

AICGS Seminar Papers

A Publication of the
American Institute for Contemporary German Studies
The Johns Hopkins University

POLICY PAPERS #6

**Cost Containment vs. Solidarity
in the Welfare State:
The Case of German and
American Health Care Reform
Susan Giaino**

**Robert Bosch Foundation Research Scholars Program
in Comparative Public Policy and Institutions
1998**

AICGS would like to thank the Robert Bosch Foundation for funding this AICGS publication as part of the Robert Bosch Foundation Research Scholars Program in Comparative Public Policy and Institutions. The author would also like to thank Henry Wend for helpful comments.

© 1998 by the American Institute for Contemporary German Studies

The views expressed in this publication are those of the authors alone. They do not necessarily reflect views of the American Institute for Contemporary German Studies.

Additional copies of this AICGS Seminar Paper are available at \$3.50 each to cover postage and processing from the American Institute for Contemporary German Studies, 1400 16th Street, NW, Suite 420, Washington, D.C. 20036-2217. Telephone 202/332-9312, Fax 202/265-9531, Email: aicgsoc@jhunix.hcf.jhu.edu, Web: <http://www.jhu.edu/~aicgsdoc/>

AICGS POLICY PAPERS

The series *Policy Papers* demonstrates AICGS' commitment to advancing policy-relevant research using the tools of comparative methodology.

Developments in Germany are of interest because of the country's size, location and history. We need to understand public policy in Germany because Germany is a key international partner and because German preferences will continue to be an important ingredient in the formulation of EU policy regimes. Sometimes German solutions to pressing policy concerns are important because they have a "model" character. This is not necessarily a matter of praise or emulation. Indeed, German solutions may be untransferable or undesirable. Nevertheless, the constellation of institutions and practices that makes up Germany's "social market economy" provides the researcher with an unparalleled real time laboratory in organized capitalism. Over a variety of policy issues, comparison with Germany illuminates advantages and disadvantages of options that would not easily come to mind if the German "case" did not exist. Industrial relations, financial institutions, health-care reform, pollution abatement, intergovernmental relations, immigration, and employment training are just a few of the sectors for which a German component might pay high dividends to policy analysis.

A generous grant has enabled us to establish the Robert Bosch Foundation Research Scholar Program in Comparative Public Policy and Institutions. The following papers are the first to issue from the program.

- #1 "Institutional Legacies: Patterns of Skill Formation and Contemporary Shop-Floor Politics," **Kathleen Thelen (Northwestern University)**
- #2 "Education, Vocational Training and Job Mobility," **Thomas Hinz (Ludwig-Maximilians University Munich)**
- #3 "Success and Failure in Training Reforms: France and Germany," **Pepper Culpepper (Harvard University)**
- #4 "Continuing Training in an Aging German Economy," **Jutta Gatter (University of Bremen)**
- #5 "Germany's New Long-Term Care Policy: Profile and Assessment of the Social Dependency Insurance," **Ulrike Schneider (University of Hannover)**
- #6 "Cost Containment vs. Solidarity in the Welfare State: The Case of German and American Health Care Reform," **Susan Giaimo (Massachusetts Institute of Technology)**

C O N T E N T S

EXECUTIVE SUMMARY	1
INTRODUCTION.....	3
THE ARGUMENT	5
GERMANY: “SOCIALY BOUNDED” MARKET COMPETITION	7
A. Cost Containment and Equity Problems in the German Health Care System.....	7
B. The German Road to Health Care Reform: Reconciling Cost Containment and Solidarity within a Socially-Bounded Market.....	11
C. The Refusal to Abandon Social Insurance and Contributory Financing	16
D. Summary	19
THE UNITED STATES: THE TRIUMPH OF “UNMANAGED COMPETITION” AND THE DEFEAT OF SOLIDARITY	20
A. Problems of Access and Cost-Shifting in a Voluntary Health Insurance System	20
B. The Reform Path: From Social Insurance and Regulated Competition to “Unmanaged Competition” and Market Segmentation.....	21
C. The Dilemmas of Reform in a Voluntary Health Care System	25
D. Summary	31
CONCLUSION	32
REFERENCES.....	36

EXECUTIVE SUMMARY

In an era of slower economic growth, all advanced industrialized countries face pressures to contain the costs of welfare state. In the 1980s and 1990s, welfare state reform has become inextricably intertwined with larger concerns about economic competitiveness. Neoliberals argue that welfare state reform requires privatization or marketization of social provision. But many countries face a difficult balancing act between pursuing welfare state cost containment without sacrificing the equity of social provision.

The subject of this paper is to explore how countries have addressed this task. The case of health care reform efforts in Germany and the United States since the late 1980s provide a window through which to answer this question. Both countries have employment-based health insurance systems. Hence, health care costs have become increasingly bound up with employers' concerns over non-wage labor costs. Both countries have also used market forces as a way to encourage health care payers and providers to provide health care services more efficiently.

Despite these commonalities, German and American health care reform experiments have struck very different balances between efficiency and equity. In Germany, the state has enjoyed greater leverage and authority to shape the contours of the market in the health care system. Moreover, the statutory and corporatist bases of health insurance have closed off employer exit from the health insurance system and have forced them to seek ways to control their share of health insurance costs by less drastic means than privatization of financing. In short, the social insurance system embeds the state, employers, and labor in ways that militate against neoliberal solutions of unregulated market competition or privatization that would destroy the solidarity of the health care system.

In the U.S., by contrast, government actors lacked the leverage and authority to intervene in a voluntaristic system of employer-provided health insurance. President Clinton's failed effort at state-led reform combining universal access with regulated market competition has given way to an employer-led strategy of unregulated market competition. With little or no effective opposition from the state or employees, employees have been free to pursue a "go-it-alone" cost-cutting strategy using market competition. But employers' actions have resulted in a further erosion of what little solidarity existed in the American health care system.

INTRODUCTION

The end of the long postwar boom in the 1970s ushered in a critical reexamination of the costs and performance of the welfare state in advanced industrialized societies. Reforming the welfare state no longer meant expanding coverage or generosity of programs; instead, it meant containing the costs of social provision. Correspondingly, those who paid for social programs became more prominent in welfare state reform debates.

By the early 1990s, policymakers and businesspeople increasingly came to view the welfare state as inextricably tied up with broader questions of economic competitiveness (Pfaller et al., 1991). This confluence of social policy with competitiveness concerns has been especially marked in countries where employers finance social provision. In these countries, many firms have argued that high fringe benefits or social insurance contributions have pushed up their non-wage labor costs to uncompetitive levels. In response to such concerns, governments have focused their energies on reforming the welfare state to make it more efficient and less costly.

A key question surrounding welfare state reform is whether cost pressures require all countries to adopt neoliberal solutions. The chief instruments in the neoliberal toolkit are privatization, such as encouraging private insurance over public schemes or private providers over public ones, and the introduction of market forces in systems of public social provision. According to neoliberals, the value of private insurance lies in its fostering of individual responsibility and its relief of public budgets or employer labor costs. These measures will free up funds for investment and encourage savings. Using private providers will encourage more efficient provision. Likewise, market competition in the delivery of welfare state services will encourage efficient provision and lead to cost savings. These measures must be adopted if advanced industrialized countries are to adjust to more competitive economic conditions.

In this paper, I examine the extent to which countries are following the neoliberal path in reforming their health care systems. Specifically, I look at health care reforms since the late 1980s under the Christian-Liberal government of Helmut Kohl in Germany, and during the presidency of Bill Clinton in the United States. The cases provide good windows to explore the project of welfare reform. First, the health care sector is an important sector in both economies, comprising a major share of gross domestic product (see Tables 1 and 2) as well as providing jobs for a significant

Gaiimo 4

number of people.¹ Thus, health care reform has been a concern of policymakers in both countries. Indeed, both Kohl and Clinton have attempted major cost containment projects, including the use of market competition, in their health care systems. Second, because both German and American employers are major financiers of health insurance, their concerns over non-wage labor costs have informed recent policy debates surrounding health care reform.

But while Germany and the U.S. have experienced common pressures to contain health care costs, they have not followed identical reform strategies. State actors in both countries have attempted to lead the process of reform, including shaping market forces in health care. But different actors have led the way in health care reform and have shaped the contours of the market in specific ways. As a result, the German and American reforms have achieved very different balances between cost containment and equity.

Table 1
Health Expenditures as a percent of GDP, 1972, 1982, 1992

	1972	1982	1992	percent change 1982/72	percent change 1992/82
Germany	6.5%	8.6%	8.7%	+32	+1
USA	7.6	10.3	14.0	+36	+36

Source: OECD, *The Reform of Health Care Systems*, 1994, 37.

Table 2
Health expenditure and GDP per capita, 1994, 1995
(purchasing power parity exchange rates)

Germany: 2200

USA: 3700

Source: *OECD Economic Surveys, 1996-1997: Germany*, 1997, 69.

¹ The Advisory Council for the Concerted Action in Health Care has highlighted the importance of the health sector as a source of employment and economic growth in Germany (KAG 1996, 36-40).

In Germany, the government of Helmut Kohl has introduced market competition in the health sector, but that market is a “socially bounded” one that has been constrained by specific rules and embedded within a framework of universal national insurance. The government has also attempted to balance cost containment with equity, or “solidarity.”² And while employers have not been shy in pressing for state action to reduce their share of health insurance contributions in order to lower their labor costs, they have not advocated a dismantling of the social insurance system.

In the U.S., by contrast, President Bill Clinton attempted to reconcile equity with cost containment with his plan for national insurance and government-regulated competition. That plan, however, failed the congressional hurdle, largely because of employers’ opposition. However, the Clinton plan’s destruction did not signal the end of health care reform. On the contrary, employers have pursued a number of “go-it-alone” strategies to reduce their labor costs, chief among them the zealous encouragement of market competition among insurers and health care providers. But when private actors rely on such a market strategy, the effects have been disastrous for what little solidarity there is in the American health care system.

THE ARGUMENT

² By solidarity I mean that all persons have access to the same level of high quality care, regardless of ability to pay. In German health care, solidarity also refers to the setting of insurance contributions as a percentage of wages rather than being based on one’s health risk. Household dependents are also insured without additional contributions (Hinrichs 1995; OECD 1997, 82). In other words, the healthier and wealthier subsidize the health care of the poorer and sicker along social insurance principles rather than along actuarial principles of private insurance (also see Stone 1993).

