenko and Moffit 2006). Senator Edward M. Kennedy (D-MA) worked hard to broker the Massachusetts deal and lauded the final bill. "Instead of facing health care cuts, we're well on our way to achieving our longstanding goal of health care for all," proclaimed the longtime champion of universal health care (Johnson 2006).

For many other health care reformers, however, Kennedy's statement appeared to be a precocious declaration of mission accomplished. The AFL-CIO, in an important break, did not side with the Massachusetts senator. John Sweeney, president of the federation, stridently denounced the Massachusetts plan, as did the state AFL-CIO. Sweeney characterized it as an "unconscionable" measure that takes "a page out of the Newt Gingrich playbook for health care reform" (AFL-CIO 2006).

The idea of the individual mandate appears to have burst into the policy limelight, seemingly out of nowhere. But just like many of the "amateur" contestants on the television hit *American Idol* who have been orchestrating their shot at stardom for years, this idea has been long in the making. Lawmakers in Washington have been critical to the emergence and ascendancy of the individual mandate. In a pivotal move in November 2003, Republicans succeeded in saddling the landmark Medicare prescription-drug bill with a capacious provision for tax-free health security accounts (HSAs). Newt Gingrich, an ardent foe of Medicare and job-based benefits, described the creation of HSAs as "the single most important change in health-care policy in 60 years" (Dreyfuss 2004b; see also Gingrich, Pavey, and Woodbury 2003). While Gingrich is prone to hyperbole, he may not be so off the mark in this case. The new law dramatically expanded the reach and attractiveness of tax-free medical accounts for individuals and employers. Health savings accounts are now available to nearly everyone, provided they are enrolled in a catastrophic insurance plan that has high deductibles of at least \$1,000 for individuals and \$2,000 for families. The law permits both employers and employees to contribute to these funds, which can be rolled over and are portable from job to job.

The legislation has spurred the growth of employment-based health insurance plans with high deductibles. In 2005, 20 percent of employ-

ers who provided health insurance offered plans with high deductibles, up from 10 percent in 2004 and 5 percent in 2003.¹⁹ While employers have not rushed in yet to develop high deductible plans with HSAs, they have expressed considerable interest in doing so in the near future.²⁰ The expansion of HSAs is a key feature of the Massachusetts plan and of Schwarzenegger's plan. In September 2006, Wal-Mart, the country's largest private employer, announced it would begin offering high-deductible plans with HSAs to its employees (Lieberman 2006: 12; Von Bergen 2006).

Treasury Secretary John Snow told a Senate committee in May 2004 that HSAs are "one of the single best ideas" to deal with rising health care costs (Dreyfuss 2004b: 27). "These accounts may be 'one of the single best ideas' . . . to deal with rising health care costs for employers, but they are one of the worst for individual employees," Barbara Dreyfuss concludes in her succinct analysis of HSAs (*ibid.*: 27). The problems for employees include exorbitant deductibles and out-of-pocket expenses and uncertainties about what medical services are covered by HSAs.²¹ Also, HSAs are likely to result in higher premiums for people enrolled in more traditional insurance programs as younger and healthier people choose HSAs, leaving traditional plans with the costlier burden of covering people who are older and sicker.

Supporters of the individual mandate have been quite successful in portraying it as a sound, incremental solution to bolster the employment-based system. Yet critics see it as a radical reform that actually transfers the entire burden of health care onto individuals. In their view, the measure establishes "a new public consensus that individuals are primarily responsible for health coverage," thus making the "dropping of coverage more acceptable" (Wilson and Horgan 2006: 2).²²

19. Some of the increase may be attributable to a change in the definition of a high deductible used in employer surveys in 2005 (KFF/HRET 2005: 90n6).

20. More than one-quarter of the firms that do not currently offer HSA plans reported that they were very likely or somewhat likely to offer such plans soon (KFF/HRET 2005: 98, exhibit 8.7). See also Von Bergen (2006).

21. Employer-sponsored plans that qualify for HSAs have annual deductibles that average nearly \$2,000 for individuals and around \$4,000 for families. The limits on out-of-pocket spending for HSA plans is a staggering \$5,000 for individuals and \$10,000 for families. Patients may end up with even higher bills because these limits apply only to approved in-network care and medical services that qualify as "covered" care under the insurer's program (KFF/HRET 2005: 5–6; Dreyfuss 2004b: 27).

22. Walter B. Maher (2003: 94), former vice president of public policy of the Daimler-Chrysler Corporation, makes a similar point about the individual mandate. See also Gladwell (2005: 48).

The individual mandate has the potential to dramatically reconfigure alliances on health policy, creating a win-win situation for employers and insurers. It paves the way for employers to divest themselves of costly health insurance obligations to their workers while providing insurance companies with state subsidies to develop cut-rate, paper-thin coverage for workers set adrift. In their joint battle for the individual mandate, employers have drawn closer to the insurance industry, the *bête noire* of many health care reformers. This makes it less likely that segments of the business sector will seek outside allies (like organized labor) to neutralize the considerable clout of the insurance industry and equitably resolve the country's health care crisis. As one official of the National Association of Manufacturers said of the HSAs, "We see the wheels coming off employer-based health care" (Dreyfuss 2004b: 27).

"Divided We Fail"

As the wheels come off job-based benefits, organized labor is pulling in at least two, possibly three, different directions. Andrew Stern of the SEIU has been courting business leaders as if they were fearfully standing on the sidelines watching health-benefit costs erode their economic competitiveness yet reluctant to join labor on the field for fear of being accused of teaming up with the enemy (Brookings Institution 2006: 24–25). He is openly dismissive of the single-payer approach, associating it with what he sees as the failed class-based, status quo politics of the past. With leading business executives by his side, Stern has been singing the virtues of market-based or consumer-directed approaches to reform and imploring the private sector to join enlightened labor leaders and be the champions of health care reform.

Elsewhere, momentum is building in some surprising quarters for the single-payer approach. Hundreds of labor organizations, including at least seventeen AFL-CIO state federations and dozens of county and regional central labor councils, have passed resolutions in favor of H.R. 676, the single-payer legislation introduced in Congress by Representative John Conyers (D-MI) (editor, Unions for Single Payer H.R. 676, "TWU, ATU, AFGE Locals, APRI Chapter Endorse H.R. 676," e-mail correspondence to SinglePayerNews@UnionsForSinglePayerHR676.org, March 28, 2007). In an important about-face, Leo Gerard, president of the United Steelworkers union (USW), is now cochair of Healthcare NOW, the national single-payer advocacy group. In 1991, under Gerard's predecessor Lynn Williams, the USW (then the United Steelworkers of America) voted

against the single-payer approach at a pivotal meeting in which the AFL-CIO's health care committee deadlocked eight to eight over whether to endorse this option (Gottschalk 2000: 139).

