Insure the Uninsured Project

HEALTH REFORM: LESSONS FROM CALIFORNIA

In December 2006 and January 2007, key leaders in California launched an effort to reform its health system with a series of measures that would cover all or most of its 6.5 million uninsured[1] and improve affordability for all Californians—the insured as well as the uninsured. In the beginning, the reform effort had the support and leadership of Governor Arnold Schwarzenegger, Assembly Speaker Fabian Núñez and Senate President Pro Tem Don Perata.[2] The measure passed the California Assembly in late December 2007 on a party line vote and failed in the California Senate Health Committee in January 2008, securing only one "aye" vote.[3] This paper examines California; the reform measures, as well as the odyssey and the policy and political lessons learned from the journey.

The Proposals

As the legislative session began, the Governor introduced a "shared responsibility" proposal[4] designed to cover all Californians. The Senate President and Assembly Speaker introduced compatible legislation[5] that differed but slightly from the Governor on some specifics. The Chair of the Senate Health Committee, Senator Sheila Kuehl, introduced a competing measure, known as "single payor," that would have covered all Californians, eliminated all private insurance, reduced copays to a nominal amount, and returned to fee-for-service medicine.[6] It would have paid for the package primarily with a sizeable payroll tax. Assembly and Senate Republicans introduced "no cost" bills that would, among other things, deregulate insurance plans. [7]

By the end of the session, the final compromise measure negotiated by the Governor and Assembly Speaker was supported by SEIU and opposed by the Teamsters; supported by some large and small employers and opposed by the California Chamber of Commerce; supported by three large health plans and opposed by one; supported by AARP, Health Access and Consumers Union and opposed by the League of Women Voters and the Foundation for Taxpayer and Consumer Rights; supported by the California Hospital Association and opposed by the California Nurses Association; and supported by some large counties and opposed by others.[8] In short, it split all the stakeholders and interest groups in a highly unusual fashion.

What would the final compromise measure have done and why did it fall short of enactment? What are the lessons to be learned from California as Congress and the Obama Administration embark on health reform?

What would the compromise measure have done?[9]

- Eligibility: It would have covered all Californians through an individual mandate and made exempt those for whom affordability is a hardship.
- Subsidized coverage: It would have: completely subsidized coverage for those with incomes below 150% of the Federal Poverty Level (FPL) through public coverage; partially subsidized those with incomes up to 250% of FPL

through sliding fee premiums for public coverage; and partially subsidized the uninsured with incomes up to 400% of FPL. Only citizens and legal permanent residents would have been eligible for program subsidies.

- Benefits: A minimum package of benefits is required for all individuals.[10]

- Insurers: Insurers would have been required to guarantee issue coverage in the individual market to all comers, regardless of pre-existing conditions.

- Cost containment and value purchasing: The bill included a combination of cost containment and quality improvement incentives and techniques with a strong trigger looming in the background. There would have been:

    - Price incentives for high-risk subscribers (e.g., smokers, diabetics and those with obesity) to participate in proven programs to improve their health status;

    - Transparent information on provider prices and quality, as well as health plan prices and benefits;

    - Hospital and physicians' payment at Medicare rates for their care to public patients, adjusted on a pay-for-performance basis;

    - A series of steps to spread health information technology throughout the healthcare industry;

    - A requirement that insurers spend at least 85 percent of their premiums on medical care for their subscribers;

    - Enhanced management of chronic diseases, medical homes for primary care, and strong components of prevention; and

    - Assurance that spending would not exceed revenues through the creation of a trigger; if the Governor and Legislature failed to rectify spending and revenue imbalances in the specified timeframes, most improvements in the legislation would self-destruct (i.e., the mandate, the fee and tax revenues, the subsidized and expanded coverage, the enhanced rates and insurance reforms would be automatically repealed).

- Financing: Employers, individuals, counties, providers, smokers, and the federal government would have all contributed toward the projected $14 billion cost of the program.[11]

- Employers would have bought coverage for their workforce or paid a graduated tax (fee) based on the size of their payroll.

- Individuals would have paid premiums for employer coverage, public coverage or individual coverage. There would have been graduated caps on the maximum amounts individuals would pay based on their incomes.

- Hospitals would have paid an assessment to help finance the coverage expansions and rate increases for hospital services.