Gaiimo 6

The character of each nation's health care system goes a long way in explaining such divergent reform outcomes. First, while payers have become more influential in health care reform debates, they are not the same actors in each health care system. In the U.S., employers are the major financiers of health care. In Germany, however, both employers and employees share the task of financing and administering the health insurance system, and their policy preferences may not be identical. Second, the ways in which employers are embedded within their particular health care systems have shaped the cost containment strategies of German and American firms. Third, health care systems grant the state different capacities to intervene in and lead reform. As a result, state actors may or may not have the authority and the means to shape market forces in health care. The question of who leads the reform process and the construction of health care markets has been decisive to the particular balance between cost containment and equity that each nation has achieved. Where the health care system grants employers free rein to lead reform, they have pursued their narrow goal of cost containment at the expense of broader solidarity. Where the health care system accords the state a leading role in reform and otherwise constrains employers, the cost containment project has been tempered by efforts to preserve a socially acceptable level of solidarity, even with market experiments. Let me develop this argument with specific reference to the German and American health care systems.

First, German and American health care systems have granted government actors more or less leverage to lead reform generally and to shape market forces in particular. In a statutory health care system like Germany's, the government has had the legal authority to intervene in and set the parameters of the system. This authority to set the parameters of the system has allowed it to define the rules and contours of the market in the health care system. And because universal access to health care is guaranteed by law, the government has faced strong public expectations to protect solidarity even as it has pursued the goal of cost containment. Additionally, the corporatist framework of public-law bodies (*Körperschaften öffentlichen Rechts*) has provided the government with the institutional means to intervene in the health sector. In the U.S., by contrast, most Americans obtain insurance at the discretion of their employers. As a result of this voluntary system of health insurance, government actors have lacked the authority or institutional leverage to lead reform developments and to shape market forces in health care. Moreover, federal-state division of labor

in regulating employment-based insurance has placed an additional constraint on government capacity to shape market developments in the American health care system.

Second, while employers in both Germany and the U.S. have desired to lower their labor costs, the health care system has provided them with different ways to do this. In the U.S., the voluntarism of employment-based insurance has given firms great latitude to pursue a range of “go-it-alone” strategies to lower their labor costs, from defining the market themselves to evading responsibility to provide health insurance for their employees. Germany’s statutory health insurance system, by contrast, has limited firms’ cost containment strategies: they cannot simply “exit” the system and refuse to offer coverage. Moreover, German employers have seen their institutionalized position in social insurance administration as a valuable instrument to contain their labor costs. As a result, they have resisted proposals to shift to a system of compulsory individual insurance because this would deprive them of a weapon of control over non-wage labor costs.

Third, health care systems may or may not institutionalize other actors to act as a counterweight to employers’ cost containment strategies. In Germany, corporatist arrangements in health insurance have granted employees equal representation in administration and financing social insurance. As a result, employees have a firmly anchored position within the social insurance system from which to counteract employers’ cost-shifting efforts. This constitutes an enduring form of employee influence over social insurance that complements other avenues of influence, such as unions’ collective bargaining strategies or ties to political parties, which may not be as stable. In the U.S., by contrast, employees have not enjoyed such institutionalized rights in health insurance administration or in financing. As a result, employers have had much freer rein to decide questions of health insurance coverage, which employees have been relatively powerless to counteract.

Fourth, those actors with prominent financing and administrative roles in the health care system also have been influential in the policy process surrounding health care reform. Policymakers have had to respond to—or at least bear in mind—their concerns, and have shaped their reform legislation accordingly. But because partisan balances of power have not been static but have instead been more fluid than the institutional configurations of the health care system, the content of and compromises surrounding specific health care legislation have varied over time. Nonetheless, the overall pattern has been fairly consistent: In Germany, the health care system has constrained the preferences and strategies of key stakeholders and politicians in such a way so as to reconcile cost

Giaino 8

containment with solidarity. In the U.S., policymakers have been unable to shield equity from the cost-cutting actions of key health care stakeholders.

GERMANY: “SOCIALY BOUNDED” MARKET COMPETITION³

A. Cost Containment and Equity Problems in the German Health Care System

³. The notion of a “socially bounded market” in health care comes from Henke (1997). It corresponds to a broader framework of the social market economy (*soziale Marktwirtschaft*). For an excellent discussion of the social market economy and the relations between state and societal actors, see van Kersbergen (1995).

Germany's national health insurance system provides statutory coverage for 90 percent of the population. Those above the statutory income ceiling⁴ may opt out and provide for themselves privately, though many of them choose to remain in the statutory system. Sickness funds (*Krankenkassen*) organized on class, occupational, and regional lines insure the population. Despite the differences by type of fund, and the sheer number of funds (over 600 of them), the *Krankenkassen* provide similar benefits packages that are mandated by law. Health insurance is financed by equal shares of employer and employee contributions. The current average contribution rate of 13.4 percent of earnings is split between employers and employees (OECD 1997, 107, 148).

The German health insurance system is distinctive for its corporatist arrangements which govern the relations between the state and health sector actors, and between those actors themselves. Under corporatism, the state sets out the parameters and goals of the health insurance system in framework legislation, while relying on public-law bodies of sickness funds and doctors' associations (*Kassenärztliche Vereinigungen*, or KVs) to implement the laws and generally run the system through collective agreements negotiated at the state level. These associations of doctors and insurers have the primary responsibility to administer the health care system and enjoy significant rights of self-governance (*Selbstverwaltung*) to do so. Employers and employees also have a role in co-managing the health insurance system through their parity representation on the administrative bodies of the sickness funds, which corresponds to their equal financing of insurance contributions. While the health care system limits direct state intervention through the principle of subsidiarity (*Subsidiarität*), the state nonetheless has the authority to set the parameters of the system so that the major actors conform their behavior to (state-defined) public policy goals rather than merely pursuing their collective self-interest. State authority to set the arrangements between health care actors extends to reserve powers to intervene in health care administration if doctors and sickness funds fail to implement their public obligations as defined in the law. However, such intervention is rare and meant to be only temporary, until doctors and insurers are able or willing to assume their public

⁴ The statutory income ceiling is approximately DM 1,650 per month in the western states and DM 5,325 in the eastern states (OECD 1997, 148).

Giaimo 10

obligations. Once they do, the state pulls back and allows them to reassert their rights of self-governance (Giaimo 1994, 1995; Giaimo and Manow 1997; Streeck and Schmitter 1985).

These corporatist actors have also had opportunities to influence health care reform debates and legislation through their links to political parties. The Christian Democratic Union (CDU) not only represents employer concerns, but also contains a trade union wing that has an important voice in social policy matters (Döhler 1991). In addition, the Social Democratic Party (SPD) has at times been able to influence health policy in ways that further the concerns of employees, unions, and the local funds (*Allgemeine Ortskrankenkassen*, or AOKs) which insure many lower-paid workers. Because the balance of power between the parties has not been constant, however, there has been some variation in successive health care reform laws. But because the German health care system grants institutionalized role to employers, employees, doctors, and sickness funds, the government has had to respond to and balance their concerns in its reform legislation.

Germany had achieved good cost control in the health sector, at least when compared to the U.S. (see Table 1). But policymakers and payers still had cause for concern. Even though the corporatist framework assumed that payers and providers would be in rough balance, in reality, doctors have had a structural advantage over the sickness funds in negotiating fees and terms of service. The doctors' side is relatively unified, with only nineteen KVs (roughly one per state, or *Land*) facing a fragmented payers' side of approximately 600 funds.⁵ The KVs have long exploited their monopoly position and the competition between the sickness funds to extract from them higher fee settlements. Policymakers thus viewed the structural imbalances between payers and providers as a major reason for rising health care costs.

But cost was not the only problem in the health care system. German health insurance also institutionalized inequities in contribution rates and choices between white-collar and blue-collar workers. While white-collar workers could freely choose from a number of different funds, blue-collar workers could not. Lack of choice thus locked in inequities between different types of fund. The largest type of insurer, the local funds (*Allgemeine Ortskrankenkassen*, or AOKs) were funds

⁵ Each sickness fund is represented by a state-level association which negotiates collective agreements with the KVs. The funds tended to cooperate in an all-payer system (Reinhardt 1990). But the system was far from perfect. White-collar funds (*Ersatzkassen*) negotiated separately from the rest of the funds in national-level negotiations with doctors. Moreover, white-collar funds had a better image as approximating private insurance, and agreed to pay doctors at a higher rate than the other funds wanted. The other funds then followed suit in order to keep up with the white-collar funds, with the result being an upward bias in doctors' remuneration (interviews; Stone 1980).

of last resort for those who did not fit into one of the occupational, class, or company funds. The result was that the AOKs' members tended to be older, sicker, and poorer than those of other types of funds. This meant that AOK members paid higher contribution rates on a lower income base than members of other funds.

As economic conditions worsened in the 1990s, the vulnerabilities of employment-based insurance became more apparent. First, the worldwide recession of the early 1990s drove up unemployment in Germany. The increased use of unemployment insurance and early retirement pensions burdened the social insurance system as a whole. German unification only aggravated the financial problems of the social insurance system. The social insurance system accounted for approximately 18 percent of the transfers to eastern Germany (Heilemann and Rappen 1997, 15).

Most of this went to financing early retirement pensions and unemployment insurance to cushion the blow of mass unemployment in the east (ibid., 13). In short, the social insurance system had to finance an enormous level of pensions and unemployment insurance even as the base of workers was contracting. Employers viewed rising social insurance contributions and the attendant escalation of non-wage labor costs with alarm, particularly as German firms were struggling to stay competitive in the world economy. Moreover, many observers argued that high non-wage labor costs were a barrier to hiring new workers and thus only aggravated the unemployment problem (Hinrichs 1995, 660-661).

Even though health insurance contributions were fairly stable and did not comprise the largest component of social insurance in the 1990s, they still figured in as part of the overall labor cost burden for firms and thus were a source of concern for employers (Hinrichs 1995, 669-670). Table 3 illustrates the rising trend of social insurance contributions since 1960, while separating out the share going to finance health insurance.

Table 3
Social and Health Care Spending Development in Germany

	Social spending/GNP	Combined employer-employee contribution rate to social insurance	Average contribution rate to sickness funds
1960	22.8%	22.4%	6.4%
1970	26.5	26.5	8.2

Gaiimo 12

1975	33.9	30.5	10.5
1980	32.5	32.4	11.4
1985	31.5	35.1	11.8
1990	29.2	35.5	12.6
1992	33.0	36.7	13.4
1995	---	39.3	13.2

Source: Bundesministerium für Arbeit und Sozialordnung, cited in Hinrichs 1995, 659.