While the USW has become a born-again supporter of the single-payer approach, the AFL-CIO has yet to take the plunge. However, its position on comprehensive health reform is not quite *déjà vu* all over again, even though John Sweeney, the architect of the federation's doomed strategy fifteen years ago, has been heading the AFL-CIO since 1995. In March 2007, the AFL-CIO's executive committee issued a statement that could be interpreted as a tacit endorsement of the single-payer approach—or not. Also, in the past couple of years, the AFL-CIO has been more willing to support state-level reform efforts rather than focus almost exclusively on a comprehensive national solution.

Andrew Stern was the force behind the 2005 rupture of the AFL-CIO and the establishment of the Change to Win (CTW) federation, which comprises seven unions and represents about 6 million workers. The SEIU president comes closer than any contemporary labor leader to achieving rock-star status in business and media circles. The business and popular press have run numerous glowing profiles of him, many of which stress his highly conciliatory approach to labor-management relations (see, e.g., Kirkland 2006; Bernstein 2004). Health care is an iconic issue for Stern—the highly public barometer of what he sees as the promising new day dawning for cooperative business-labor relations.

In breaking away from the AFL-CIO, which now represents about 9 million workers, Stern implored organized labor to radically reposition itself on organizing new members and other issues. Yet his stance on health care reform is remarkably similar to the pro-business position Sweeney maneuvered the federation into as chair of the AFL-CIO's health care committee in the lead-up to the battle over the Clinton plan.²³ Stern is more willing now than Sweeney was fifteen years ago to acknowledge that the employment-based system of health benefits is broken, perhaps irreparably so. But like Sweeney years ago, Stern has focused on courting the business sector. He sees corporate leaders as the most important agent for health care reform—if they would not let their ideological blinders get in the way of their real economic interests. In his view, no fundamental change in health care will “arrive until American business leaders make the call for change” (Brookings Institution 2006: 15).

23. For excellent analyses of the development of and battle over the Clinton plan, see Hacker (1997) and Skocpol (1996).

Stern has aggressively identified the interests of the SEIU with the interests of the business sector in a number of high-profile venues and events. In July 2006, he sent a letter to every Fortune 500 CEO asking them to make health care their national priority (Stern 2006b). After reading an op-ed on health care reform written by Stern (2006a) in the *Wall Street Journal*, Safeway CEO Steve Burd told an audience at the U.S. Chamber of Commerce: "I could have written that" (Raine 2006). In 2003–2004, Safeway was embroiled in a bitter four-month strike and lockout over health benefits in southern California that resulted in a two-tier contract that drastically eroded health care coverage for grocery workers and dramatically increased staff turnover. A new contract agreed upon by the United Food and Commercial Workers International Union (UFCW) in mid-2007 eliminated the two-tier system (UFCW 2007).

In January 2007, Stern's union launched a new health care coalition with the Business Roundtable, the elite organization of dozens of top CEOs, and the AARP, the country's largest organization for senior citizens (Hamburger and Alonso-Zaldivar 2007). The union cosponsored a full-page ad in the *New York Times* with the Business Roundtable and the AARP that proclaimed in large bright red and white type, "Divided we fail," the name of their new organization. Both the Business Roundtable and the AARP have checkered histories on health care reform. The last time the Business Roundtable took such a major public stance on health care was in early 1994, when it torpedoed the Clinton plan, which spurred defections by the U.S. Chamber of Commerce and other business groups (Gottschalk 2000: 153). During the 1993–1994 debate, the AARP largely sat on the fence. In 2003, under the leadership of Bill Novelli, who became the AARP's executive director in 2001, the organization threw its support behind the controversial Medicare prescription-drug bill. The AARP provided crucial support for the drug bill at a pivotal moment and outraged many of its members (Dreyfuss 2004a).

In December 2006, Stern joined Safeway's Burd and Senator Ron Wyden (D-OR) to introduce the Healthy Americans Act, which Wyden is sponsoring in Congress (Graves and Colburn 2006). The bill is modeled on the individual-mandate solution lionized in the Massachusetts reform effort. It requires businesses to pay an extremely modest tax to help pay for health insurance for low-income people. The bill also includes a radical proposal to end employer-sponsored health insurance altogether. Employers would give their workers a one-time lump-sum increase in their wages equal to what employers were paying at the time for employee health insurance. Workers would be required to purchase their own health insur-

ance directly from private insurers or face a penalty. Under this scheme, employees would shoulder the burden of any future increases in health care costs as the relationship between employers and health insurance is severed (Gruenberg 2007a).

Stern's most controversial public dalliance is with H. Lee Scott Jr., CEO of Wal-Mart. In February 2007, Stern appeared at a press conference with Scott and a couple of other business executives to announce the creation of "Better Health Care Together," a business-labor coalition. At the conference, labor and business leaders outlined some general principles for universal health care and for ending the nation's reliance on employer-backed health insurance within five years (SEIU n.d.). At the time, Stern admitted that his new alliance with Wal-Mart was risky. After all, for several years labor organizations, including the SEIU, have invested heavily—and quite successfully—in turning Wal-Mart's poor employee health benefits into a searing symbol of how American businesses fail workers in the United States on many fronts, including wages, benefits, and the right to organize. The political pressure on Wal-Mart has intensified as the Democrats have joined labor in castigating the retail chain. Even Senator Hillary Rodham Clinton (D-NY), a former Wal-Mart board member, has joined in the political assault on the Arkansas-based retailer. In 2005, she returned a \$5,000 campaign contribution from Wal-Mart to protest its meager health benefits (Nagourney and Barbaro 2006).

