

NEW AMERICA
FOUNDA T I O N

**LESSONS FROM CALIFORNIA'S HEALTH REFORM EFFORTS
FOR THE NATIONAL DEBATE**

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EXECUTIVE SUMMARY

In January 2007, Governor Arnold Schwarzenegger unveiled a comprehensive health care plan that aimed to provide quality, affordable health insurance to all Californians. Based on individual responsibility, the plan focused on prevention and wellness and emphasized a shared responsibility approach to financing.

After almost a year of negotiations between Governor Schwarzenegger and Democratic legislative leaders, compromise legislation with a framework and goals similar to the governor's original proposal passed the State Assembly with a large majority. This compromise legislation, however, was later rejected by the California Senate's Health Committee.

The effort to reform California's health care system faced several obstacles unique to the state. Californians seeking reform had a very narrow margin of error within a complex set of legislative, political, and demographic challenges. Health reform proponents also encountered several systemic roadblocks regarding affordability and sustainability common to health care reform proposals generally.

Nonetheless, the bipartisan spirit displayed by Governor Schwarzenegger and Assembly Speaker Núñez showed that Republicans and Democrats can work together to solve our nation's challenging health care crisis and proved that lawmakers can reach consensus without compromising core values. This bipartisan effort to cover all Californians united a broad coalition of advocates representing citizens, patients, workers, employers large and small, hospitals, insurers, and politicians.

While comprehensive health reform legislation was never signed into law, efforts to reform California's health system produced a number of lessons for the national health care debate and other states seeking to institute reforms. Among the most important: leadership matters, broad coalitions can be built and maintained, and the issues of affordability for families and sustainability for taxpayers must be satisfactorily addressed.

INTRODUCTION

While legislation to extend health care coverage to all Californians was never signed into law, the recent efforts in California hold lessons for the proponents of health care reform on the national level.

Despite strong leadership from the highest levels of government and key private-sector stakeholders, obstacles unique to California and systemic problems related to health reform efforts generally proved too difficult to overcome. Because of these barriers, health reform in California was always a long shot. However, the California experience demonstrated that thoughtful compromise within a coherent policy framework can attract broad support for comprehensive health reform.

CALIFORNIA'S REFORM EFFORT, 2007-08

In 2006, California's Republican Governor Arnold Schwarzenegger signaled an increasing willingness to have a serious conversation about covering all Californians. In December 2006, Assembly Speaker Fabian Núñez, a Democrat, and Senate President pro Tempore Don Perata, also a Democrat, introduced health reform legislation that relied heavily on employer financing. In January 2007, Governor Schwarzenegger released his plan to provide all Californians with quality, affordable health coverage under a system of individual and shared responsibility.

Throughout 2007, there was much debate between the governor and Democratic legislative leaders over shared financing and how to provide health coverage to all Californians. In a special fall session of the state legislature devoted to health care and water bonds, the governor worked with Democratic leaders to develop compromise legislation that addressed concerns with affordability and financing. On December 17, 2007, the California Assembly approved the compromise legislation by a vote of 46 to 31.¹

Governor Schwarzenegger joined Assembly Speaker Núñez and a host of health care advocates, policymakers, and stakeholders in an attempt to persuade the Senate to follow the Assembly's lead. On January 28, 2008, the Senate Health Committee rejected the proposed bill by a vote of seven to one, with three senators abstaining.²

Both the governor's initial proposal and the subsequent compromise legislation were similar in many respects to proposals put forward by federal lawmakers, other state lawmakers, and stakeholder groups elsewhere. Elements of the California plan may be found in the Massachusetts plan, the proposals of presidential candidates John Edwards, Hillary Clinton, and Barack Obama, and the plan offered by Ron Wyden (D-OR) and Robert Bennett (R-UT) in the U.S. Senate.³ Broad-based blue ribbon commissions in Colorado and Illinois have also recommended features of the California plan to policymakers in their own states in the last 14 months.⁴

California's compromise legislation¹ included the following elements commonly found in other health coverage proposals:

A new insurance marketplace. By requiring insurers to sell to all individuals regardless of health status, the legislation would have made private markets work for all Californians. In the context of a purchase mandate, this rule would have led to reduced underwriting and selling costs.