Both employers and the government had an interest in reducing health insurance contributions. Employers wanted relief from what they perceived as uncompetitively high labor costs. But the Kohl government had a dual stake in stabilizing health insurance contributions. First, stabilizing health insurance contributions would offset the rising pension and unemployment insurance contributions. Keeping a lid on social insurance contributions would stabilize labor costs, encourage employers to hire more workers, and thus address the politically sensitive issue of unemployment problem. Second, the government had introduced a pension reform in 1992, which linked pension payments to net wages. If net wages shrank or stagnated because of rising social insurance contributions, so would pensions. And pensioners were a key constituency of the CDU. (Hinrichs 1995, 659-661; interviews 1992).

B. The German Road to Health Care Reform: Reconciling Cost Containment and Solidarity within a Socially-Bounded Market

The Kohl government set out to address the cost and equity problems in the health sector in a series of reform laws beginning in the late 1980s. The main goal has been to control the growth of health insurance contributions. But the government has also borne in mind the need to preserve, and at times, even advance, the equity of the system. The general pattern of reform has been one in which the government has sought to work through the corporatist framework to achieve cost containment. In doing so, it has introduced measures to rectify the structural imbalances in the relationship between doctors and insurers in order to give the sickness funds the wherewithal to be more assertive purchasers of health care. At certain points, however, the Kohl government has deemed it necessary to resort to emergency budgeting through direct state decrees. In doing so, the state has intruded into doctors' and funds' domain of administration. The government has also introduced market

competition in the health sector. The competition strategy has attempted to address a number of goals: to reduce the need for enduring state *dirigisme*, to give payers the incentives to demand more cost-effective treatments from providers, and to redress long-standing inequities in the health insurance system. Finally the Kohl government has introduced increased patient copayments.⁶

The first law, the Health Care Reform Act (*Gesundheitsreformgesetz*, or GRG) went into effect in 1989. With this law, Kohl sought to correct the imbalances in the relationship between sickness funds and doctors as a means of controlling costs. First, the law mandated sickness funds and doctors to pursue the goal of contribution-rate stability (*Beitragssatzstabilität*) in their contract negotiations. Second, the government hoped to strengthen the sickness funds by granting them new areas of authority and mandating joint tasks between them and the KVs, such as negotiating prescribing guidelines. Third, the law introduced a fixed reference pricing system for prescription drugs and delegated the task of negotiating drug prices to a federal-level committee of sickness funds and physicians, thereby extending the scope of corporatist bargaining beyond traditional fees of physicians (Döhler and Manow-Borgwardt 1991). Finally, the GRG introduced minor copayments for drugs and hospitalizations. But it retained some notion of equity by exempting low-income persons from such copayments.

The GRG failed, however, to control health care costs. Much of this failure had to do with the refusal of the doctors' associations to negotiate the terms of the law with the sickness funds. As a result, the public, the media, and the opposition Social Democratic Party (SPD) charged that physicians had not done their part in cost containment and that patients had shouldered the brunt of the burden through copayments. In response to this state of affairs, the government introduced a second law, the Health Care Structural Reform Act (*Gesundheitsstrukturgesetz*, or GSG), which went into effect in 1993.

⁶ For details of the 1989 and 1993 laws and their effects on physicians and sickness funds, see Giaimo 1994, 1995. Also, Giaimo and Manow (1997) provide a historical context to current German health care reforms.

Gaiimo 14

The GSG represented a significant intrusion of government power into the domain of corporatist self-administration of health care. In the government's view, such action was needed because corporatist actors—particularly doctors—had failed to assume their cost containment tasks under the last law. With the GSG, then, the government legally specified budgets for all sub-sectors of the health care system and thereby curtailed the freedom of doctors and funds to negotiate levels of reimbursement. At the same time, the Kohl government imposed a price cut for prescription drugs. However, the government intended that such intrusions into corporatist actors' self-governance would be temporary and a means with which to prod them to take on their responsibilities to implement the goals of the law through their own negotiations. Hence, the GSG mandated a three-year limit on legally-set budgets. Moreover, the Kohl government continued to rely on corporatism by mandating doctors and payers to implement other aspects of the law through collective agreements.

The GSG was also notable for its introduction of market competition into the health sector. The GSG required payers to compete for patients by granting blue-collar workers similar rights of choice of sickness fund as those that white-collar workers enjoyed. But this was no *laissez-faire* market. Instead, the government laid the groundwork for the free movement of patients by introducing a system of financial transfers (*Risikostrukturausgleich*) between different types of funds to even out their disparities in contribution rates and health risks. The risk-pooling scheme would “level the playing field” between funds prior to the start of free choice, and would minimize or compensate problems of adverse selection, especially for the AOKs. In addition, because funds could not legally offer different benefits packages, they would be forced to compete on price rather than on attracting only healthier risks. Thus, the market in health care sought to address both efficiency and equity concerns. Free choice of fund would encourage payers to be more responsive to patients, but restrictions on the scope of competition, combined with the risk-adjustment scheme, would encourage them to compete by offering lower contribution rates or better service rather than by selecting better health risks. And by diminishing the differences between blue- and white-collar workers in the area of choice of fund and differences in contribution rates, the market sought to

advance the goal of equity.⁷ Finally, while the GSG raised copayments for most patients, it continued to exempt hardship cases from such out-of-pocket payments.

⁷ The risk-adjustment scheme was quite effective in narrowing the differences in contribution rates. Prior to the risk adjustment, only 64 percent of insured paid one percentage point above or below the average contribution rate. In 1996, after the risk adjustment scheme was introduced, 86 percent of the insured were within this band (OECD 1997, 107).

Gaiimo 16

The GSG's budgeting through legal decree was only a short-term cost containment solution, and the government was unhappy with the degree of intervention it had entailed. Thus, it embarked upon a "third stage of reform" shortly after the GSG went into effect. That reform effort yielded the first and second Health Care Restructuring Acts (*Neuordnungsgesetze*, or NOG 1 and 2) of 1997. With these two laws, the government sought to pull back from detailed intervention in health care system administration and to shift the unpleasant job of cost containment squarely onto the corporatist actors. First, the laws lifted the state-set budgets from most sub-sectors of the health care system.⁸ Second, the laws extended corporatist-style bargaining to other subsectors of the health care system.⁹ Third, in substituting for direct state budgeting, the legislation further strengthened competitive forces on the sickness funds' side as the primary means of cost containment. If a sickness fund raised its contribution rate, such action would trigger an automatic increase in copayments by a corresponding percentage. But to discourage funds from raising their contributions, the law relaxed prior restrictions on blue-collar workers' freedom of choice. Whereas under the GSG, wage-earners could only switch funds once per year, now they could change insurers immediately without any waiting period. Thus, sickness funds that raised contributions might feel the immediate pain from the forces of the market, as patients exercised their freedom of choice to seek out a less expensive insurer. Fourth, funds received new freedom to experiment with benefits packages: they could now

⁸ For example, the health ministry would no longer set regional budgets for prescription drugs; instead, the KVs and sickness funds agreed to negotiate indicative (or target) budgets with which to monitor the prescribing of individual doctors. In addition, the government lifted the long-standing global budget on doctors' fees. In exchange, the KVs agreed to negotiate and enforce a budget cap for each individual doctor (*Dienst*, February 20, 1997; OECD 1997, 85, 96-98)

⁹ Legislation extended corporatist-style collective bargaining to the hospital sector, as well as to physical therapy, home care, spa cures, rehabilitation (*Dienst*, February 20, 1997; interview 1998).

offer marginal services to patients as “extras,” while charging correspondingly higher contribution rates.¹⁰ Finally, the funds could negotiate experimental forms of ambulatory care provision with subgroups of doctors, but subject to the approval of the KVs (*Dienst*, February 20, 1997; Gaiimo and Manow 1997; Manow 1997; OECD 1997, 85-117).

¹⁰. In 1996, the Kohl government enacted the Contribution Relief Act, or *Beitragsentlastungsgesetz*, which scaled back the catalog of services covered by statutory health insurance. The types of excluded services, however, are marginal, and 85 percent of health care services remain under statutory insurance. As a temporary budgeting device, the 1996 law also mandated a slight decrease in sickness fund contribution rates for 1997 (Gaiimo and Manow 1997; OECD 1997, 85).

Gaiimo 18

The “third reform stage” legislation signalled subtle but important policy shifts. First, the laws showed the government’s willingness to curtail benefits as a way to control health care costs, and transform them into voluntary benefits for those able and willing to pay for them. Second, the stronger link between contribution rate actions by funds and patients’ freedom to choose their insurer implied that patients would shoulder an increasing burden of health care financing through both higher contributions and copayments, unless, of course, sickness funds could figure out ways to avoid raising contribution rates. Finally, copayments would be dynamized, that is, linked to wage developments. As many observers note, these changes pose a serious challenge to the principle of parity financing between employers and employees, since the latter would not only pay half of the insurance contribution, but also shoulder a potentially escalating level of out-of-pocket costs.¹¹

However, there were still some limits to the extent of decreasing solidarity contained in the NOGs. First, the NOGs included hardship clauses to exempt those on low incomes or with chronic illnesses from the copayments.¹² Second, the market itself remained sharply circumscribed. The sickness funds’ ability to compete by attracting better health risks was limited, since most benefits remained legally mandated, and funds were legally required to take all comers. Moreover, the risk-adjustment scheme was expected to compensate funds with sicker and poorer members. (However, it is uncertain whether risk-adjustment is sufficiently fine-tuned to capture all adverse or risk selection, since the scheme does not take into account morbidity factors.) Lastly, patients yet to experience

^{11.} For examples of the analysis on the challenge to parity financing, see Manow (1997), “Schlag gegen Kranke,” *Frankfurter Rundschau*, September 25, 1996, 3.