Wal-Mart, which was an incidental player in the debate about health care reform fifteen years ago, has become a force to be reckoned with. The retailer has doggedly fought state-level reform initiatives such as the Fair Share Health Care Fund Act in Maryland (nicknamed the "Wal-Mart bill"), which would significantly penalize giant employers who do not provide health care for their workers. It also opposed Proposition 72 in California, a ballot initiative defeated in 2004 that would have required large employers to provide affordable health insurance for their workers or pay into a state insurance pool.²⁴

Wal-Mart has quickly moved from playing defensive to playing offensive as it aims to reframe the health care issue as a national rather than a local or state problem. Health policy has become a major feature of the emerging public-policy persona of Wal-Mart's Scott. Shortly after Maryland enacted the nation's first Fair Share bill in early 2006, Scott made a dramatic pledge at the National Governors Association. He offered to travel to any governor's office to discuss health care. He also volunteered

24. Wal-Mart reportedly spent \$500,000 to defeat Proposition 72 (Abelson 2004).

Wal-Mart's remarkable technical expertise to help states manage benefit costs (Barbaro 2006). When asked how the country could solve the crisis in health care, Scott said, in an extraordinary appearance on the *Charlie Rose Show* in August 2006, "I think first of all, business and labor are going to have to participate and probably play more of a leadership role than government." Scott went on to say, "Business and labor are going to have to bring the political side of this thing along with them because the politics are so polarizing on this" (Edwards 2006).

Given Wal-Mart's virulently antilabor history, its unyielding stance on state-level health care initiatives, its growing ties to conservative groups, and its persistently stingy benefits, one might wonder what kind of ally Scott is prepared to be for organized labor.²⁵ Moreover, Wal-Mart has taken some important steps toward becoming a health provider in its own right. The company now has dozens of walk-in, retail primary-care clinics leasing space in its stores. There may be thousands more of these clinics at Wal-Mart and other retailers in the future (Freudenheim 2006b; Schmit 2006). In light of Wal-Mart's take-no-prisoners approach to entering new and potentially lucrative markets, it is fair to wonder whether the retail giant is poised to become a major provider of primary health care and other medical services in the future. This will further complicate its interest in finding a national health care solution that provides universal, high-quality care while containing costs.

The Bottom Line of Health Care Reform

Despite Wal-Mart's dismal record on health benefits and other labor issues, Stern appears confident that the bottom line provides compelling reasons for Wal-Mart and other employers to be constructive allies in health reform. In a familiar refrain, he contends that the health care issue needs to be pitched primarily as an economic, not a moral, issue.²⁶ "Obviously, we have a huge problem for American business because it is pretty hard to compete in a global economy when the price of your health care is put on the cost of goods, while in other countries, it is shared among society," he argues (Brookings Institution 2006: 9).

25. For an excellent overview of Wal-Mart's political and economic strategies, see Lichtenstein (2005). On Wal-Mart's conservative ties, see Barbaro and Strom (2006).

26. In an interview with the *Los Angeles Times*, Andrew Stern said, "In 1993, it was seen more as a moral issue in our country: Is healthcare a right or a privilege? I think now it's become an economic issue" (Alonso-Zaldivar 2007).

In tapping big business as a key ally in the health care debate beginning in the 1980s, much of organized labor took a stance remarkably similar to Stern's position today (Gottschalk 2000: chap. 6). Labor leaders largely accepted the Fortune 500's definition of what was ailing the American economy and hence the American worker. Many of them jumped on the "competitiveness" bandwagon. In their public statements, labor and business leaders regularly sang off the same song sheet. Their refrain was a simple one—higher medical costs were making American products less competitive in the international marketplace, severely hurting the U.S. economy and the American worker.

At the time, organized labor treated highly contested claims about the U.S. political economy as fact. Labor leaders portrayed the stemming of health care costs as the magic bullet that would critically wound, if not slay, the dragon of intensified economic competition that was reportedly pricing American workers out of the global marketplace and eating away at their standard of living. They portrayed U.S. employers as largely willing—but increasingly unable—to offer health benefits because of this intensified competition.

Health care economists have raised numerous objections to the contention that escalating health care costs imperil the economic competitiveness of the United States and the overall health of the U.S. economy (see, e.g., Pauly 1997; Reinhardt 1989). Their analyses, however, have made little headway against the shared folklore that higher health care costs are pricing U.S. products out of the market.²⁷ In his eagerness to woo business on the health care issue, Stern has become a leading purveyor of this simplistic folklore. For example, in widely promoting the claim of a recent McKinsey report that the average Fortune 500 company may be spending more on health care than it earns in profits by 2008, Stern and business leaders may be overly alarmist (Stern 2006a; Bleil, Kalamas, and Mathoda 2004). They fail to take a comprehensive and nuanced view of the relationship between corporate profits and health care costs.

It is true that employer spending on health care measured as a percentage of profits did jump in the late 1990s.²⁸ Yet a closer look at these fig-

27. The phrase "shared folklore" comes from Reinhardt (1989: 6).

28. Corporate spending on health care as a percentage of after-tax corporate profits increased from 56 percent in 1998 to 67 percent in 2001. These figures include contributions by business to health insurance premiums, Medicare, workers' compensation, temporary disability insurance, and industrial plant health services. Employer spending on health insurance as a percentage of after-tax profits increased from 44.8 percent to 54.5 percent over the same period (Employee Benefit Research Institute [EBRI] 2006: table 34.2).

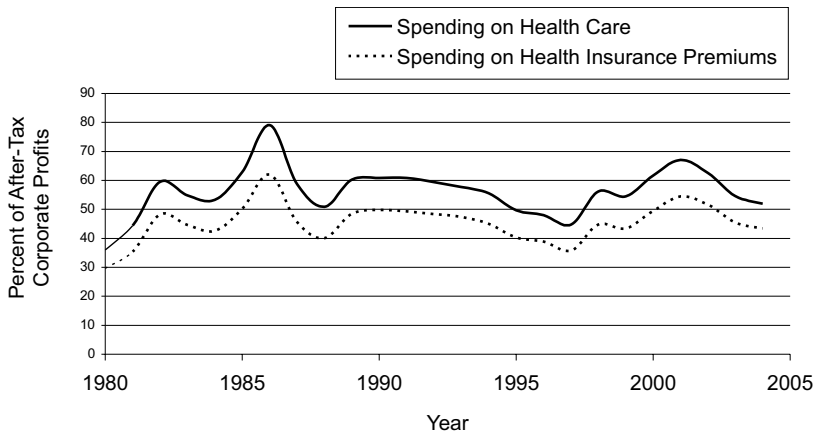


Figure 1 Employer Spending on Health Care and Health Insurance Premiums, 1980–2004

Source: Employee Benefit Research Institute (2006): table 34.2

Note: Figures for spending on health care include contributions by employers to health insurance premiums, Medicare, workers' compensation, disability insurance, and industrial plant health services.

ures calls into question the claim that rising health care costs imperil the profitability of U.S. firms. The jump in health care costs as a percentage of profits in the late 1990s was due partly to a drop overall in after-tax corporate profits as the dot-com and high-technology sectors went bust (see figure 1).²⁹ Spending on health care measured as a percentage of after-tax corporate profits declined steadily from 1986 to 2004, except during the 1998–2001 period.³⁰ More significantly, employer spending on wages and salaries and on total compensation as a percentage of after-tax profits has dropped precipitously since 1986, except during the 1998–2001 period

29. Had corporate profits held steady from 1997 to 2001, employer spending on health care as a percentage of after-tax profits would have been 61 percent, not 67 percent, in 2001. The figures on spending for health insurance premiums would have been about 50 percent, not 54.5 percent, in 2001 (calculated from EBRI 2006: table 34.2).