Sliding scale subsidies. The compromise legislation included sliding scale subsidies for families with incomes of up to 250 percent of the federal poverty level, or \$51,625 for a family of four. It also included sliding scale tax credits designed to limit premiums to 5.5 percent of income for individuals with incomes of up to 400 percent of the poverty level.

Expanded government insurance programs. The compromise legislation expanded income eligibility for both Medicaid (Medi-Cal) and the State Children's Health Insurance Program (SCHIP or Healthy Families in California).

An individual mandate. Once supported by sliding scale subsidies and insurance market reforms, all Californians would have been required to obtain either public or private health insurance coverage.

Efforts to reform the delivery system and enhance quality. The legislation required all health plans to offer a benefit package that included incentives linked to healthy behavior and chronic care management. It also encouraged the development and implementation of health information technology.

The compromise legislation passed by the California Assembly in December 2007 placed a unique emphasis on shared responsibility in its financing approach, as seen in the following elements:

Federal matching funds. The proposed plan included expanded coverage under Medi-Cal, California's version of Medicaid, and Healthy Families, California's SCHIP program. In addition, the plan increased Medi-Cal provider payment rates. Federal matching allotments and higher Medi-Cal reimbursements were central to the financing plan.

Hospital fees. Under the proposed plan, hospitals would have admitted greater numbers of insured patients in return for higher Medi-Cal reimbursement rates. In exchange for these provisions, the California Hospital Association agreed that hospitals would contribute four percent of gross revenues toward the health plan. Governor Schwarzenegger initially imposed a two percent gross revenue fee on physicians, but this proposal was met with intense opposition and dropped from consideration by the legislature.

Employer participation. All employers would have been required to participate in the health insurance market through a "pay or play" provision. Under this provision, employers could either offer health coverage to their workers (play) or be required to pay a sliding-scale fee of between 1 percent and 6.5 percent of their total payroll.

Tobacco tax. The compromise legislation required a \$1.75 cigarette tax hike.

Given California's budget rules, explained in greater detail below, the revenue provisions of the legislation would have been subject to public approval on the November 2008 ballot.

ACHIEVEMENTS OF THE CALIFORNIA EFFORT

While the effort to reform California's health system ultimately did not succeed, the attempt shows it is possible to foster the sort of cooperation and coalition building that will be necessary to pass health reform elsewhere.

Bipartisanship

The bipartisan spirit displayed by Governor Schwarzenegger and Assembly Speaker Núñez proved that leaders can cross party lines and find common ground in addressing the nation's challenging health care crisis. Negotiations between the governor and the speaker resulted in compromise legislation that incorporated elements important to each, including: individual responsibility, wellness, a stronger Medicaid program, a consumer-friendly insurance market, and a guarantee that the financial burden of expanded coverage would be widely shared. If health care reform efforts are to succeed, leaders on both sides of the aisle must see their core values reflected in proposed legislation. California met this test.

A Broad Coalition

The campaign to cover all Californians united a disparate group of policy advocates representing consumers, patients, workers, large and small employers, hospitals, insurers, and faith communities. In this respect, the California experience differed greatly from the 1993–94 national debate over the Clinton health care plan.

Major consumer groups, including the American Association of Retired Persons (AARP), Consumers Union, and Health Access California, also viewed

the compromise plan as a victory and supported the Núñez-Schwarzenegger effort. The Service Employees International Union (SEIU), the California State Council of Carpenters, and the American Federation of State, County and Municipal Employees (AFSCME) were also vocal and positive contributors to the reform effort.