^{12.} Hardship clauses exempt eight million low income adults and twelve million children. Copayments for those with chronic illnesses will be limited to one percent of their incomes. Nonetheless, copayments represent greater patient cost-sharing, and may increase from DM nine billion to DM fourteen billion (OECD 1997, 103-104).

adverse financial effects from the linkage of contribution increases to copayments, since the funds thus far have avoided taking such action.¹³

The health care laws at each stage of reform reflected compromises between cost containment and solidarity that different health care stakeholders demanded. Yet, because the balance of power between the political parties was not static, the influence of health care stakeholders varied over time as did the specific legislative outcomes. With the GRG, the trade union wing of Kohl's CDU assented to higher copayments only in exchange for the hardship exemption clauses, while the doctors received easy treatment as a result of their from the Free Democratic (FDP) allies in the coalition (Webber 1989, 1991). With the GSG, however, Kohl faced the constraint of divided government, since the SPD had gained a majority in the upper house of the parliament. In order to win the support of the SPD for the GSG, the Kohl government agreed to grant wage-earners the free choice of fund that salaried employees enjoyed, the risk-adjustment scheme, and the hardship clauses for copayments. These provisions not only met the demands for solidarity from the SPD, who represented unions and the AOKs, but also sat well with the trade union wing in Kohl's own CDU. The cross-party deal surrounding the GSG came at the expense of the FDP. Kohl's health minister Horst Seehofer used his agreement with the SPD to fend off FDP demands for more cost-sharing by patients. Concomitantly, the FDP's weakness during the GSG meant that doctors bore the brunt of the government's cost containment measures (Giaino 1994).

¹³. Manow (1997) suggests that implementing the linkage reforms would be politically risky in the 1998 election year. Moreover, technical problems have also slowed implementation.

Gaiamo 20

The NOGs represented a clear setback for patients and sickness funds. This outcome owed to the electoral resuscitation of the FDP and its unwillingness to cut a deal with the SPD. Kohl believed that the survival of his governing coalition required that his health minister, Horst Seehofer, accommodate the demands of his junior partner and not cut a deal with the SPD. Moreover, the CDU's trade union wing exerted far less influence than with the previous two reform laws (interviews 1998). Unable to strike a deal with the SPD, Seehofer's effort to enact further structural reforms was frustrated. Instead, he had to settle for the cost containment method of linking contributions to copayments. With the FDP back in the game, doctors' associations also achieved partial successes under the NOGs. The KVs successfully defended their monopoly position and the government agreed to lift the legally-set budgets for physician and prescribing services. But in exchange, the KVs finally agreed to take up their corporatist responsibilities to negotiate target prescribing budgets and to bring their members into compliance with the law.¹⁴

Thus, the political process of health care reform under Kohl has been one involving negotiation and compromise with key health sector actors over the terms of agreement. But because the constellation of health care actors involved at each "stage" of negotiations has not always been the same, the particular settlements surrounding cost containment and solidarity have not been static, either. Nonetheless, Kohl faced limits to how far he could advance cost containment over solidarity.

C. The Refusal to Abandon Social Insurance and Contributory Financing

The NOGs were the government's clumsy answer to employers' demands for relieving their burden of social contributions while at the same time preserving the integrity of social insurance system. The idea to link contributions and copayments placed much of the burden of cost containment onto sickness funds. At the same time, the government hoped that the discipline of the

¹⁴ On the difficulties Seehofer faced in negotiating the "third stage of reform," see "Da passt kein Krankenschein mehr dazwischen," *Frankfurter Rundschau*, September 25, 1996, 3.

market would persuade them of the folly of raising their contribution rates. But this was a second-best solution to placate employers when other options had been closed off.

A number of alternatives to address employers' labor cost concerns before settling on the one embodied in the NOGs (see Hinrichs 1995, 637-679; KAG 1995, 44-47). Members of the governing coalition, as well as the Advisory Council of the Concerted Action in Health Care, which makes recommendations on health policy to the government, were the source of the various proposals. Two proposals represented an effort to make financing more equitable. The first one would have expanded the base of taxable income for financing health insurance by including rents, assets, and other forms of non-wage income. The second proposal would have brought civil servants and self-employed persons into the statutory health insurance scheme. Both of these measures would have gone some way to address the mismatch between growing health insurance costs and a financing base that encompassed only wages and salaries. But neither of them were enacted. An alternative possibility was to rely more on general revenues to finance social insurance. But at least in the immediate term, transferring the burden from social insurance to the federal budget was not a realistic option, since Germany was hoping to join the European Union's single-currency club. Adding to the government's budget deficit would have shattered Germany's chances to meet the stringent criteria for European monetary union (EMU).¹⁵

Other proposals would have favored employers more directly but at the expense of employees. Early in the "third reform stage" of debate, Seehofer considered a proposal from the Concerted Action's Advisory Council to fix the employers' share of the health insurance contribution while allowing the employees' share to float freely. Another alternative, offered by the CDU, proposed changing the voting majority on the sickness funds' administrative boards so that a decision to raise contributions would have required a super-majority of three-fourths of the board rather than the existing simple majority.¹⁶ But these two changes would have altered the parity of financing and

¹⁵ EMU required that countries' budget deficits could not exceed three percent of gross domestic product.

¹⁶ "Union und FDP geben einander die Schuld am Abbruch der Gespräche über die Gesundheitsreform," *FAZ*, October 9, 1995, 1-2; "Wettbewerb zwischen Krankenkassen soll verstärkt werden," *FAZ*, December 15, 1995, 1.

Gaiamo 22

administration in effect since the early days of the Federal Republic. Like the first two proposals, these were not enacted into the reform legislation.

The most radical proposal found its champion in the FDP. To relieve employers of the worry of non-wage labor costs, the Liberals proposed to get rid of parity contributions altogether and instead shift the entire burden of financing health care to employees through individual compulsory insurance. A wage subsidy to workers would substitute for the employers' share of the contribution ("Haarscharf wieder so," *Der Spiegel*, October 23, 1995, 30-31).

The FDP scheme faced formidable obstacles. For one thing, the proposal would have probably been ruled unconstitutional ("Haarscharf," 1995; "Seehofer lehnt FDP- Pläne für Gesundheitsreform ab," *FAZ*, September 22, 1995, 17). Moreover (and not surprisingly), employees and their union and SPD allies opposed such a scheme. But interestingly enough, employers also rebuffed the FDP proposal. Employers argued that the FDP proposal would not solve their labor costs problem since unions would simply demand higher wages to make up for the significantly higher insurance burden of their members ("Haarscharf" 1995). Facing a relatively powerful union movement in the collective bargaining arena, employers had no guarantee that they would be able to contain the pressures of higher wage demands. In addition, because the FDP proposal implied a fundamental break with financing arrangements of social insurance, employers would have also lost their representation on sickness funds' boards and in health policy more generally ("Haarscharf" 1995). Parity financing was a cost to employers, but it also provided them the right to co-determine the level of insurance contributions with employee representatives on the sickness fund boards. This provided employers with important leverage over non-wage labor costs which they were not willing to surrender.

Finally, Health Minister Seehofer refused to accept the FDP proposal. The FDP's plan for a wage subsidy was part of its broader neoliberal vision of individual responsibility and market provision. It sharply contrasted with both the solidarity and corporatist arrangements embodied in social insurance ("Die FDP unter Druck," *FAZ*, October 9, 1995, 1; "Haarscharf," 1995). For Seehofer, corporatism may have had its flaws, but it remained an effective tool for the state to steer the health sector without detailed and enduring intervention.

With employers and the government unwilling and unable to break with contributory social insurance, Kohl settled for the contribution-copayment solution in the NOGs. This solution had the

advantage of retaining the formal 50-50 contribution share between employers and employees. But it meant that the system's solvency increasingly depended on a third actor, namely patients, assuming a greater share of financing through higher copayments. The solution was also likely to put insurers into a temporary financial vise and did nothing to address the basic problem of financing health insurance from an inadequate base of wages and salaries.

D. Summary

In sum, the German approach to cost containment has been one that has also had to balance strong demands for an equitable sharing of the burdens. The government has introduced market competition, but has tempered it with provisions that prevent or compensate for socially unacceptable inequities arising from competition. In addition, formal parity financing remains, though in actual practice it has been eroded somewhat through (as yet) minor cost-sharing by patients. The question remains as to whether copayments will rise so much in the future that they severely undermine parity financing.

The reasons for Kohl's delicate balancing act between cost containment and solidarity lies in the nature of the health care system itself, which constrains the state. Because health insurance in Germany guarantees all person universal access, the government faced public expectations to guarantee not only the solvency but also the equity of the social insurance system. And corporatism required the state to actively set the parameters and relationships among health care actors. Moreover, the health care system privileges employees and employers in financing and administration. As a consequence, the government could not easily ignore their demands when formulating its health care reform strategy.

Just as the institutional configuration of the health sector constrains the state, it also limits employers' ability to reduce their labor costs in ways that would completely destroy the solidarity of the health insurance system. The statutory nature of German health insurance prevents employers from "exiting" the system by refusing to offer health insurance. Nor have they supported such an option since it would have meant the end of their role in health insurance administration and the elimination of what they saw as a handle over their non-wage labor costs. Employees have also acted as a counterweight to employers' cost-cutting demands. As a result, employers had to find less drastic ways to relieve their labor cost burden.

Gaiamo 24

Finally, the state has had the means to lead the way in health care reform and shape market forces in ways that have not destroyed solidarity. The statutory nature of national health insurance has provided the state with the authority to intervene in the health sector. In addition, corporatism has granted the state the institutional means to direct policy in the health sector itself. The government can impose public obligations onto corporatist associations that require them to implement policy on its behalf in the health care system. Thus, in mandating competition on the payers' side, the state has limited the ability of the sickness funds from pursuing competitive strategies that would deprive the poor and sick of access to comprehensive benefits. The statutory and corporatist nature of German health care, then, has not merely constrained the state but has also allowed it to shape the course of health care reform, even if through less obtrusive means.

THE UNITED STATES: THE TRIUMPH OF “UNMANAGED COMPETITION” AND THE DEFEAT OF SOLIDARITY

A. Problems of Access and Cost-Shifting in a Voluntary Health Insurance System

Germany had already solved the problem of universal access through its statutory insurance system. For German policymakers, the problem was to contain health care costs without sacrificing existing solidarity. In the U.S., by contrast, policymakers faced a much more formidable task of simultaneously solving the twin problems of rising health care costs and severe gaps in coverage.