30. Corporate spending on health care as a percentage of after-tax profits steadily fell from a high of 79 percent in 1986 to 52 percent in 2004. Spending on health insurance premiums fell from a high of 62 percent in 1986 to 43.5 percent in 2004 (EBRI 2006: table 34.2).



Figure 2 Employer Spending on Wages and Salaries and Total Compensation, 1980–2004

Source: Employee Benefit Research Institute (2006): table 34.2

(see figure 2).³¹ While health care costs continue to escalate, employers have had great success at squeezing wages and other forms of compensation and shifting more health care costs onto their employees. Today wages and salaries comprise the smallest portion of the country's gross domestic product since the government began collecting such data in 1947. Meanwhile, corporate profits have climbed to their highest share in four decades, prompting U.S. Bancorp, the investment bank, to declare that this is "the golden era of profitability" (Greenhouse and Leonhardt 2006).

To underscore the exceptional severity of the health care cost crunch, Stern and some business leaders emphasize (as they did in the late 1980s and early 1990s) the amount U.S. employers are paying out in direct costs for health care compared to the amount paid out by their foreign competitors. Once again, the automobile industry is the designated poster child,

31. Corporate spending on wages and salaries as expressed as a percentage of after-tax profits dropped from a high point of 1,262 percent in 1986 to 565 percent in 2004, the lowest figure in the 1960–2004 period. Employer spending on total compensation fell from a high of 1,501 percent of after-tax profits in 1986 to 688 percent in 2004, one of the lowest figures in the 1960–2004 period (EBRI 2006: table 34.2).

even though GM and Ford outperformed Toyota in the stock market in the past year and “the next year may be no different as Cerberus Capital Management seeks to turn Chrysler around” (J. Green 2007). Executives and labor leaders regularly bemoan how crippling medical expenses add \$1,500 to the cost of each car manufactured by GM, while some of its competitors pay as little as \$200 per vehicle (Levy 2006). They enlist this compelling example from the automobile sector to bolster their contention that an irrefutable bottom-line logic will force business to seek some satisfactory legislative solution with the state and labor on health care reform. But the U.S. automobile sector, which has a heavily unionized workforce and massive numbers of retirees with expensive health benefits, is not a reliable barometer of the financial pressures that rising health care costs are putting on business.³²

Instead of focusing on one exceptional sector, we need to consider the broader trends in health care costs and expenditures. While the cost of health insurance premiums continues to rise, the pace has slowed. In 2006, premiums for employer-sponsored health plans rose 7.7 percent on average, the lowest increase since 2000 (Kaiser Family Foundation 2006). In 2005, overall spending on health care in the United States increased at its slowest pace since 2000. This was the third consecutive year of slower growth in the country’s total medical tab (Catlin et al. 2007).

In 1993–1994, we saw a similar de-escalation of health care costs at the brink of reform. In their analysis of the role of business in the Clinton health reform effort, Peter Swenson and Scott Greer (2002) argue that business quickly and dramatically lost whatever interest it had in a comprehensive solution because health inflation subsided. In my view, business was able to quickly lose interest because of the absence of a major political mobilization around health care reform that kept the pressure on employers and government officials.³³ Instead, the political energy went primarily into forging an elite-level deal between labor, business, and the government. When one of the major players walked away from the table, there was no sustained grassroots pressure to bring business back to the table. The ingredients for that mobilization had been squandered by promises that business would do right by workers on health care, even as it was engaged in a massive assault on workers in other areas, such as limiting

32. For more on why the automobile sector is an unreliable barometer, see Gottschalk (2000: 89–101, 106–113).

33. On the importance of grassroots political mobilization for health care reform, see Hoffman (2003).

the right to unionize and passing the North American Free-Trade Agreement (NAFTA) in late 1993 (Gottschalk 2000: 143–146). Business was repeatedly portrayed as ready to do the right thing—until it was not.

The focus on comparing what U.S. companies pay directly for health care relative to what their foreign competitors pay directly skews the health care debate. It ignores the higher indirect costs that many European and Japanese firms and individuals shoulder due to higher corporate and personal income taxes to support more extensive public welfare states. This amount generally exceeds what even the most generous U.S. firms spend on health care for their employees. “The cost of employment-related health benefits as a percentage of payroll is nearly 50 percent greater in Germany than in the United States, but little is heard about this,” according to health care economist Mark Pauly (1997: 119). The failed Clinton plan, which caused such an uproar with much of the business sector, called for larger employers to contribute a modest 7.9 percent of their payroll to help pay for employees’ health coverage. According to Drew Altman, president of the Henry J. Kaiser Family Foundation, “You couldn’t have done more to pay off corporate America than they did with the Clinton plan, but in the end, companies turned on it because it was viewed as a big government plan” (Nocera 2006). The fact is that many European and Japanese firms are highly competitive even though their workers enjoy more generous health, vacation, maternity, and other benefits.³⁴ A recent World Bank report ranked several countries with vast welfare states, including Denmark, Finland, Norway, and Sweden, as extremely high in international competitiveness (World Bank and International Bank for Reconstruction and Development 2005: 6).