- County governments would have paid a match for coverage of their indigent county residents.[12]

- The federal government would have paid a match for the rate increases and coverage expansions permissible under Title 19 of the Social Security Act.[13]

- The federal government would have also paid in foregone revenues, as employee premium contributions were designed to be tax protected under the provisions of Section 125 of the Tax Code. In other words, the deductions from employees' wages for their share of plan premiums would be exempt from taxation.[14]

- Smokers would have paid an additional $1.60 per pack.

- All of the revenue-generating proposals would have been placed on the state ballot for voters to decide in November 2008.

- Safety nets: Safety net providers would have been paid through the Medi-Cal and Healthy Families public safety net plans for their previously uninsured patients.
  - There would have been a four-year transition period for local safety nets before normal competition with commercial plans and private providers would have ensued.
  - Public plans would have been given the option to coalesce and compete in all insurance markets under the reform.
  - After reform was fully implemented, the residual pool of the uninsured would have been primarily undocumented adult workers—estimated at one million individuals or 20 percent of California's uninsured adults.[15] Safety net providers would have been left withfederal and state resources to serve the residual uninsured.

How California is Different

Because of its size and diversity, California's experience with health reform yields important insights into how the issue might play out at a national level. That said, there are several variables that are unique to California.

The California political context:

- First, in terms of governance, a two-thirds legislative vote is required to raise new taxes. California suffers from a very wide ideological partisan divide among its state policymakers. Thus, the state often finds itself in political gridlock with most major changes in policy directions that require taxes going before the state's voters in stakeholder-sponsored ballot initiative campaigns.

- Second, California has short term limits of six years in the State Assembly and eight years in the State Senate. The learning curves for new legislators are steep, and complete turnover in leadership and membership is a constant. While California has been trying to pass reforms to cover the uninsured and make coverage more affordable for the past 20 years,[16] few of the current legislators, but nearly all the stakeholder organizations, played major parts in past ballot efforts and legislative debates. This resulted in a discontinuity of information, attitudes, and experience.

- Third, California's budget spending and revenues were, and continue to be, seriously out of balance. There was an estimated $14 billion deficit (14 percent of California's annual General Fund) at the very time the legislature was voting on health reform.[17]

In terms of health policy and infrastructure, California is quite different from most other states and the nation as a whole.

- First, nearly half of the privately insured population is enrolled in HMOs—more than double the rate for the nation.[18]

- Second, a very high percentage of California's population is uninsured—6.5 million or about one in five Californians under the age of 65—which puts it in the top ten states with the highest percentage of uninsured.[19]

- Third, the state's Medi-Cal and Healthy Families programs are expansive, covering about 7.5 million Californians.[20] Per capita spending in these programs is typically at or close to the bottom of all 50 states.[21]

- Fourth, many managed care plans for the Medi-Cal and Healthy Families programs are local public entities committed to strengthening the local

safety net. They compete with commercial plans for enrollment of public patients.

- Fifth, California's 58 counties are responsible for care to the medically indigent adults (MIAs)—the working poor and homeless, who have no eligibility for Medi-Cal, because they are not disabled, elderly or the parents of minor children living at home.[22]

With those caveats, the following ten lessons from California's experience have salience to the health reform debate at the national level.

Ten Lessons from California

1. Popular political leadership can keep things on track, but many voices of support are needed.

California's popular Republican Governor, Arnold Schwarzenegger, partnered with his Democratic counterpart, the powerful Assembly Speaker Fabian Núñez, to fight for passage. Their leadership was central from the start through negotiations to the finish. Their bipartisan effort was unrelenting in its effort to bring in all stakeholders to find a viable compromise. Even so, and despite much outreach and negotiation, health reform was never able to find Republican legislative support, either from leadership or members. California's partisan divide proved too large to be bridged; moreover, there was no working group of moderates with a vision and desire to help bridge it.

Success will require flexibility, outreach and willingness to compromise from executive branch and congressional leadership. Congressional moderates from both political parties who also embrace a broad vision of reform[23] *may play a key role in negotiating the final reform.*

2. Success requires many parents across both legislative branches as well as the executive branch.

At the start of the session, the Governor and Democratic leaders from both the Senate and Assembly had compatible approaches and were engaged in resolution of the policy issues with stakeholders. As the legislative session progressed, Assembly Democrats took the lead on health reform, while Senate leaders became less involved. In the end, the Senate Health Committee blocked the compromise that had been negotiated between the Governor and the Assembly Speaker.

All leadership needs to engage early on and through to the finish.