The double problem of rising costs and inadequate access was inherent in the configuration of the American health care system itself. The American health care system typifies a liberal welfare state in which social provision is made through the private market or through limited social insurance programs (Esping-Andersen 1990). Most Americans obtain health care coverage through their place of work on a voluntary basis: either as a fringe benefit negotiated by their labor union or as a result of an employer's decision to offer insurance. Those unable to obtain insurance through an employer have the option to buy individual policies in the private market, though these tend to be prohibitively expensive. Many private insurers refuse to cover persons with existing medical conditions (Bodenheimer and Grumbach 1994; Stone 1993). Public insurance programs, in which the federal government acts as payer, cover only certain defined categories, such as Medicare for the elderly and disabled and Medicaid for the poor, or programs for federal employees and the armed forces.

The absence of a universal health care program meant that many Americans went without coverage.¹⁷ Their access to treatment for non-acute conditions was effectively rationed by their ability to pay. As a consequence, they were generally limited to emergency care in hospitals. However, the cost of such care was subsidized largely by employers who provided insurance for their workers. Providers who received low reimbursements from government insurance programs or who cared for the uninsured as charity cases were able to recoup their losses by charging patients with private insurance higher fees. Insurers, in turn, passed on their cost increases to employers through higher premiums for their employees. Thus, an elaborate but largely hidden cost-shifting game was being played, but with only some employers footing the bill (Reinhardt 1992). This cost-shifting game did not arouse too much complaint from employers as long as the economy kept growing and American businesses were shielded from the effects of competition.

Broader changes in the American labor market, however, exposed the shortcomings of the voluntarism of employment-based insurance and aggravated the cost and access problems in the health care system. As the manufacturing sector declined, so did the number of unionized jobs providing fringe benefits. Many of the new jobs created in the U.S. since the 1970s offered only subcontracted, temporary, or part-time work without fringe benefits (Freeman 1996). The use of contingent labor was a key way for firms to keep their labor costs down and compete in the market on the basis of price. But this left firms that provided insurance coverage at a disadvantageous position relative to those that did not, particularly with the intensification of competition in the 1980s. Indeed, employers' insurance premiums rose 90 percent between 1987 and 1993 (Cooper and Schone 1997, 142). Naturally, these firms became less willing to continue to subsidize the care of the uninsured.

¹⁷. The proportion of uninsured Americans had declined throughout the 1960s, 1970s and the 1980s, and had bottomed out at 12.8 percent (31 million persons) in 1988. The decline in the uninsured was due to expansions of Medicare, Medicaid and employer-based insurance during that period. However, the downward trend began to reverse itself in the late 1980s, so that by 1992, the number of uninsured stood at 15 percent of the population (39 million persons) (Banks et al. 1994, 19).

B. The Reform Path: From Social Insurance and Regulated Competition to “Unmanaged Competition” and Market Segmentation

The Clinton administration’s Health Security Plan, unveiled in the autumn of 1993, tried to correct all of the problems of the health care system at once. Clinton’s strategy was a government-led attempt to introduce national health insurance and shape market forces in health care. First, the Clinton plan mandated all firms to provide insurance, with government subsidizing the costs of insurance for small firms or those individuals unable to obtain insurance through the workplace. By pooling all risks within a national insurance system, Clinton hoped to solve the access problem and eliminate cost-shifting by firms that did not provide insurance to those that did.

Second, Clinton believed that injecting market competition into the health care system would have reined in health care costs. To encourage competition, the Clinton plan required that all subscribers be offered a choice of at least three different types of plans. Clinton pinned his hopes for cost containment on the growth of managed care plans, particularly more restrictive health maintenance organizations, or HMOs.¹⁸ HMOs would have been attractive to many patients because of their lower costs, and presumably would have forced traditional indemnity plans to keep their costs in line or charge patients more for such “extras” as choice of provider and additional benefits.

But the Clinton plan required significant regulation of the insurance market, or “managed competition,” through government entities to ensure equitable access to care. Unregulated competition would only have destroyed access, particularly for the most vulnerable groups in society (Enthoven 1988, 1993; Starr 1994). Facing severe competitive pressures, insurers would have been sorely tempted to intensify their existing strategies of attracting only healthier, wealthier patients and avoiding sicker, poorer patients (known as “cream-skimming”). Thus, the Health Security plan required states to establish health alliances on a regional basis to ensure that small businesses and individuals had access to affordable insurance. Large firms, however, could constitute their own alliances. State governments would have had the authority to enforce budgetary controls over regional alliances and health plans, regulate premium increases, and help smaller market players band

¹⁸ HMOs have achieved lower costs than traditional insurers for a number of reasons. The most important one is that HMO hospital admission rates are lower, and their hospital lengths of stays shorter, than those of traditional insurers. In addition, HMOs employ a variety of monitoring techniques to control patient access to specialist physicians and to monitor hospital and specialty care. Finally, many HMOs employ fixed prospective payment of providers. If providers’ treatment costs exceed payment, they must absorb the loss.

together into larger purchasing cooperatives in order to increase their market power vis-a-vis insurers and providers. Alliances would have also monitored plans to prevent them from cream-skimming.

The president's plan granted new powers not only to the states but to the federal government in order to ensure universal access and cost containment. The Health Security Act would have legislated a minimum comprehensive benefits package for all plans to offer under national health insurance. Further, a National Health Board, with members appointed by the President, would have possessed wide-ranging powers to regulate alliances and health plan and to mandate additional benefits. Because the Clinton administration doubted that market forces alone could control costs, it provided the federal government with the means to enforce a global budget cap: the National Health Board would have had the authority to limit premium increases to the rate of inflation (White House Domestic Policy Council 1993, 82, 105-109; Starr, 1994).¹⁹

While Clinton's effort to introduce national health insurance came to an inglorious end, this did not mean that health care reform was dead. On the contrary, transformation of the health care system has continued apace at breathtaking scope and speed. But rather than the federal government leading the charge in actively shaping and regulating the market, private actors—employers in particular—have taken control of the reform process. As employers' drive to contain their own costs has become the overriding aim of health care reform, the goal of universal coverage has fallen by the wayside. Opting to “go it alone,” many employers have chosen to contain their health insurance costs by encouraging competition among managed care plans and providers. Under pressure from employers to hold the line on premiums, managed care plans have become increasingly aggressive with doctors and hospitals, forcing them to slash their costs by negotiating steep price discounts or

¹⁹ Here, Enthoven and Clinton parted company on the role of government. Enthoven believed that competition alone could have ensured cost containment and that a budget cap was unnecessary.

Gaiimo 28

capitation arrangements (Gaiimo 1996).²⁰ Many employers have even banded together in voluntary purchasing cooperatives, somewhat along the lines envisioned by the Clinton plan, to gain leverage over providers and insurers. Other firms have narrowed employees' choice of insurer or provider by forcing them into less expensive HMOs.

But the go-it-alone approach is a broad canopy that provides employers with a range of cost-cutting strategies beyond using market competition. Indeed, many firms have shifted a greater share of the costs of insurance onto their employees by forcing them to pay higher premiums or copayments or by limiting the range of benefits in health insurance plans they provide. Still others have sought to confine their risks to their own immediate workforce through a self-insurance strategy and thereby avoid co-optation into states' efforts to expand coverage for the uninsured. Finally, firms continue to exercise the ultimate exit option by refusing to offer insurance at all. These go-it-alone strategies point in the direction of desolidarity (Gaiimo 1996).

²⁰ For an excellent survey of recent managed care developments, see Wilkerson, Devers, and Given, (eds.), 1997, esp. chap. 1 and conclusion chapter. The editors point out that while managed care plans have a long history, the phenomenon of intensified price competition among these health plans is a recent development. For an earlier discussion of employers' go-it-alone strategies of cost containment, see Gaiimo, 1996.

American employers' use of market forces as a cost containment strategy is best characterized as "unmanaged competition" which has proceeded in the absence of an effective regulatory framework that would prohibit or compensate for market failures (Giaino 1996). Under pressure from employers to rein in their premiums, insurers face strong incentives to intensify their cream-skimming practices or to ration care to patients, sometimes in questionable ways.²¹ Federal and state controls over managed care plans' practices are piecemeal, weak, or nonexistent. Where government action has occurred, it has largely taken the form of incremental regulation of the insurance market to foster competition, as with federal and state oversight of mergers (Given 1997), or to make it conform to the dictates of the larger economy. Or, under pressure from consumers and provider groups, governments have introduced limited consumer protection and regulation of employers' and insurers' practices at the state level. Thus far, however, a comprehensive framework of national regulation that would apply to all employer plans is absent.²²

^{21.} While HMOs tend to have a good track record in providing appropriate care for those who are younger and healthier, evidence is mixed as to whether they provide appropriate care for those with chronic conditions. Studies have shown that HMOs and traditional indemnity plans provide roughly comparable quality of care for chronic diseases, though some studies showed less adequate care by HMOs, particularly for those with mental health problems (Miller and Luft 1994, 1516). HMOs save money by restricting access to specialists or expensive treatments. Thus, in a highly competitive market, they could be tempted to engage in hidden rationing of such care to keep costs down. But quality of care is notoriously difficult to measure. Given the weaknesses of such measures, the issue of rationing becomes more uncertain and politically charged.

^{22.} A prime example of piecemeal regulation is the 1996 federal law mandating a 48-hour hospital stay for mothers who

give birth. To halt the proliferation of such piecemeal legislation for discrete diagnoses, Clinton attempted more systematic regulation of HMOs by appointing a panel, the Advisory Commission on Consumer Protection and Quality in the Health Care Industry, to investigate the managed care industry, assess the need for federal regulation of private insurance, and draft a bill of rights for consumers (Robert Pear, "Clinton Names Panel to Draft Health Consumer Bill of Rights," *New York Times*, March 27, 1997, p. A29). But the failure of Clinton's quality commission to recommend federal legislation to mandate consumer protection for patients in HMOs means that much of the employment-based insurance market will remain exempt from any effective regulation (Pear, "Health Panel Declines to Endorse Laws for Patients' Bill of Rights," *New York Times*, March 13, 1998, p. A1). A number of bills also before the Congress would offer comprehensive consumer protection and procedures for appeal of HMOs' denials of care (Robert Pear, "Congress Weighs More Regulation on Managed Care," *New York Times*, March 10, 1997, p. A1). But their fate is uncertain, given the Republican majority in Congress and the quality commission's timidity on the question of legal regulations.