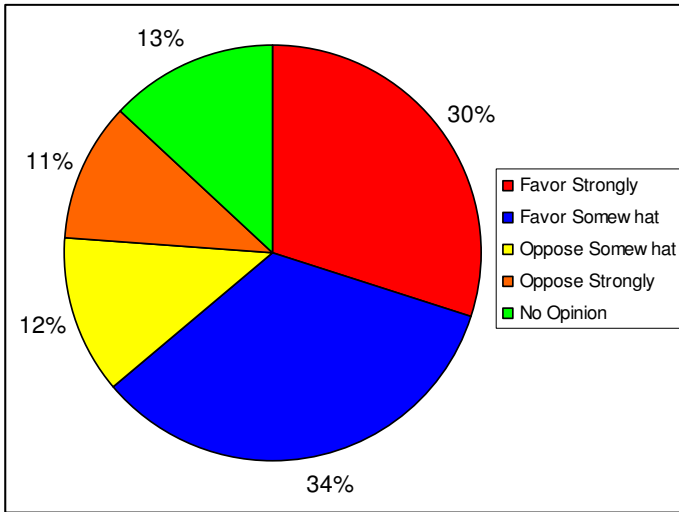
Business groups like the Coalition to Advance Health Care Reform led by Safeway CEO Steve Burd, smaller businesses such as those represented by the Small Business Majority, large businesses such as those represented by the Bay Area Council, and chambers of commerce in such key localities as Los Angeles and San Diego also supported the contours of the reform plan. Business groups were particularly drawn to the governor's "hidden tax" argument – those with insurance pay higher premiums because of cost-shifting by providers as a result of uncompensated care for the uninsured.

The compromise legislation had significant support from health care stakeholders, including the California Hospital Association, and most insurers, including Kaiser Permanente, Blue Shield of California, and HealthNet.

Public Support

The public strongly supported the health reform effort in its broadest terms and favored the compromise proposal. In a poll conducted by the Field Research Corporation during the week of December 10–17, 2007, 64 percent of Californians said they favored the compromise reform proposal.⁵ This sentiment was echoed in a recent national poll conducted by Consumers Union, which found that more than half of Americans support "a mixed public/private system that would require all uninsured Americans to buy health insurance."⁶

Fig. 1: Support for Assembly Health Reform Bill, December 2007



Source: Poll conducted by the Field Corporation, as cited in Tom Chorneau, "Assembly Health Care Reform Bill Shows Strong Support in Field Poll," *San Francisco Chronicle*, December 21, 2007.

OBSTACLES TO REFORM UNIQUE TO CALIFORNIA

The California health reform proposal's threshold for success was very high given the unique legislative, political, fiscal, and demographic challenges it faced.

Legislative Rules

The California constitution gives significant power to a minority of legislators. California is one of only eight states that require a two-thirds majority to approve any legislation to raise revenues.⁷ In addition, it is one of only three states that require a two-thirds majority to pass the state budget.⁸

Furthermore, in California the state budget must be approved by both the Assembly and the Senate before any other legislation can be sent to the governor.⁹ In the summer of 2007, Republican legislators were responsible for the third-longest budget stalemate in California history, which effectively stalled the debate on health reform for an additional two months.¹⁰ The Republican tactics poisoned the political atmosphere and wasted

valuable time that might have been spent fashioning a compromise health care bill between the Assembly and the Senate.

Politics on the Right

The constitutional requirement of a two-thirds majority vote for any revenue increases plays into the hands of such anti-tax crusaders as Grover Norquist, the head of Americans for Tax Reform. In 2007, Norquist orchestrated an anti-tax pledge promising no tax increases under any circumstances that was signed by all but one of California's Republican legislators.¹¹ This commitment made it impossible for the governor and Republican legislators to engage in a serious conversation about competing legislative priorities or the cost of doing nothing about health reform, much less about the financing of alternative proposals.¹² Policymakers in favor of reform had to resort to a "two-track" approach, under which health reform legislation would be passed by the legislature without financing provisions. If the legislation had passed, the financing package would have appeared as a ballot initiative in November 2008.