The emphasis in the United States on what employers pay directly for health insurance also obscures who really shoulders the U.S. health care bill. Government expenditures account for about 36 percent of the tab. Household spending comes in next at 33 percent, and employers are in third place at 27 percent (Cowan et al. 2002: 136, table 1). The burden on households is even greater than these figures suggest because “individuals ultimately bear the responsibility of paying for health care through taxes, reduced earnings, and higher product costs” (ibid.: 132). Ironically, the portion that employers shoulder is roughly equal to what it costs to administer the U.S. health system, which Henry Aaron (2003: 801) characterizes

34. For example, employment benefits comprise, on average, 50 percent of the payroll in Germany, compared to just 36 percent in the United States. On top of that, salaries and wages average nearly \$5,000 more per year per employee in Germany (KPMG International 2006: exhibit 5.2).

as “an administrative monstrosity.” Administrative costs for employers, insurers, and health care providers comprise at least one-quarter of total spending on health care in the United States (Himmelstein, Woolhandler, and Wolfe 2004: 79–86). Administrative costs are so much higher in the United States because of the country’s reliance on a complex, fragmented, for-profit health insurance industry with high marketing and overhead costs (Reinhardt, Hussey, and Anderson 2004: 14). Streamlining U.S. administrative costs to levels comparable to those of Canada would reduce the U.S. health tab by an estimated 17 percent (calculated from Himmelstein, Woolhandler, and Wolfe 2004: 79).

The automobile sector provides a cautionary reminder that crushing medical costs do not necessarily spark maverick political leadership among business executives. GM reportedly has tens of billions of dollars in future retiree health costs and is \$40–\$50 billion behind in its health care and pension obligations (Slaughter 2005; Gladwell 2006: 30). Despite its massive health care tab, GM has been decidedly equivocal on the question of comprehensive health care reform. In an appearance before Congress in July 2006, Rick Wagoner, GM’s CEO, made only tepid suggestions to tinker with the current health system, such as modest prescription-drug reform, better use of information technology, and greater attention to the high costs of catastrophic medical cases.³⁵ Senator Hillary Clinton (D-NY) told Wagoner that she was bewildered by the company’s reticence on health care reform. “Companies like yours are getting an especially bad deal,” she said. “Why is it that American business doesn’t just rise up and say there’s got to be a better way here?” (French 2006b). When the Big Three automakers finally secured their long-awaited sit-down with President George W. Bush in November 2006, they bemoaned their health care burden but did not propose any major solutions to the president (Nocera 2006).

Health Care Reform and Labor Reform

Stern’s insistence that economic pressures have the potential to force business to be a constructive partner in health care reform has multiple sources. It is not merely a consequence of a selective understanding of economic competitiveness pressures in an era of globalization. His perspective on health care reform complements his broader vision for the

35. See, for example, Rick Wagoner’s testimony in July 2006 to the Senate Special Committee on Aging (Thomas 2006).

revival of organized labor. That vision is founded on creating deeper partnerships between labor, management, and government, or what he calls “Team USA” (Stern 2006c: 20; Johnson 2005b; Moberg 2007a). Stern regularly lauds the joint program that several unions, including the SEIU, worked out a decade ago with Kaiser Permanente Health Care in California. Kaiser agreed to voluntarily recognize unions formed by its employees in exchange for closer cooperation from organized labor on items like budget cuts, staffing, introduction of new technology, and health care quality (Johnson 2005b). Stern characterizes his more cooperative, less combative approach to labor-management relations as a radical shift necessitated by the unprecedented economic and technological revolution of the past couple of decades. These labor-management partnerships have some promise.³⁶ Yet in many ways Stern’s approach is an updated, technocratic version of the Dunlop style of labor-management relations that emerged in the 1950s. Identified with John Dunlop of Harvard University, this approach is premised on forging elite-level agreements between labor and management with little involvement from the rank and file, the government, and the wider public.

Stern does concede that a grassroots social movement is needed to rekindle health care reform. Toward that end, his union has provided critical support for some important health care initiatives at the local and state levels. The SEIU played a pivotal role in creating New York State’s Family Plus program for uninsured adults in 1999 and expanding its Child Health Plus program. In northern California, the union has pushed to expand coverage for the children of undocumented workers (Stern 2003: 98; Nathanson 2003: 463–465). At the SEIU’s 2004 convention in San Francisco, the union organized a “Health Care for All” march of thousands of people across the Golden Gate Bridge. So far, however, the SEIU has created more motion than movement on health care reform. Stern has resisted calls for a genuine bottom-up mobilization of workers and for greater internal democratization of labor unions, two important preconditions for an effective social movement that includes labor (Tucker 2005; Johnson 2005a). Moreover, his framing of the health care question as an economic competitiveness issue is hardly a compelling message that will resonate widely and animate a broad-based social movement.³⁷

The sine qua non for Stern is organizing more union members, pref-

36. For the advantages of such partnerships in health care, see Kochan (2006).

37. On the importance of creating ideological messages that will resonate widely for the success of a social movement on health reform, see Nathanson (2003: 461–464).

erably SEIU members. The SEIU is already the largest union in the health care industry, with more than one-half of its 1.8 million members employed in that sector. The SEIU under Stern has supported some controversial health care measures in order to protect and expand its organizing capacity. For example, in 2004 the SEIU fought for limits on the right of handicapped and elderly patients in California to sue nursing homes for abuse. In 2005, it successfully worked alongside California's nursing-home industry to derail a bill of rights for nursing-home residents that, among other things, would have enhanced enforcement of state laws requiring certain staffing levels to ensure patient safety. In exchange for its support of the nursing-home industry, the SEIU expected to gain greater access to organize nursing-home workers (Smith 2004, 2005).

Stern's corporatist twenty-first-century vision of labor-management relations and his stance on health reform are controversial. One of Stern's first high-profile partnerships with business was an alliance with the business-dominated Essential Workers Immigration Coalition, which has been pushing for an expanded guest-worker program and other immigration reforms, such as militarizing the border with Mexico. Many union members, including some of the rank and file of Stern's own SEIU, which has many Hispanic members, oppose Stern's stance on immigration reform (Benjamin 2006).

Differences over health care, immigration, and other issues are sowing discord and pessimism among Change to Win's leaders. These differences raise doubts about the future viability of the breakaway labor organization (Kelber 2007). No other CTW unions joined Stern and Scott in establishing the group "Better Health Care Together." The only other union to sign on was the Communications Workers of America, which is affiliated with the AFL-CIO. The UFCW, a member of the CTW federation, has stridently opposed Stern's high-profile courtship of Wal-Mart and questioned the retailer's credibility on health care (Kavilanz 2007; Hansen 2005). Before Wal-Mart embarks on a campaign for universal health care, it should provide health coverage for its 1 million workers, charged UFCW president Joe Hansen, whose union has been trying to organize Wal-Mart workers (Press Associates, Inc. 2007). "Wal-Mart's attempt to insert itself into the healthcare debate fuels the kind of cynicism and mistrust that comes out of the say-one-thing-but-do-another form of public discourse from powerful interests—whether in the corporate or political arena," declared Hansen. Officials of the CTW did join Stern at a July 2006 health care summit organized by Schwarzenegger that was widely seen as a way for the governor to terminate growing support in

California for single-payer legislation introduced by state senator Sheila Kuehl (D–Santa Monica). Rose Ann DeMoro, executive director of the California Nurses Association (CNA), denounced Stern and other labor officials as scabs for crossing a picket line that the CNA organized during the summit to protest Schwarzenegger’s health policies (Mathews 2006).