The Health Insurance Portability and Accountability Act of 1996 (also known as the Kassebaum-Kennedy Act) best illustrates the government's market-promoting action. While the law bars insurers from denying coverage to new employees who have preexisting medical conditions, it provides only modest protection against the workings of the insurance market. For example, the law does not guarantee that individual policies will be affordable and it allows for a waiting period before workers with preexisting medical conditions can obtain coverage. And since the law only addresses those already in the labor market rather than extending to those outside it who lack insurance, it does not approach anything like universal coverage.²³ The law's market-conforming elements are evident in its attempt to accommodate employer concerns with labor immobility ("job-lock") by making it easier for employees with preexisting conditions to switch to new jobs without fear of losing insurance. But even here, the law does not go far enough, since it does not force employers to offer insurance in the first place. And because the law does not guarantee that insurance will be affordable, sicker workers may find the waiting period an insurmountable barrier to seeking out different employment. Not surprisingly, the law is popular with many employers, since its provisions target insurers and individuals rather than firms. Indeed, the law contains no employer mandate, and it allows individual policies to substitute for group insurance.

C. The Dilemmas of Reform in a Voluntary Health Care System

²³. Adam Clymer, "Accord Reached on Expanding Workers' Health Benefits," *New York Times*, August 1, 1996, p. D22; Adam Clymer, "House Backs Bill Granting Workers Portable Benefit," *New York Times*, August 2, 1996, p. A1; Fuchs et al. 1997; Todd S. Purdum, "Clinton Signs Bill to Give Portability in Insurance," *New York Times*, August 22, 1996, p. B12.

Giaimo 32

How can one explain the American reform path, which began as an ambitious attempt to create a new branch of social insurance but which ended up as an atomistic, “every-firm-for-itself” strategy? Explanations of the Clinton plan’s failure abound,²⁴ and it is not my intention to provide a detailed analysis of the legislative process. However, the nature of the American health care system provides much of the explanation for both the Clinton plan’s failure and the subsequent reform path of unregulated market competition and employers’ “go-it-alone” approaches. In brief, because employers were major actors in financing insurance, they consequently carried important weight in debates over health care reform. Indeed, the Clinton plan itself was heavily influenced by policy legacies,²⁵ relying as it did on existing employment-based insurance as its foundation for national health insurance. But this only magnified the role of employers in the legislative outcome surrounding Health Security. At the same time, the voluntarism of employment-based insurance shaped how firms defined the health care problem, allowed them multiple ways to pursue their goal of lower labor costs, and made it that much more difficult for their political associations to forge a common position toward the Clinton plan. Finally, the extremely limited institutional linkages between government actors and the health care system blocked policymakers’ subsequent efforts to regulate or shape the course of employer-led market reform.

First, existing health sector arrangements strongly influenced Clinton’s choice of reform strategy. That strategy, in turn, magnified the pivotal role of employers in the legislative process. Because Clinton calculated that his national health care effort would fail unless it had the support of key health care system stakeholders, particularly employers and private insurers, he opted to not fundamentally transform the employment-based financing of insurance with a state-financed or -provided health care system.²⁶ However, in basing the financing of national insurance on employers, the survival of the Clinton plan depended on the support of the business community, which proved unable to deliver.

^{24.} Among the good, albeit fragmentary, early analyses on the Clinton Plan’s failure are *Health Affairs* 14 (1) (Spring 1995); *Journal of Health Politics, Policy and Law* 20 (2) (Summer 1995); Mann and Ornstein (eds.) (1995); and Aaron (ed.) (1994). See also Manow and Giaimo (1995). Skocpol (1996) provides a comprehensive treatment of the politics and legislative process behind the Clinton Plan.

^{25.} Pierson (1994) has demonstrated how policy legacies have constrained government choices in welfare state reform.

^{26.} **A national health service like Britain’s would have had the additional disadvantage of expanding the federal budget during a period of record budget deficits.**

Second, the position of employers in the health care system shaped the ways in which they defined the health care problem, and their position toward the Clinton plan. Many firms saw the health care problem as one of labor costs. But they saw the link between health insurance and labor costs differently. Many employers who already provided insurance saw the labor cost problem rooted in the free-riding of their colleagues who did not offer coverage. The former thus saw the answer to their labor cost problem in the Clinton plan's employer mandate, which would have spread the costs of insurance to all firms. Other firms, however, viewed the Clinton plan in the opposite terms.

Many small businesses liked the voluntarism of the health insurance system because it gave them the freedom to not provide insurance. For them, the exit options that the voluntary system provided them allowed them to keep their labor costs down to competitive levels. As a result, the vehemently opposed to the Clinton plan on the grounds that it would saddle them with prohibitively high labor costs. But employer opposition was not simply a question of large versus small businesses, or firms already providing insurance against those that did not, though such fault lines did exist. The divisions within the business community were more complex and involved different perceptions of risk and calculations of costs.²⁷ Some firms already providing insurance did not support the Clinton plan because it would have forced them to subsidize insurance for smaller firms. Larger firms feared that state alliances able to exert muscle in the marketplace would negotiate better deals from insurers and leave them with higher premiums (Martin 1995b). These firms believed they could better control their own costs by "going-it-alone."

Aside from its effects on labor costs, national health insurance hit a nerve with many employers because it involved basic questions of corporate autonomy. Some employers—and they were not just small businesses—opposed Clinton's national insurance proposal on more ideological grounds concerning the proper reach of the state in corporate governance. They believed that the employer mandate would have encroached upon their freedom to decide on insurance coverage for

²⁷. On risk pooling and social insurance, see Baldwin (1990).

Gaiimo 34

their employees, and feared national insurance as an entering wedge for further government intrusion into other areas of corporate governance (Judis 1995).²⁸

²⁸. On business attitudes toward the Clinton plan and employer mandates, see Martin (1995a, 1995b). On their actions in the legislative process, see Judis (1995); Adam Clymer, Robert Pear and Robin Toner, "For Health Care, Time Was a Killer," *New York Times*, 29 August 1994, p. A1, A8-9; Jurek Martin, "Business Snubs Clinton Health Bill," *Financial Times*, 4 February 1994, p. 5; Robin Toner, "Autopsy on Health Care," *New York Times*, 27 September 1994, pp. A1-cf.

Third, the multiple go-it-alone strategies of cost containment that the health sector offered employers only aggravated the business community's organizational weakness in the political arena and made it all but impossible for its peak associations to rally their members around a common line toward the Clinton plan. Unlike German employers, American firms have a number of competing voluntary-membership associations to represent them in politics. Such organizational fragmentation makes the task of forging a common policy line formidable even on relatively uncontroversial issues. But on the question of national insurance, the financial survival and corporate freedom of individual firms was at stake.²⁹ Coupled with the multitude of cost containment strategies that the voluntary insurance system gave to employers, business leaders found it impossible to unify their rank and file around the Clinton plan. Indeed, those business associations whose leaders supported the Clinton plan found themselves facing defections of members to rival associations that did not. To staunch the loss of members to rivals, these associations' leaders felt that they could not, in the end, support the president's plan for national insurance.³⁰

Finally, because the health care system denies government actors anything more than tenuous and incomplete links to employers and insurers, employers have been largely free to pursue an unregulated market strategy of cost containment that further erodes the already shaky foundation of equitable health care financing. Lacking the statutory authority to set the parameters of a

^{29.} Employers' attitude toward the Clinton plan resonates with Vogel's (1978) observation that businesspeople rarely do not think in terms of their class interests, but instead identify with the interests of their individual firm. Many employers will resist government action that could help capitalism as a whole because they see such policies as a threat to the individual firm.

^{30.} Thus, even though the leaders of major employers' associations, such as the Chamber of Commerce, favored the Clinton plan, they could not force member firms to commit to such a course of reform. Instead, they found their position undercut by rival associations, such as the National Federation of Independent Business (NFIB), which represented small business and opposed national health insurance. Faced with defections of its members to the NFIB over this issue, the Chamber reversed its earlier support for the Clinton plan (Judis 1995).

Gaiamo 36

voluntaristic health care system, Clinton could not impose a solution on employers. Instead, he had to rely on persuasion to get them to support his plan. And that support was not forthcoming.

In addition, federalism's perverse division of government jurisdiction over employment-based insurance has stymied policymakers' efforts to shape the course of health care reform since the Clinton plan's demise. In general, the division of labor between federal and state officials is clear: states are responsible for regulating private insurance while the federal government regulates public plans (such as Medicare and Medicaid). The federal government has some indirect leverage over private plans to the extent that the latter choose to adopt regulations that apply to public insurance. But the boundary between federal and state regulation has worked at cross-purposes and has undercut the authority of either one to effectively curb the excesses of market competition in the employment-based insurance sector. The most glaring example of this is the federal pension law, the Employee Retirement and Income Security Act (ERISA). The law bars states from regulating health insurance plans set up by employers (known as self-insured plans). This exemption from state regulation has stymied state efforts to expand access to the uninsured through state-sponsored risk pools. Many employers have chosen to self-insure their workforce to avoid cooptation into such risk pools. And because Washington has generally left regulation of private insurance plans to the states, an effective federal regulatory framework over self-insured plans is absent. As more firms choose to self-insure, increasing numbers of workers lack any effective regulatory protection in their dealings with health insurance plans.³¹

Employers' reform through market competition and go-it-alone strategies thus has a number of serious implications for both the equity and costs of health care. Such cost-containment approaches only segment the market further and threaten what little solidarity there is in the American health care system. Indeed, the current trend shows the number of uninsured growing as employers—willingly or otherwise—exercise their exit option and refuse to offer coverage. Evidence suggests that even when employers do offer coverage, many workers in low-wage jobs find their incomes too meager to afford their share of the premium and other associated costs of employment-based insurance

³¹. After the Clinton plan's failure, many expected that state governments would act as laboratories for universal coverage. But state efforts have had only limited success here, not least because of the obstacles posed by ERISA. For an overview of various limitations on states, see Grogan (1995). On ERISA, see Chirba-Martin and Brennan (1994), O'Keefe (1995), and Polzer and Butler (1997). Were the federal government to legislate national regulations over private insurers, this would go some way in filling the regulatory vacuum for self-employed plans.

(Cooper and Schone 1997). The situation for employees who are insured has also deteriorated. Many of them find their employers shifting to them an increasing share of health care costs through higher premiums and copayments and restricted scope of coverage.