Timing and Governance Issues

California ballot initiatives must meet strict deadlines. In order to be registered for the ballot in November 2008, it was necessary for the financing legislation to be submitted almost immediately following the Assembly vote in December.¹³ Because Republican legislators, enabled by the two-thirds rule, had effectively stalled the budget process until late August the Senate had not yet considered the compromise bill when the ballot initiative had to be filed. This left the Senate under intense pressure to consider a sweeping overhaul of California's health system under rushed circumstances, severely curtailing the opportunity for a full debate. Senate President pro Tempore Don Perata did not react favorably under these constraints, and neither did the Senate Health Committee.

Politics on the Left

To further complicate matters, the chair of the Senate Health Committee, Sheila Kuehl, believed strongly in her own single-payer health reform proposal, which had been approved by both houses of the legislature and vetoed by the governor in 2006.¹⁴

California is home to a committed and well-organized set of single-payer advocates, and Senator Kuehl is their champion. Throughout 2007 and 2008, the single-payer community actively opposed the compromise efforts of Governor Schwarzenegger, Assembly Speaker Núñez, and Senator Perata. This opposition had the effect of splitting labor advocates and creating conflict on the left among those seeking reform.

Of the major labor groups in California, SEIU, the California State Council of Carpenters, and AFSCME endorsed the Núñez-Schwarzenegger compromise. The California Labor Federation or AFL-CIO was aggressive in its criticism of the legislation and of the policy consensus it represented.¹⁵

The Overall Political Climate in California

With most Republican legislators having signed the Norquist pledge and labor split on the proposed plan, Governor Schwarzenegger and Assembly Speaker Núñez were left with few options. Unified support from labor would have made it far more difficult for Democratic members in the Senate to oppose the legislation. The split on the labor front made it easier for them to do nothing. Given the extreme political polarity in California, the leadership positions on health reform taken by the governor and the speaker are all the more impressive.

Fiscal Challenges

California relies on a progressive income tax within its overall revenue structure, which means that state revenues are highly responsive to the business cycle and economic conditions.¹⁶ Also, 40 percent of California's General Fund revenues must be applied

toward public education, which decreases the share of increased revenues that can be used for new programs.¹⁷

As the economy weakened, California's looming \$14.5 billion budget deficit took center stage in the health reform debate as legislators prepared to consider the compromise bill. By the time State Legislative Analyst Elizabeth Hill released her cost projections for the \$14 billion health care reform plan, it was clear that state spending would have to be curtailed. While the health care bill was to be financed separately, legislators feared that any decline in dedicated revenues, or a rise in anticipated costs, would spill over and put pressure on the General Fund during a period of rising deficits and uncertain revenues.

As to the health proposal itself, Hill acknowledged that under baseline premium estimates the plan would be self-financing for five years. However, under an alternative scenario of higher premiums, she reported that costs could exceed revenues by \$1.5 billion in the fifth year of the program.¹⁸ Hill's more pessimistic estimates, coupled with the budget deficit, gave an intellectual rationale to Democratic senators who had misgivings about the bill and were under pressure from some labor advocates who would have preferred a single-payer plan.

Demographics

Finally, there are several underlying demographic challenges that made achieving health reform in California difficult. Compared to the national average, California has more uninsured residents, fewer people enrolled in employer-sponsored insurance, and a higher percentage of illegal and legal immigrants. Twenty percent of Californians are uninsured, compared to 16 percent nationally.¹⁹ Almost seven million of the nation's uninsured live in California.²⁰ Without an adequate safety net to fund coverage for the uninsured, California needed to find new revenue sources.

SYSTEMIC CHALLENGES TO REFORM

In addition to obstacles unique to California, health reform proponents in the state faced several systemic challenges related to any health care reform proposal.