Alternatives for Organized Labor

Stern’s most controversial stance is his dismissal of the single-payer approach popular with many progressive groups and union members, including the SEIU’s rank and file. At its 1996 convention, the SEIU passed a resolution that committed the union to a Canadian-style, single-payer system (J. P. Nixon, senior policy analyst, SEIU, interview, June 3, 1996). A number of SEIU locals have endorsed H.R. 676, the single-payer legislation in Congress. In California, SEIU members have provided important support for Kuehl’s legislation, which Schwarzenegger vetoed in fall 2006 and which has since been reintroduced. Adamant that the United States needs “to find a new system that is not built on the back of government,” Stern contends that “we are going to build an American system because we are Americans and we don’t like anyone else’s system” (Brookings Institution 2006: 15).³⁸ Despite recent public opinion data indicating otherwise (Toner and Elder 2007), Stern appears certain that Americans will not support a single-payer system because of their deeply ingrained mistrust of government.³⁹ In distancing himself from the single-payer option, Stern also appears to be repudiating the New Deal understanding that recognizes a pivotal role for government in the provision of social welfare and the regulation of economic relations (Stern 2006c: 102).

While Stern remains stridently opposed to the single-payer approach, other labor leaders have become prominent advocates. Foremost among them is Leo Gerard of the USW, who has been outspoken on a number of progressive causes, including opposition to the war in Iraq. In making his pitch for a single-payer plan, Gerard does not dwell on the economic competitiveness question. He acknowledges that the health care issue is

38. Until recently, the SEIU’s Web site proclaimed, “It’s Time for an American Solution to Our Health Care Crisis” (www.seiu.org/issues/american_solution.cfm [accessed August 9, 2006; page now discontinued]).

39. Asked if the United States is likely to end up with a government-run single-payer system like Canada’s, Stern answered, “That’s unlikely. I don’t think Americans have a great trust of government in general” (Alonso-Zaldivar 2007).

a piece of the larger “de-industrialization of America” and is the gas that threatens to burn down “the house of social progress” (Gerard 2006). While Gerard expresses some sympathy for employers pressed by rising medical costs, he contends that health care is fundamentally a civil and human-rights issue, not a question of economic competitiveness. Whereas Stern defends the U.S. health system as the best in the world (Brookings Institution 2006: 11), Gerard and some other labor officials highlight its gross inequities, inefficiencies, and exorbitant costs. These failures help explain why only 40 percent of Americans surveyed describe themselves as satisfied with the country’s medical system, placing the United States nearly last in public satisfaction.⁴⁰

A Canadian, Gerard appears more open to considering health care models from abroad than Stern. Unlike many other would-be reformers, Gerard suggests that advocates of health care reform should examine the political origins of national health insurance elsewhere, especially bottom-up initiatives. He notes how the initial experimentation with universal health care in the province of Saskatchewan in the mid-1940s was pivotal in the ultimate triumph of national health insurance in Canada. Gerard also reminds audiences that universal health care did not arrive overnight. In Canada, it took an additional twenty years after its initial beachhead in Saskatchewan.⁴¹

Historically, the national leadership of organized labor has been ambivalent or downright hostile toward attempts to extend the safety net on a bottom-up, state-by-state basis (Gottschalk 2000: 151–152). Among other things, the leadership of the AFL-CIO has feared giving up control of the social welfare agenda to the states. It has feared that the most socially backward and poorest states would set the national standard for social welfare. Also, AFL-CIO leadership has doubted the capacity of individual states to develop and implement adequate social welfare programs on their own and has dismissed state-level initiatives as a drain on political energy for national action. That appears to be changing. The last few years, the AFL-CIO has identified promising health care reform efforts at the state level and has lent them critical support (Nack 2006: 7). For example, it agreed to fund an important study analyzing the costs and consequences

40. The United States ranked fourteenth out of the seventeen industrialized countries polled in public satisfaction. It came in dead last among public health experts evaluating overall system performance, according to the World Health Organization (Blendon, Kim, and Benson 2001: 16, exhibit 1).

41. For a detailed analysis of the Saskatchewan case, see Maioni (1998), Taylor (1990), and Chandler (1977).

of a single-payer proposal in Wisconsin modeled after that state's pioneering worker-compensation system. This study has been pivotal in framing the discussion in Wisconsin about health care reform (*ibid.*: 15).

The AFL-CIO's main initiative at the state level has been its Fair Share Health Care campaign, which has been pressing state legislators to require large employers to spend a certain percentage of their payroll on employee health benefits. Wal-Mart has been the primary target of the Fair Share campaign. In early 2006, the Maryland legislature enacted the country's first Fair Share Health Care bill, defying the veto of Governor Robert Ehrlich. The legislation, which the SEIU helped draft, requires megaemployers in Maryland (i.e., Wal-Mart) to spend at least 8 percent of their payroll on employee health benefits or pay the state for Medicaid costs incurred by their workers (Coie 2006). The Maryland victory spurred reformers in dozens of other states to push similar bills.

The debate in Maryland came to a head under exceptional circumstances that created the perfect storm to propel this legislation. Wal-Mart, which tended until recently to be a low-profile political player, was caught off guard by the savvy and scrappy actions of critics like Wal-Mart Watch and Wake Up Wal-Mart. Just as the retailing giant was establishing a war room to respond more quickly and effectively to its critics, Wal-Mart faced a public relations disaster (Barbaro 2005). In October 2005, an internal memo to its board of directors that suggested ways to contain health spending while preserving the retailer's reputation was leaked to the press. The memo proposed, among other things, hiring more part-time workers and discouraging older and less healthy people from working at Wal-Mart. The memo also conceded a point that many of Wal-Mart's critics had been making: nearly one-half of the children of Wal-Mart's 1.33 million employees are either uninsured or on Medicaid (Greenhouse and Barbaro 2005).