3. A high degree of sustained attention, a fast pace and an adherence to deadlines is required.

The reform effort required a major commitment of time and energy from political leaders, their staffs and consultants, and all the relevant stakeholders who engaged in nearly constant negotiations with each other. Not all stakeholders were prepared, ready, and able to negotiate on a tight time frame; deadlines slipped, and momentum was lost. Both a prolonged budget stalemate, which lasted well past the state's budget deadline, and the negotiating tactics of reform supporters played a role in sapping and diverting some of the momentum and energy required for health reform.

Health reformers need to be well prepared from the start to move swiftly, resolve matters promptly and keep their eyes on the end goals of reform.

4. Starting and finishing with a labor-business coalition will be key to victory.

On many issues, labor and business have natural enmities, but on some health reform issues they have a shared and common purpose. Areas for fruitful collaboration are financing and cost containment. During the California debate, labor interests gravitated to the Speaker and Senate President's proposals, while the engaged employer groups, for the most part, preferred the Governor's approach. When the Governor and Speaker negotiated their final compromises, some components of labor and business stayed on board, while others shifted from support to guarded neutrality or hard opposition.

Negotiations should start with the understanding that a labor-business coalition is the fundamental building block of the reform effort. Reform efforts can sow seeds of cooperation between some components of business and some of labor; those ties would need to be cultivated, deepened and spread for reform to pass.

5. A diverse and powerful coalition is possible with support from reform-minded leaders within broader constituencies.

California's major insurance leaders, some prominent business CEOs and large chambers of commerce from the Southern California and Bay Area regions, certain physician groups, and some of the state's prominent labor leadership all came on board despite sometimes vigorous opposition by some of their compatriots.

It is possible to design policy that, while it may not win over an entire sector, will address stakeholder needs sufficiently to attract support of prominent/influential leadership from within the key stakeholder sectors. It is essential to find those champions within a sector who are willing to take a reasoned stance for reform, even against opposition from their own associations. Their leadership can be key.

6. Support must be timely and communicate intensity around centrist "shared responsibility" proposals.

The California reform proposal was presented as "shared responsibility" (i.e., many pay a little bit more to cover everyone, and everyone gives up a little bit to get rising costs under control). This approach had enormous appeal with voters and politicians, as it sounds fair. However, shared responsibility also meant that each stakeholder or interest group wanted to negotiate a little less "give" and a little more "take."

This meant there was little enthusiastic stakeholder support for the proposal expressed during lengthy negotiations and a fairly large dose of skepticism. Standard negotiating tactics thus damaged the overall positive perception of the reform effort with legislators, the media and the public.

Consumer groups, labor, counties, concerned providers and other reformers were oftentimes slow to commit and at times focused more on ironing out details than in taking advantage of a singular historic political moment/opportunity. Possible compromises by stakeholder negotiators had to be approved by stakeholder organizations, creating a drag on the process.

A missing ingredient was passion to get the reform done and presented to the legislature and voting public.

Consumer groups, labor, providers, sympathetic business and insurance executives, and single payer advocates who have a hunger for change need to think fast and big as the reform effort unfolds. Reformers must move, in a timely manner, beyond their most favored "silver bullet" solutions to support each other's efforts or face—once again— the ultimate victory of an ever-deteriorating status quo.

7. Transparency and opportunities for genuine public input are essential.

California should receive high marks for the transparency of the proposals and the outreach and opportunities created for broad public input. Foundations and state government played complementary roles in assuring opportunities for public engagement.[24] In a statewide citizen participation event called California*Speaks*, nearly 3,500 Californians came together with the Governor and a bipartisan mix of legislative leaders for a day of discussion and participatory decision-making on the critical health policy options being considered.

Traditional polling showed the reform effort remained popular, with about 70 percent approval from its introduction through its defeat in the Senate.[25] Yet, while public opinion was favorable, California voters did not flood the Capitol with calls for reform.

Immense amounts of time by staff and political leadership were devoted to negotiations with stakeholders. When momentum appeared to stall during these negotiating periods, the reforms were declared "dead" but then resuscitated. This

roller coaster ride meant that when critical votes were scheduled, there was little public pressure brought to bear on policymakers.

While solid polling numbers may provide some assurance to decision makers that they are on the right track, alone they are not sufficient for legislators to feel confident in the reforms being considered when faced with daily countervailing stakeholder pressures. It will be important to assure the voices of real Americans are steadily heard in the halls of Congress.

8. Embrace the unbearable tension of the necessary reform components: marrying coverage expansion with control of rising costs.