Such strategies point to one of three possible scenarios. One possibility is that the health care cost spiral will reassert itself, as insurers raise premiums to recover profits after years of belt-tightening. A second possibility is that larger market players, such as big HMOs and employer purchasing groups, will succeed in shifting the costs of uncompensated care to smaller market players. But their success in doing so will aggravate the uninsured problem, as small firms and individuals find themselves forced to shoulder the cross-subsidy and are priced out of the insurance market by exorbitant premiums. Under the third and worst-case scenario, employers' and managed-care plans' cost-cutting actions, combined with spending cuts in public insurance programs, will effectively destroy the cross-subsidy for the uninsured. Starved of funds to cover the costs of care for these people, the public hospital system—the providers of “last resort” for the most vulnerable populations—will face financial ruin and disintegration.³² Thus, absent effective public intervention, the ultimate logic of an employer-led market strategy in a system of voluntary insurance threatens not only the cost containment goals of individual firms, but also the survival of the health care system itself.

D. Summary

In the U.S., Clinton's ambitious attempt to create a new branch of social insurance ended in failure because it could not win the support of key health care stakeholders. Employers held the trump card in Clinton's game, since they were the foundation of his national insurance scheme. But

³² Early indications suggest that health care costs are likely to rise sharply in 1997 as insurers try to recoup years of lean profits and as the threat of national insurance recedes. Employers may see double-digit premium increases in 1997 (Milt Freudenheim, “Health Care Costs Edging Up and a Bigger Surge Is Feared,” *New York Times*, January 21, 1997, p. A1, D20). For evidence of the worst-case scenario and the threat to the public hospital system, see *Los Angeles Times* series (October 1995). Others offer a somewhat more sanguine picture, predicting that while public hospitals may survive, they will be chronically underfunded as large employers and insurers effectively shift the burden of cross-subsidy onto smaller insurers and firms (Reinhardt, 1995a). But even under this less dire scenario, the numbers of uninsured will continue to grow, as small firms' premium increases are so high as to price them out of the insurance market, leading them to limit or drop coverage, or as persons continue to find individual policies beyond their financial reach. Reinhardt (1995b) notes that the number of Americans insured their employer has been shrinking at an annual rate of almost one percent per year, and that by the year 2000, estimates are that only 50 percent of workers will receive health insurance from their job. (His sources on the uninsured are the U.S. Census and the employee Benefit Research Institute.)

Gaiamo 38

the business community proved unable to support the president because too many firms had a stake in the existing health insurance system, which allowed them to pursue a variety of go-it-alone in controlling their labor costs, even to the point of not offering insurance at all.

Employers have thus chosen to lead the way in health care reform through the market. But they—and, to a lesser extent, private insurers—have been largely immune from government regulation of their methods. Unlike Germany, where statutory national insurance sets limits to employers' or sickness funds' cost containment strategies, and where the government has the authority to regulate the actions of public-law bodies, American firms can choose to not provide insurance at all. And whereas in Germany, a statutory benefits catalog requires that employers and sickness funds provide all medically necessary services, U.S. employers and insurers can decide both the level of coverage and the degree of cost-sharing by patients. **Also in contrast to Germany, unions or employee representatives do not act as an effective counterweight since they are largely uninvolved in decisions on financing or in the actual administration of employee benefits.**³³ Absent effective government regulation to limit the damage of market competition, many employees find their choice of insurer and provider significantly narrowed, while health insurance remains beyond financial reach for the most vulnerable groups in the population.

CONCLUSION

The German and American health care reform cases highlight the different ways in which countries have grappled with two critical goals of social policy in recent years but within the context of employment-based welfare provision. One of the goals has been to contain welfare state costs so that they do not impose ruinous labor costs on firms. Otherwise, a vicious cycle may ensue: as firms refuse to hire costly new workers, unemployment rises, and the social insurance system faces the double-bind of financing benefits (not just unemployment insurance but also pensions and health care) from a shrinking financial base of fewer workers. The second goal has been to ensure that welfare state cost containment does do not erode equitable financing of and access to necessary services and

³³. The exceptions are cases in which unions negotiate with employers on the terms of health insurance and fringe benefits, or in which unions run their own health insurance or pension plans. But since unions cover only 15 percent of workers (and only 10 percent of private-sector workers) (Freeman 1996), employees do not have anywhere near the influence in matters of insurance that their counterparts have in Germany.

benefits, and that the burden of adjustment does not fall disproportionately onto more vulnerable groups in the population.

Both Germany and the U.S. have used market competition within the welfare state as an instrument of cost containment. But their health care markets look very different, and as a result, have had very different implications for equity. The crucial difference is whether the state or private actors lead the way in health care reform and set the parameters of market competition. In Germany, state actors have led the way not only in health care reform in general, but in shaping the contours of the market in particular. The statutory nature of health insurance has provided the state with the authority—as well as the public expectations—to set the parameters of the health care system and to ensure universal access to necessary care, regardless of ability to pay. Further, corporatism has provided the state the means to intervene and shape market reforms: the state has had at its disposal the instruments of framework legislation with which to specify policy goals, while the public-law status of health care associations means that they are legally bound to implement public policies and their activities are subject to government regulation. As a result, the Kohl government has been able to set the rules of market competition, and require health care actors to abide by them, in ways that do not destroy solidarity.

In contrast to their German counterparts, American policymakers have enjoyed no such authority or leverage to lead the way in health care reform or to shape the contours of the market. The voluntary nature of employment-based insurance limited the Clinton administration's leverage over a large chunk of the health insurance sector. Moreover, the perverse and conflicting jurisdictional lines between federal and state authorities have blocked effective government regulation of the health care market since the Clinton plan's defeat. Government actors' regulation of the market has been piecemeal, reactive, and more often market-promoting than market-hindering. Employers and insurers have had relatively free rein to segment the market and pursue other cost containment strategies that point to further erosion of what little solidarity there is in the American health care system.

The German and American health care reform experiences suggest further differences in the conception and purposes of markets. Many neoliberal economists (particularly in the US) assume a zero-sum trade-off between the goals of efficiency and equity, and commonly conceive of markets as only furthering the cause of efficiency. Inequities are a natural but unavoidable byproduct of

Gaiamo 40

market competition, and any state action to prevent or redress such inequalities will inevitably mean interference in the workings of the market and a consequent reduction of efficiency. However, the German case of health care reform shows that markets can in practice serve *both* efficiency and equity goals. Competition among sickness funds for patients was not only intended to induce funds to be more responsive and efficient, but was also meant to extend blue-collar workers the same rights of choice as those long enjoyed by white-collar workers. The financial risk-adjustment scheme not only was a device to lay the groundwork for fair competition among funds but has also worked to equalize contribution rates among richer and poorer, healthier and sicker people. The German market in health care thus is a “socially bounded market” one that attempts to achieve both efficiency and equity, and that is hemmed in by a statutory guarantee of universal access.

The two countries’ health care reform experiences also provide important insights into the role of employers in welfare state reform. While employers everywhere are likely to favor low labor costs, their position in the welfare state provides them with different options to achieve this. German employers have had a much narrower menu of cost-cutting options from which to choose than have their American colleagues. German firms have faced a strong employee counterweight in health insurance administration and the statutory requirement to finance insurance on a parity basis with employees. For these reasons, employers have made only limited headway in shifting the burden of financing health care onto employees. In the U.S., by contrast, employers have been in a far more powerful position to dictate the terms of health insurance. The decision to provide insurance remains employers’ discretion. And employees have not been an effective counterweight to employer efforts to shift costs onto them, given the weakness of unions and the lack of an institutionalized role in administering health insurance. Nor have government actors provided much of a countervailing force to employers’ cost-cutting strategies. Moreover, the German and U.S. cases demonstrate that not all employers see the welfare state as their enemy. Indeed, German employers have seen their role in the social insurance system as a valuable instrument to gain leverage over labor costs, while many American firms saw the national insurance route as the solution to their cost problems.

Finally, the health care reform experiences of the Federal Republic and the United States demonstrate the interdependence between welfare state reform and firms’ broader strategies of economic adjustment. Many American businesses compete on the basis of price, and providing low wages and refusing to offer fringe benefits—including health insurance—has allowed them to do so.

The danger, however, is that this strategy will result in a slow erosion of employment-based welfare capitalism, with no statutory national health insurance program to replace it.

German firms, by contrast, have long competed on the basis of high-quality goods in niche markets. That strategy underwrote high wages and a generous welfare state (Streeck 1995). Today, however, German firms argue that they must also compete on price as well as quality. But the institutional legacy of generous social insurance financed out of equal shares of employer-employee contributions makes an adjustment strategy based on rock-bottom labor costs more difficult to pursue than in the U.S.

Germany thus faces difficult choices in welfare state reform.³⁴ As the recent health care reform debate indicates, there may be possibilities for more solidaristic financing of social insurance, such as finding new revenue sources beyond wages and salaries. But less solidaristic alternatives are also possible, as the higher copayments for health insurance indicate. Alternatively, policymakers might opt for “creeping privatization,” by restricting the menu of statutory benefits and allowing wealthier people to buy supplementary coverage in the name of greater choice. However, as long as the statutory menu of benefits remains comprehensive (i.e., all medically necessary services covered), universal, and protections are made for vulnerable groups, the possibility for arriving at a socially acceptable balance between cost containment and equity exists.

The debate over the future financing and comprehensiveness of statutory health insurance mirrors the broader debate on the future of the welfare state in Germany. Policymakers there face difficult choices in attempting to fashion a socially acceptable compromise that reconciles the goal of welfare state cost containment with equitable provision. But if the recent health care reform experiences are any indication, the chances of Germany striking a better balance between the two goals are much better than those in the U.S.

³⁴ See, for example, KAG 1997, chap. 4, on the various proposals for financing health insurance.