Persistent Institutional Obstacles

The Maryland bill, while initially a significant victory for organized labor, may demarcate the limits of state-level reform. After its defeat in the Maryland legislature, Wal-Mart turned to the courts. The Retail Industry Association and Wal-Mart sought to block implementation of the Fair Share legislation by enlisting one of the most durable obstacles to state-level reform initiatives—ERISA, the landmark 1974 pension reform legislation that preempts state laws that “relate to any employee benefit plan” (Fox and Schaffer 1989: 240; see also Sass 1997: chap. 8; Farrell 1997).

Citing ERISA, a federal-court judge ruled in July 2006 that Maryland's Fair Share law is invalid (Witte 2006). In January 2007, a federal appeals court upheld the lower court ruling. It agreed that the Maryland law conflicted with the intent of ERISA by denying companies the right to create a uniform system of health benefits across the country (Barbaro 2007). Maryland state officials decided not to appeal this decision to the U.S. Supreme Court because it would entail years of litigation, hinder other efforts to expand health care in the state, and likely not be overturned by the nation's highest court (A. Green 2007).

For decades now, ERISA has acted like a "black hole," sucking up promising health care initiatives.⁴² Since the defeat of Clinton's Health Security Act, the Supreme Court has reaffirmed ERISA's remarkable power to derail many state-level health initiatives (Zanglein 2005; Jost 2004). In one landmark ERISA case, Justices Ruth Bader Ginsburg and Stephen Breyer urged the Court and Congress to "revisit what is an unjust and increasingly tangled ERISA regime." They acknowledged that ERISA leaves a "gaping wound . . . that will not be healed until the Court 'start[s] over' or Congress 'wipes the slate clean'" (quoted in Zanglein 2005: 7). So far, Congress has been either unwilling or unable to significantly curb or eliminate the vast ERISA preemption. Organized labor has not pushed legislators for ERISA reform, partly because many unions want to keep their Taft-Hartley health funds and national contracts shielded from state-level regulations and patient lawsuits.

Like ERISA, the Taft-Hartley health funds are an institution that maintains a tenacious grip on the shadow welfare state, strangling promising reforms at both the state and national levels. These union-run health funds are an important source of private-sector benefits for nearly 10 million union members—or more than one-half of all unionized workers.⁴³ Almost 26 million unionized workers, retirees, and their dependents receive health coverage from the 2,200 collectively bargained health funds established in accordance with the 1947 Taft-Hartley Act (National Coordinating Committee for Multiemployer Plans 2005: 5).⁴⁴ The typical Taft-Hartley plan established under collective-bargaining agreements requires employers to contribute some negotiated amount to a pension, health, and/or welfare fund for each hour worked by the eligible employee. The plans

42. This comparison of ERISA to a "black hole" comes from Zanglein (2005).

43. See the chapter "Characteristics of Multiemployer Plans," in International Foundation of Employee Benefit Plans (1996: 1).

44. About 161 million workers and their dependents were covered by employment-based health plans in 2005 (EBRI 2006: table 26.3).

provide health benefits either by directly paying for certain covered medical services or by purchasing health insurance for eligible workers and their dependents. In most instances, the union essentially runs the fund.

Many Taft-Hartley plans have been under “severe stress” (Five Borough Institute and the New York City Central Labor Council 2003). Escalating health care costs have forced union-run funds to draw down reserves, reduce coverage, and increase annual deductibles and co-payments. Union officials, who often serve as the key administrators of the funds, find themselves in the unenviable position of having to tell their members that they must make do with less. Despite this acute financial stress, top union officials have been reluctant to support any health care proposal that would put their funds out of the health care business. In a move that bitterly divided organized labor and alienated some health care reformers, Taft-Hartley unions fought long and hard to get a provision included in Clinton’s Health Security Act that would have permitted Taft-Hartley funds with five thousand or more members to opt out of the proposed health alliances if they so wished (Gottschalk 2000: 149–150).

The funds are extremely lucrative for some union officials. They have created a huge conflict of interest for organized labor because some union officials are both labor leaders and insurers. This conflict of interest dramatically came to the fore in spring 2002 when an insider-trading scandal rocked the Union Labor Life Insurance Company (ULLICO). Established more than fifty years ago, ULLICO is a private company that provides insurance, investments, and benefits management for the Taft-Hartley plans of hundreds of union locals and holds about \$5 billion in assets (Fishgold 2006). The scandal forced Robert Georgine, ULLICO’s long-time CEO, to resign in 2003. A leading and persistent opponent of the single-payer approach when he headed the AFL-CIO’s Building and Construction Trades Department from 1972 to 2000, Georgine was also forced to pay back millions of dollars to ULLICO to settle charges that he had breached his fiduciary responsibilities (*ibid.*; Gottschalk 2000: 51–52).

Material conflicts of interest alone do not explain why Taft-Hartley unions have held onto these funds so tenaciously. Many local and national labor leaders contend that the Taft-Hartley funds provide an important sense of identity and cohesion to union members who may have few other meaningful attachments to their union or to their fellow union members, scattered as they are at various and changing work sites.

Some contend that the ULLICO scandal was the spark that ignited the strong vocal opposition to Sweeney that spurred the establishment of the CTW coalition (Fishgold 2006; Fitch 2006: 26–28). Ironically,

the CTW's split with the AFL-CIO may liberate the federation to forge a more coherent, compelling, and progressive stance on health care. Stern's CTW coalition is dominated by unions with large Taft-Hartley funds, notably the Teamsters, UNITE HERE, the UFCW, and, of course, the SEIU, which runs the country's largest Taft-Hartley fund. In the past, the Taft-Hartley unions were one of the major reasons why the federation resisted making a resounding endorsement of a single-payer plan and did not align itself with the most progressive forces in the health care debate (Gottschalk 2000: 51–52, 150–151). In a recent interview, Stern made an oblique reference to the Taft-Hartley funds and lauded them as potentially critical building blocks of any new health insurance system that replaces the current employment-based one (Rose 2006).