Consumers, hospitals, doctors, some health plans, and labor typically support coverage expansion. Business, labor, and some consumer groups support cost containment/value purchasing. California's Governor and Assembly Speaker correctly assessed that negotiations and trade-offs are in fact easier in the context of a complete reform package. Addressing both issues together from the start is one way to link reform to fiscal responsibility.

If the health reform's architects combine the two—coverage expansion and cost control—sufficiently artfully and do not allow separate reform paths, there could be wall-to-wall support for the final reform package.

9. Do not force individuals to drop existing coverage. Watch out at the intersections.

This refers to the intersections between public and private coverage and between employer and individual coverage. California reformers did not want to encourage employers and employees to drop their coverage and move onto public coverage (crowd out) or to be shifted into individual coverage (no tax advantages and a high percent of premium devoted to administration). They wanted to make new coverage more affordable to employers, employees and individuals by using federal financing where available (Section 125 tax protected premium contributions and federal matches of Medicaid and S-CHIP).[26]

California reformers did not want to force individuals to change their coverage. They did want the new purchasing pool to offer options for more affordable coverage.

The designers of the California reform proposal set out to ensure that most of the insured stayed with their existing coverage; that employer coverage increased modestly; that most of the newly insured moved onto the Medi-Cal and Healthy Families programs, where a federal match was available, and that there was a new pool (Health Insurance Exchange), where they were able to purchase more affordable coverage. [27] Many stakeholders were very supportive of these outcomes.

At the federal level, reformers need to assure that new funding is targeted to expanding coverage of the uninsured and does not disrupt coverage for the already

insured. It will be critical to preserve and enhance consumer choice of plans, benefits, providers and the costs of these choices.

10. The evolving role of the safety net must be considered carefully.

While most of California's uninsured have no usual source of care, those who do, rely on public and private safety net providers.[28] This raised the following question: After reform is implemented, do these providers close and go out of business or do they become central to the managed care delivery networks for those newly covered?

Substantial federal, state and county dollars are already invested in these safety net institutions, and they are located in areas that are medically underserved. As part of reform, do existing funds follow the patients as they enroll in coverage? What happens if substantial numbers of the newly insured choose to receive their services outside the traditional safety net?

California tried to answer these questions by designing a transition period for the safety net and affording increased opportunities for public safety net plans to compete on a level playing field. Safety net providers and plans were supportive of these provisions, and they did not cause opposition from other stakeholders.

Federal reforms will need to assure safety net providers a real opportunity to continue to serve their patients and participate significantly in the new system of care for those heretofore uninsured. They will also need to assure a transition of care and funding from an episodic care model to a well-managed system of patient care.

Conclusion

While California's recent effort to cover its uninsured did not result in a signed bill, the participants in that effort developed important compromises that advanced learning about the key building blocks for health reform, not only for California, but for the nation. Significant political progress was made as stakeholders broke from monolithic positions, found new allies and rallied strong public support. The reform stakeholders are still energized and committed to assisting in passage of the federal reform efforts and to designing the best ways for California to participate in a federal health reform.

This paper was commissioned by Blue Shield of California Foundation and prepared by Lucien Wulsin, Executive Director of the Insure the Uninsured Project in California with the wise counsel and advice of Maryann O'Sullivan.