Affordability

In absolute terms and relative to income, health care and health insurance cost more in the United States than in any other industrialized nation.²¹ This makes it difficult to balance politically sustainable goals regarding affordability and tax increases. Today, families at the federal poverty level pay 38.5 percent of their income for health insurance and health care, while families at three times the poverty level pay 17.4 percent.²² Thus, keeping such payments below 7.2 percent of income, as under Massachusetts' law, or below 5.5 percent, as under the proposed California plan, would represent stunning reductions in average household costs.²³

In light of the importance of the individual mandate (that is, requiring everyone to purchase coverage with the intent of making private insurance markets work well for all), the left in California was legitimately concerned over how much families might be expected to pay out of pocket for health insurance and medical care. For some advocates, nothing less than zero cost-sharing was acceptable. This position made good faith negotiations difficult.

The governor's original proposal included sliding scale subsidies for individuals with incomes of up to 250 percent of the federal poverty level; Assembly Speaker Núñez had proposed subsidies for those with incomes at 300 percent of the federal poverty level. The compromise package limited premium costs so that individuals at between 150 percent and 250 percent of federal poverty level would not have to spend more than 5 percent of their income on health care. In addition, the compromise bill provided sliding scale tax credits for individuals with incomes of up to 400 percent of poverty level if the cost of insurance exceeded 5.5 percent of

income.²⁴ Another important, but related, aspect of affordability was how the mandate would be enforced. The compromise bill developed a concept called "seamless coverage," which focused on giving support to individuals and using penalties as a last resort.²⁵ As a result of this compromise, the reform effort was better suited to attract support from traditional left-leaning organizations like the SEIU, Consumers Union, AARP, and Health Access California.

Despite these steps to ensure affordability, there was no provision under the California plan to cap out-of-pocket expenditures. Although the new system would have offered significantly greater financial protection for consumers than the current system, opponents of the compromise plan believed that such a provision was a necessary element of any health package.

Financing

While many economists believe that a reformed insurance marketplace and a more efficient health care delivery system would inevitably drive down the cost of health care and health insurance, such savings would not be realized in the short term.²⁶ Therefore, any comprehensive health reform proposal must include a financing mechanism to pay for subsidies for low-income households. As mentioned previously, the two-thirds rule, coupled with the position of Republican legislators on fiscal issues, made this particularly difficult in California.

Originally, the governor proposed a shared responsibility system with an employer pay-or-play provision combined with a fee on physicians and hospitals to finance reform.²⁷ While some key members of the business community—including both large and small businesses—supported the pay-or-play concept, other traditional voices of business, like NFIB-California and the California Chamber of Commerce, opposed any form of employer obligation. In addition, the California Medical Association opposed the physician fee, which was removed from the compromise legislation.²⁸ Focusing largely on the 85 percent

minimum loss ratio, Blue Cross of California, the largest single insurer in the state, broke ranks with other large insurers in opposing the concept of shared responsibility.

As pressure grew to increase subsidies for individuals, the governor also proposed leasing the California lottery system, which would have provided \$2 billion annually.²⁹ Other financing options that were not incorporated into the final financing package, or even considered seriously because they were seen as politically unworkable, included: a tax on high-income individuals, a payroll tax, a sales tax, an increase in the vehicle licensing fee, and property tax reform.³⁰

The compromise legislation included an employer pay-or-play contribution and hospital fee. Eventually, Schwarzenegger and Núñez also agreed on a \$1.75 tobacco tax hike as a source of revenue.

Reliance on the politically expedient tobacco tax added another challenge to California health reform efforts. Critics argued that the tax is not only regressive—tobacco use is higher among low-income individuals—but was likely to become a declining revenue source over time.³¹

Furthermore, the proposed tax engaged the tobacco lobby in the California health reform debate for the first time. Since 2006, when California voters defeated a ballot measure that would have tripled the state's tobacco tax, the tobacco lobby's power has grown.³² After the compromise was announced, the tobacco lobby's opposition was apparent.³³

Many proponents of health reform feared that the proposed tobacco tax would be rejected by the public in a ballot initiative and questioned the wisdom of forcing such a vote in an election year in which national health reform was likely to be a defining issue of the presidential campaign. This concern contributed to the desire on the part of some proponents of reform to scuttle the compromise plan without outwardly opposing it.