In March 2007, the AFL-CIO's executive committee agreed to support Medicare for all. While the federation did not use the term "single-payer," some single-payer advocates hailed the statement as a "giant step forward" (editor, Unions for Single Payer H.R. 676, "News Report on AFL-CIO Healthcare Statement," e-mail correspondence to Single PayerNews@UnionsForSinglePayerHR676.org, March 10, 2007). The AFL-CIO's position was arguably ambiguous. The executive council's statement does affirm a "central role" for the government in "regulating, financing and providing health care," but it says nothing about eliminating the dominant role of private insurers in health care (AFL-CIO 2007; see also Gruenberg 2007b). Elaborating on the executive council's position, Gerald Shea, the federation's leading analyst on health policy, singled out several bills currently under consideration in Congress that are consistent with the principles that the AFL-CIO affirmed in its call for Medicare for all. These bills include H.R. 676, the single-payer legislation, and three other Medicare-for-all bills crafted by Senator Kennedy, Representative John Dingell (D-MI), and Representative Pete Stark (D-CA) that would retain a significant role for private insurers by grafting an expansion of Medicare onto the existing system of employment-based benefits (Gruenberg 2007b).⁴⁵

The AFL-CIO statement finesses a big divide between those in organized labor and elsewhere who see retaining the private health insurance industry as the most politically expedient solution and those who see its elimination as an essential pillar of health care reform. For some single-payer advocates, the AFL-CIO's artful ambiguity does not appear to be

45. JoAnn Volk, another leading AFL-CIO lobbyist on health care, said, "The political will isn't there now, but it could get there for single-payer" (Moberg 2007b).

a problem. In September 2005, the CNA, which represents 65,000 nurses and is one of the most outspoken champions of a single-payer plan and other major health care reforms in California, applied for AFL-CIO membership. It made its affiliation conditional on AFL-CIO endorsement of a single-payer plan. Just days after the AFL-CIO's executive committee agreed to support Medicare for all, the CNA announced it would affiliate with the federation (Raine 2007).

Conclusion

The AFL-CIO's endorsement of Medicare for all affirms a major role for the government in a reformed health care system. But so far, the AFL-CIO has not publicly engaged in many of the other fundamental questions Stern and others have pointedly raised over health care: Should health care reform be pitched primarily as an economic issue or a moral issue? What role, if any, should private insurers have in a reformed system? Are unions prepared to give up their Taft-Hartley funds? Should labor focus primarily on courting business, which has proved to be an elusive and unreliable ally on health care reform in the past? Or should it focus more on mobilizing its own rank and file and reaching out to other progressive groups to put moral, social, and political pressure on business and public officials to do the right thing? Also left unsaid is whether the federation is prepared to commit serious resources to a campaign for universal health care. In the early 1990s, a number of unions, notably the UAW and AFSCME, remained rhetorically committed to a single-payer plan but invested little in mobilizing their members and the wider public (Gottschalk 2000: 100–101, 142–143).⁴⁶

The AFL-CIO has been conspicuously silent on Stern's health care proposals and his corporatist vision for labor-management relations in the twenty-first century (Kelber 2006). President Sweeney of the AFL-CIO has lobbed some indirect criticisms at Stern's labor-business vision for health care reform but for the most part has taken a conciliatory stance (Press Associates, Inc. 2007). The AFL-CIO has not crisply defined a compelling alternative and earmarked major resources for the cause of health care reform. This may help explain why Stern has garnered so much attention for his business-labor coalitions while the mainstream

46. Recently dissidents in the UAW have been calling upon the union to commit \$100 million of its nearly \$900 million strike fund to the cause of single-payer health care (*Future of the Union* 2005; Hoffman 2007a).

media have largely ignored the AFL-CIO's endorsement of Medicare for all. Perhaps the desire to lure the CTW unions back to the AFL-CIO sooner rather than later helps to explain why the AFL-CIO has not directly challenged Stern. In its silence, the federation has ceded to Stern and key business leaders like Safeway's Burd and Wal-Mart's Scott disproportionate influence to define the terms of the debate. This has, once again, led to overinflated expectations in the popular media and public-policy circles about the capacity and willingness of the business sector to resolve the country's health care crisis in a fair and equitable way (see, e.g., Cohn 2007). It also obscures the importance of cultivating a wider social movement if we are to finally attain the holy grail of high-quality, affordable health care for all.

This persistent faith that business will somehow unlock the door to universal, affordable health care flies in the face of the experience of other countries. While analysts may disagree about precisely why universal and near-universal health care took root in Western Europe and Canada, they concur that business was at best a passive player and at worst an obstructionist force. In late-nineteenth-century Germany, Otto von Bismarck extended social protections, notably the Health Insurance Act of 1883, primarily because he feared popular uprisings at home in the aftermath of the Paris Commune of 1871 and the Long Depression of 1873. By tying citizens closer to the paternalistic state, Bismarck aimed to weaken the attraction of the rival Social Democrats (Rimlinger 1971: 112–113). In the case of Great Britain, it is also hard to discern much of a part for business in the establishment of the National Insurance Act of 1911 and the subsequent creation of the National Health Service shortly after World War II (Fox 1986; Hollingsworth 1986: 124; Navarro 1994: 143–144; Sakala 1990). While there is no ironclad consensus on why national health insurance took root in Canada, by most accounts business played only a negligible role. The decisive political leadership of the social-democratic Cooperative Commonwealth Federation (CCF) in Saskatchewan and the unwavering and uncompromising support of organized labor paved the way for truly universal medical care in Canada (Taylor 1978: 353; Maioni 1998: 120–121, 129–130; Coburn, Torrance, and Kaufert 1983; Swatz 1977; Dickinson 1993).⁴⁷ Comparative studies of the politics of health policy indicate that the medical providers, the business sector, and other “conservative political forces” fiercely opposed the establishment

47. For one of the few accounts that puts business at the center of its analysis, see Walters (1982).

of universal health care (Steinmo and Watts 1995). Furthermore, these studies demonstrate the importance of labor and other nonbusiness actors in securing universal health care. As labor economist John Commons (1961: 854) once said, “Social responsibility is never accepted *effectively* by employers or any other class of individuals, until they are faced by an alternative which seems worse to them than the one they ‘willingly’ accept” (emphasis in the original).

As some labor leaders in the United States look backward to the last battle over health care reform, business rapidly stakes out a new frontier with the individual mandate. The hope among some labor leaders that business once again holds the key to the health care deadlock is a false hope. It is an inadequate strategy to successfully challenge the individual mandate and construct an alternative vision of reform that leads to a truly universal and just health care system. Labor appears to be vexed with internal divisions exacerbated by institutional obstacles like ERISA and the Taft-Hartley funds, but these divisions and obstacles are not insurmountable. They do not foreclose a major role for organized labor in moving the United States toward the laudable goal of a universal health care system that is equitable and affordable.

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