REFERENCES

- Aaron, Henry (ed.) (1994). *The Problem that Won't Go Away*. Washington, DC: The Brookings Institution.
- Baldwin, Peter (1990). *The Politics of Social Solidarity*. Cambridge, MA: Cambridge University Press.
- Banks, Dwayne, Kimberly Kunz, and Tracy Macdonald (1994). "The Uninsured." In Banks, Kunz, and Macdonald (ed.) *Health Care Reform*, Berkeley, CA: Institute of Governmental Studies, pp. 17-26.
- Bodenheimer, Thomas and Kevin Grumbach (1994). "Paying for Health Care." *Journal of the American Medical Association* 272 (8) 24/31 August, 634-639.
- (BMG) Bundesministerium für Gesundheit. Pressemitteilung ("Bundestag bestätigt Richtungsentscheidung im Gesundheitswesen") June 12, 1997.
- Chirba-Martin, Mary Ann and Troyen A. Brennan (1994). "The Critical Role of ERISA in State Health Reform." *Health Affairs* (13) Spring II, 142-156.
- Cooper, Philip F. and Barbara Steinberg Schone (1997). "More Offers, Fewer Takers for Employment-Based Health Insurance: 1987 and 1996." *Health Affairs* 16 (6): November/December, 142-149.
- Dienst für Gesellschaftspolitik*. February 20, 1997. 7-97.
- Döhler, Marian (1991). "Policy Networks, Opportunity Structures and Neo-Conservative Reform strategies in Health Policy." In Bernd Marin and Renate Mayntz (eds.) *Policy Networks: Empirical Evidence and Theoretical Considerations*. Frankfurt-am-Main: Campus, 235-296.
- Döhler, Marian and Philip Manow-Borgwardt (1991). "Korporatisierung als gesundheitspolitische Strategie." MPIFG Discussion Paper 91/9. Cologne: Max-Planck-Institut für Gesellschaftsforschung, October 1991.
- Enthoven, Alain C. (1988). "Managed Competition: An Agenda for Action." *Health Affairs* 7 (3): 25-47.
- _____ (1993). "The History and Principles of Managed Competition." *Health Affairs* (Supplement 1993) 24-48.
- Esping-Anderson, Gosta (1990). *The Three Worlds of Welfare Capitalism*. Princeton: Princeton University Press.
- Financial Times*, various.
- Frankfurter Allgemeine Zeitung* (FAZ), various, 1995-1996.
- Frankfurter Rundschau*, various, 1996.
- Freeman, Richard B. (1994). "How Labor Fares in Advanced Economies." In *Working Under Different Rules*. New York: Russell Sage Foundation, 1-28.

- Fuchs, Beth C., Bob Lyke, Richard Price, and Madeleine Smith. (1997). *The Health Insurance Portability and Accountability Act of 1996: Guidance on Frequently Asked Questions*. CRS Report for Congress. Washington, DC: Congressional Research Service, The Library of Congress. Updated April 10, 1997.
- Gaiimo, Susan M. (1994). *Health Care Reform in Britain and Germany: Recasting the Political Bargain between the State and the Medical Profession*. Ph.D. Dissertation, Department of Political Science, University of Wisconsin-Madison.
- _____. (1995). "Health Care Reform in Britain and Germany: Recasting the Political Bargain with the Medical Profession." *Governance* 8 (3): July, 354-379.
- _____. (1996). "Health Care Reform in Britain and Germany: Lessons for the United States." Paper presented at the Robert Wood Johnson Foundation Scholars in Health Policy Research Program Meeting, Aspen, CO, 29 May-2 June 1996.
- Gaiimo, Susan and Philip Manow (1997). "Welfare State Adaptation or Erosion? The Case of Health Care Reform in Britain, Germany, and the United States." Paper presented at the American Political Science Association Annual Meeting, Washington DC, August 28-31, 1997.
- Given, Ruth S. (1997). "Ensuring Competition in the Market for HMO Services." In John D. Wilkerson, Kelly J. Devers, and Ruth S. Given (Eds.), *Competitive Managed Care*. San Francisco: Jossey-Bass, 167-197.
- Grogan, Colleen (1995). "Hope in Federalism: What Can the States Do and What Are They Likely to Do?" *Journal of Health Politics, Policy and Law* 20 (2): Summer, 477-484.
- Health Affairs* (1995). *Special Issue on Health Reform: Past and Future*. (Spring).
- Heilemann, Ulrich and Hermann Rappen (1997). *The Seven Year Itch? German Unity from a Fiscal Viewpoint*. AICGS Research Report No. 6, Economic Studies Program. Washington DC: American Institute for Contemporary German Studies.
- Henke, Klaus-Dirk (1997). "Sozial gebundener Wettbewerb als neuer Ordnungsrahmen im Gesundheitswesen." In Arbeitskreis Evangelischer Unternehmer in Deutschland e.V. (eds.) *Die Soziale Marktwirtschaft als Wirtschafts- und Werteordnung*. Kölner Texte u. Thesen 36. Cologne: Deutscher Instituts-Verlag, pp. 171-194.
- Hinrichs, Karl (1995). "The Impact of German Health Insurance Reforms on Redistribution and the Culture of Solidarity." *Journal of Health Politics, Policy and Law* 20: (3) Fall, 653-688.
- Journal of Health Politics, Policy and Law* (1995). *Special Section on The Failure of Health Care Reform*, 20 (2) Summer.
- Judis, John B. (1995). "Abandoned Surgery: Business and the Failure of Health Care Reform." *The American Prospect* (Spring) 2: 65-73.
- (KAG) Advisory Council for the Concerted Action in Health Care (Sachverständigenrat für Konzertierte Aktion in Gesundheitswesen) (1995). *Health Care and Health Insurance 2000: A Closer Orientation towards Results, Higher Quality Services and Greater Economic Efficiency. Summary and Recommendations of the Special Expert Report, 1995*. Bonn.

Giaimo 44

- _____. (1996). *The Health Care System in Germany: Cost Factor and Branch of the Future. Volume I: Demographics, Morbidity, Efficiency Reserves and Employment. Special Report 1996. Summary.* Bonn.
- _____. (1997). *The Health Care System in Germany: Cost Factor and Branch of the Future. Volume II: Progress and Growth Markets, Finance and Remuneration. Special Report 1997, Summary.* Bonn.
- Los Angeles Times*, October 1996.
- Mann, Thomas and Norman J. Ornstein (eds.) (1995). *Intensive Care: How Congress Shapes Health Policy.* Washington, DC: American Enterprise Institute/Brookings.
- Manow, Philip (1997). "Structural Characteristics and Potential Effects of Current Reforms in the German Health Care System." July. Typescript.
- Martin, Cathie Jo (1995a). "Nature or Nurture? Sources of Firm Preference for National Health Reform." *American Political Science Review* 89: (4) December, 898-913.
- _____. (1995b). "Stuck in Neutral: Big Business and the Politics of National Health Reform." *Journal of Health Politics, Policy and Law* 20: (2) Summer, 431-436.
- Miller, Robert and Harold S. Luft (1994). "Managed Care Plan Performance Since 1980: A Literature Analysis." *Journal of the American Medical Association (JAMA)*, 271 (19): May 18, 1512-1519.
- New York Times*, various.
- O'Keefe, Anne Marie (1995). "Will ERISA's Wall Come Tumbling Down?" *Business and Health*. February, 35-40.
- Organization for Economic Cooperation and Development (OECD) (1994). *The Reform of Health Care Systems: A Review of Seventeen OECD Countries.* Paris.
- _____. (1997). *OECD Economic Surveys: Germany 1996-1997.* "Reforming the Health Sector: Efficiency through Incentives," 67-117. Paris.
- Pfaller, Alfred, Ian Gough, and Goran Therborn (1991). "The Issue." In *Can the Welfare State Compete? A Comparative Study of Five Advanced Capitalist Countries.* London: Macmillan, pp. 1-14.
- Pierson, Paul (1994). *Dismantling the Welfare State? Reagan, Thatcher, and the Politics of Retrenchment.* Cambridge and New York: Cambridge University Press.
- Polzer, Karl and Patricia A. Butler (1997). "Employee Health Plan Protection under ERISA." *Health Affairs* 16 (5): September/October, 93-102.
- Reinhardt, Uwe (1990). *West Germany's Health-Care and Health-Insurance System: Combining Universal Access with Cost Control.* Report prepared for the United States Bipartisan Commission on Comprehensive Health Care, August 30, 1989. Revised June 25, 1990.
- _____. (1992). "The United States: Breakthroughs and Waste," *Journal of Health Politics, Policy and Law* (Winter), 637-666.

- _____ (1995a). "Turning Our Gaze from Bread and Circus Games." *Health Affairs* 14 (1): Spring 33-36.
- _____ (1995b). "Why Doctors Will Take Back Health Care." Interview with Uwe Reinhardt by Stephen Murata. *Medical Economics*, 72 (24): December 26, 1995, 72-87.
- Skocpol, Theda (1996). *Boomerang: Clinton's Health Security Effort and the Turn against Government in U.S. Politics*. New York: Norton.
- Der Spiegel*, various.
- Starr, Paul (1994). *The Logic of Health Care Reform: Why and How the President's Plan Will Work*. New York: Penguin /Whittle Books.
- Stone, Deborah A. (1980) *The Limits of Professional Power: National Health Care in the Federal Republic of Germany*. Chicago: University of Chicago Press.
- _____ (1993). "The Struggle for the Soul of Health Insurance." *Journal of Health Politics, Policy and Law* 18 (2): Summer, 287-317.
- Streeck, Wolfgang (1995). "German Capitalism: Does it Exist? Can it Survive?" In Colin Crouch and Wolfgang Streeck (eds.) *Modern Capitalism or Modern Capitalisms?* London: Francis Pinter. February 1995 ms.
- Streeck, Wolfgang and Philippe C. Schmitter (1985). "Community, Market, State--and Associations? The Prospective Contribution of Interest Governance to Social Order." *European Sociological Review*, 1 (2): 119-138.
- Van Kersbergen, Kees (1995). *Social Capitalism: A Study of Christian Democracy and the Welfare State*. London and New York: Routledge.
- Vogel, David (1978). "Why Businessmen Distrust their State: The Political Consciousness of American Corporate Executives." *British Journal of Political Science*, 8: 45-78.
- Webber, Douglas (1989). "Zur Geschichte der Gesundheitsreformen in Deutschland--II. Teil: Norbert Blüms Gesundheitsreform und die Lobby." *Leviathan* 2: 262-300.
- _____ (1991). "Health Policy and the Christian-Liberal Coalition in West Germany: The Conflicts over the Health Insurance Reform, 1987-8." In Christa Altenstetter and Stuart C. Haywood (eds.) *Comparative Health Policy and the New Right: From Rhetoric to Reality*. Basingstoke and London: Macmillan.
- (WHDP) White House Domestic Policy Council.(1993).*The President's Health Security Plan: The Clinton Blueprint*. New York: Times Books.
- Wilkerson, John D., Kelly J. Devers, and Ruth S. Given (Eds.) (1997). *Competitive Managed Care: The Emerging Health Care System*. San Francisco: Jossey-Bass