The legislative analyst's pessimistic budget scenario served this purpose.

LESSONS FOR THE NATION

The effort to reform California's health system holds many lessons for the nation. The negotiations between Governor Schwarzenegger and Assembly Speaker Núñez demonstrated that lawmakers can reach bipartisan consensus without compromising core values. In addition, California proved that disparate interest groups could embrace a system of individual and shared responsibility, quality improvement, and cost containment.

However, the California experience also serves as a reminder that comprehensive health reform contains many complex elements that require carefully crafted and politically feasible policy solutions. Above all, the cost of providing comprehensive health coverage—to both households and governments—represents a real impediment to reform.

Leadership Matters

No health reform effort will be sustainable without tenacious bipartisan leadership. In the context of the national debate, the need for strong leadership extends beyond Congress to business, labor, health system stakeholders, and the American people.

In the years leading up to the Clinton-era health reform movement there was little effort to promote a bipartisan conversation about health care. Today, we can point to three current bipartisan health care efforts in Congress sponsored by Senators Wyden and Bennett, Representatives Brian Baird (D-WA) and Joanne Emerson (R-MO), and Representatives Jim Langevin (D-RI) and Christopher Shays (R-CT), respectively. Senators Wyden and Bennett have gained ten co-sponsors for their proposal from both parties including: Sen. Chuck Grassley (R-IA), the ranking member of the Finance Committee, Sen. Judd Gregg (R-NH), the ranking member of the

Budget Committee, Sen. Lamar Alexander (R-TN), chairman of the Republican Conference, and Sen. Debbie Stabenow (D-MI), a long-time champion of organized labor and consumer perspectives on health care reform. Compared to the years leading up to the 1993–94 health care debate, this demonstrates real progress and a commitment to succeed.

Coalitions Can Be Built

Past health care efforts have been met with strong opposition from interest groups aligned to defeat reform. Rarely have such disparate interest groups united in favor of a health reform proposal as in California. The lack of strong coalition leadership proved particularly troublesome during the Clinton-era efforts, when insurers and many other stakeholders were united and implacably opposed to reform.

On the national level, much as in California, several “unlikely bedfellow” coalitions have emerged in support of comprehensive reform. Groups like Divided We Fail (Business Roundtable, AARP, SEIU, and National Federation of Independent Businesses) and Better Health Care Together (Walmart, AT&T, SEIU, Center for American Progress, and others) have spearheaded efforts to push health care reform to the top of the national agenda.

Affordability and Sustainability

Two policy questions were crucial to the outcome of the California debate: How can affordability be guaranteed for individuals? Can the plan be financed in a sustainable fashion?

Ultimately, affordability and sustainability are political or community decisions. When developing their legislative plan, Massachusetts lawmakers set the affordability threshold at between 2 percent and

8 percent of income.³⁴ After much debate, under the California plan insurance premiums were to be capped at 5 percent of income for individuals with incomes between 150 percent and 250 percent of the federal poverty level and at 5.5 percent for individuals with incomes of up to 400 percent of the poverty level.³⁵

On the national level, the debate is just getting under way. Lawmakers and presidential candidates considering an individual mandate are proposing subsidies that would reach as high as 400 percent of the federal poverty level. Balancing affordability for individuals with affordability for society is the crux of the problem. While California experienced unique obstacles in trying to finance its health reform proposal, paying for health reform on the state level is inherently more difficult than it would be nationally. While financing national health reform would not be easy, the government in Washington has access to major financing levers—mainly the federal tax system—that are not available to state lawmakers.

CONCLUSION

While the comprehensive health reform debate in California is now on the back burner, the national conversation continues to gain momentum. There is a growing consensus among lawmakers, employers, clinicians, policymakers, and, most importantly, the American public that our nation's health care system is in need of serious repair. While success in California would have been an extraordinary achievement, the outcome of the reform effort should not dampen the prospects for national reform if policymakers and opinion leaders take its lessons to heart.

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