[1] www.chis.ucla.edu. The California Health Interview Survey reports two different figures for the uninsured: 5 million represents those uninsured at a given point in time and 6.5 million is the most recent CHIS number for uninsured at some point over the course of the year.
[2] AB 8 (Nunez) and SB 48 (Perata). The bills are summarized and contrasted with the Governor's Proposal, the Single Payor Proposal, the Senate Republican package and the Assembly Republican approaches in the "The Big Five: a Comparison of Major Health Care Reform Proposals In California" Insure the Uninsured Project, March, 2007 at www.itup.org/reports.
[3] The Committee consisted of seven Democrats and four Republicans; three Democrats joined all the Republicans in voting no. See AB X1 1 (Nunez) Senate Health Committee votes at http://leginfo.ca.gov/cgi-bin/postquery?billnumberabx1_1&sess=PRE&house=B&author=nunez.
[4] See n. 2.
[5] See n. 2.
[6] See n. 2, SB 840 (Kuehl).
[7] See n. 2.
[8] See AB X1 1, Senate Health Committee analysis at http://leginfo.ca.gov/cgi-bin/postquery?billnumberabx1_1&sess=PRE&house=B&author=nunez.
[9] AB X1 1, Assembly Floor analysis
[10] Employers and individuals can and do purchase more than the minimum benefits package to be decided under the bill's provisions as do the Medi-Cal and Healthy Families programs; there would have been no changes to these policies.
[11] Employers would pay 18%; individuals 12%; hospitals 23%; federal matching funds 29%, and redirected county matching funds 5%. California Legislative Analyst, Fiscal Analysis of AB X1 1 (Nunez) at www.lao.ca.gov/2008/health_reform/health_reform_012208.aspx. See also Gruber, Modeling Health Reform in California (May 16, 2007) at www.calhealthreform.org.
[12] Roughly 1.5 million adults are uninsured with incomes of less than 200% of FPL. A federal match for these funds can now be secured only through an 1115 waiver as Oregon, Arizona, New York and Massachusetts already have. For a discussion of covering the county indigent with a federal waiver see Harbage, A Road Map to Coverage: Implementing a Childless Adult Medi-Cal Waiver in California (March 2008) at www.blueshieldcafoundation.org
[13] Roughly 1.5 million California parents are uninsured with incomes of less than 200% of FPL. See Fox and Wulsin, The Safety Net Caring for California's Uninsured, ITUP presentation to the Working Committee on Waiver Development and Medi-Cal Expansion (April 25, 2007) at www.itup.org/reports
[14] Section 125 applies to premium contributions; it does not apply to health plan deductibles as an HSA would.
[15] Gruber, Population Movement Estimates for Health Care Reform Under AB X1 1 with the Voter Initiative Filed on December 28, 2007 (January 11, 2008) at www.calhealthrefrom.org
[16] Past voter based efforts included several ballot initiatives for a single payor plan and an employer mandate; each of which was endorsed by only a small share of the

health reformers and defeated soundly, and a referendum narrowly repealing an employer mandate (SB 2) passed by the legislature. Past legislative efforts include employer mandates, single payor, pay or play, individual mandates; only one, SB 2 (Burton) an employer mandate signed by Governor Davis, survived the journey from introduction to Governor's signature.

[17] California's budget deficit has now grown to $40 billion. The Governor has signed a narrow bi-partisan compromise, which cuts benefits, raises taxes, borrows and relies on the federal stimulus package to balance the state budget.

[18] National Opinion Research Survey, California Employer Health Benefits Survey 2008 (December 2008) at www.chcf.org

[19] Paul Fronstin, Employee Benefit Research Institute, Snapshot: California's Uninsured 2008 at www.chcf.org

[20] Dam and Wulsin, Overview of Health Insurance Coverage and Financing for Low Income Californians 1998-2008 at www.itup.org/reports.html

[21] Medi-Cal Facts and Figures: a Look at California's Medicaid Program (May 2007) at www.chcf.org

[22] For a discussion of county, clinic and hospital programs for the uninsured, see Tuttle and Wulsin, California's Safety Nets and the Need to Improve Local Collaboration in Care for the Uninsured (November 2008) at www.itup.org/reports.html#californiacounties.

[23] The Wyden-Bennett bill, the Healthy Americans Act, has had bi-partisan support from many influential moderates on health policy.

[24] California Speaks. http://www.californiaspeaks.org/ At the end of the day's discussion, 82% of the participants indicated that major health reforms were needed and 84% were willing to help pay for the reforms.
Another excellent resource was the California Health Reform website at www.calhealthrefrom.org.
California foundations played a critical role in funding independent analyses of the financing and design options for the different state reform efforts.

[25] DiCamillo and Field, As Insecurities with the Health Care System Grow, Californians are Concerned about the State's Failure to Enact Health Reform Legislation (The Field Poll, April 28, 2008) http://field.com/fieldpollonline/subscribers/ Voters were divided about the solutions: 4 in 10 preferred expanding the employment based system; 3 in 10 favored a government run system, and 2 in 10 supported a system of individual responsibility.

[26] One key insight of the California reformers was that while state and federal matching and tax policies were adequate to assure affordability for the low income uninsured and high income uninsured, Section 125 tax deductibility did not help as much as needed with affordability for the moderate and middle income uninsured who did not have employment based coverage; they therefore devised a refundable tax credit through the state purchasing pool to help with affordability for those with incomes between 250 and 400% of FPL.

[27] Gruber, Population Movement Estimates for Health Care Reform Under AB X1 1

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[28] Fox and Wulsin. The Safety Net Caring for California's Uninsured, ITUP presentation to the Working Committee on Waiver Development and Medi-Cal Expansion (April 25, 2007) at www.itup.org/reports and Wulsin, Safety Nets and Coverage Expansion: ITUP Recommendations (July 2007) at www.itup.org/reports.