

**Towards an End Result:  
Comprehensive Health Care Reform in  
Massachusetts and California**

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## INTRODUCTION

Access, cost containment and quality of care each occupy a point of the so-called iron triangle of health care policy. Over time a conventional wisdom has developed – that health care reform legislation with any hope of being enacted can only focus on one point of the iron triangle. If a policy focuses on all three points simultaneously it becomes too broad, requiring too much from too many interests. Comprehensive reform is thus felt to be politically infeasible, and therefore it is better for legislators to settle for piece-meal incremental reforms. Through tinkering with the existing state and national health care systems, policymakers hoped that reforms could be brought about without engaging any of the powerful health care special interests in a legislative battle.

However, it has become increasingly clear that the incremental approach to health care reform legislation is over. The end of solely incremental approaches to health care reform has originated in the states. Several states have introduced comprehensive health care reform legislation in the absence of comprehensive reforms initiatives from the federal government<sup>1</sup>. These new comprehensive state health care reform efforts stem from both a necessity of policy (because health care systems are in such a state of disrepair) and from renewed public interest in issues of health care reform.

While public interest is often fickle, it is an important factor behind health care reform efforts, and public support of reform is particularly important when elections are imminent. In what promises to be a marathon 2008 presidential primary season it is worth noting that a March 2007 tracking poll compiled by the Kaiser Foundation shows health care reform ranks just behind Iraq as the second most important issue for both Democrats

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<sup>1</sup> George W Bush's current tax credit policy is a perfect example of incremental policy, addressing only the problem of increasing access while largely ignoring quality and cost containment.

and Republicans alike who would like to hear health care reform addressed in their party's nomination process (26% of those polled answered health care whereas 44% answered Iraq when asked the open ended question of what they would most like to hear presidential candidates talk about in 2008) (Kaiser Health Tracking Poll 3/2007, 1). The importance of health care reform to the 2008 presidential campaign has given an increased impetus for state governors who may become presidential candidates to prove they have a track record of effective health care reform.

Interest group political theory valuably informs discussions of health care reform. While health care reform may seem like an issue with the potential for a public-interest model of policymaking, because it invokes broad issues of equity and social justice, in practice the legislation of health care reform is much different. There are so many interests with large stakes in any change in the current health care system, that pretending they do not exist or attempting to legislate around them is both impractical and counterproductive. Health insurance companies and business groups generally oppose health care reform initiatives while consumer advocacy groups are supportive. Health care provider organizations fall somewhere in between. Douglas Arnold notes that citizen's develop policy preferences based on the perceived costs and benefits of proposed legislation on. Currently the public is of two minds as to the costs and benefits inherent in health care reform. On the one hand they recognize the failures of the current system and fear for the future while simultaneously seeing the potential costs in reforming the status quo. It is therefore the job of legislators to continually inform the public as to what they stand to benefit from health care reform and to remind them of the large costs they are paying under the current system because, "citizens are more likely to

have preferences about an issue then they see relatively large costs and benefits for themselves” (Arnold 1990, 65). The current comprehensive health care reform efforts being considered and implemented in the states recognize the presence and importance of these interest groups to the successful legislation health care reform. The reform efforts are therefore politically feasible and, for better or worse, shaped by pressure from various stakeholders.

State health care reforms are often precursors to national reform, and as such it is important to observe reform efforts as they occur in the states so that successes can be duplicated and mistakes avoided at the national level. In examining current health care reform efforts, first an analysis of the nature of the health insurance problem and alternatives to reform will be discussed. Then policy analysis will be presented in the form of two specific case studies in order to examine the current trend of health care reform in the states and implications for replication on a national scale, and thus providing remedies to the ailments endemic in the American health care system. The first case study presented is Massachusetts, which is in the process of implementing comprehensive health care reform passed last year. The second case study is California, which is still in the midst of legislating health care reform. Massachusetts presents a valuable study of the implementation of comprehensive reform, while California presents an example of health care reform that could be extrapolated nationally.

### **The Nature of the Health Insurance Problem**

A majority of Americans across party lines (Altman 2006, 2093) favor universal health care coverage. The problem has historically been in the implementation of universal health care programs. Those on the left traditionally favor a single-payer

government run national health insurance system resembling a streamlined and expanded Medicare. Under this program, insurance would be provided to all Americans. Single-payer reform would eliminate the existing barriers to medical care. Those on the ideological right have come to favor a system of Health Savings Accounts (HSAs) coupled with a high-deductible private health insurance plan. Akin to IRA's for health insurance, HSAs are tax-deductible savings accounts to be used for specified medical procedures. The HSA system is intended to create greater patient responsibility, assuming that patients will act more like prudent consumers when they have to pay their medical costs out of pocket.

The United States leads the world in health care spending. The combined public and private costs for 2006 are estimated to be \$2.1 trillion (Tsu Lecture), and this estimate expected to nearly double in nine years. Despite astronomical health care spending, Americans enjoy a life expectancy of 2-3 years less than other European nations (Tsu Lecture). The inefficiencies of the American health care system are apparent from these estimates; Americans are paying more for health care, and yet receiving less. The cost of health insurance continues to rise, partially in response to increases in the cost of medical care and partially because, "each individual and corporate entity with in a private entrepreneurial system seeks to manipulate financial incentive to its own advantage without regard to its impact on the system as a whole" (Shi and Singh 2001, 6). Many businesses previously offering employees health insurance either can no longer afford to do so, or target employee health insurance programs as the first area of cost-cutting.

Thus, the traditionally uninsured (a group includes young adults, the self-employed, those with low-income or part-time jobs, and undocumented immigrants) are being joined by workers who are no longer offered employer-sponsored health insurance. The stringency of Medicaid eligibility requirements means that many who are too poor to purchase health insurance are ineligible for state assistance. Non-elderly adults have the most stringent requirements, “and even the poorest are generally ineligible for Medicaid if they have no children” (Robert Wood Johnson Foundation). Additionally, there are individuals who meet eligibility requirements for government health insurance assistance programs and yet continue to remain uninsured. It is estimated that, “fewer than 50% of people eligible for public programs actually enroll” (RWJ Foundation). Reasons for not enrolling in Medicaid programs include the size of the benefit versus the inconvenience of enrolling, stigma, lack of information, and illegal immigration status which precludes participation in federal entitlement programs. Some studies have shown that, “convenience of enrolling had the largest effect on take-up rates” (RWJ Foundation).

Being uninsured is both an individual and a social problem. Individuals who lack insurance are less likely to seek routine and preventative medical treatment, more likely to accumulate large amounts of health related debt and more likely to use the emergency rooms as their primary care provider. Regardless of the ethics of equitable health care, the problems posed by those who do not have insurance to cover medical needs are also hazardous to the public health. An infectious disease, for example, presents not only a personal danger, but a social danger if left undetected and untreated. HIV/AIDS, tuberculosis and sexually transmitted diseases are large public health risks if not detected and treated early. It has also been shown that for a number of conditions it is cost-

effective to provide care in the early stages, rather than postponing care. For example, screening for diabetes during routine health care visits has proven to be more cost-effective than treating the complications of undetected and untreated diabetes – which include blindness and kidney failure that requires costly dialysis (U.S. Preventative Services Task Force).

Large amounts of debt are incurred by those lacking health insurance both as a result of leaving medical conditions undetected and untreated and of using emergency rooms (ERs) as primary care providers. Using the ER for non-emergency care (an ear infection, for example) is more expensive to the individual because hospitals attempt to dissuade non-urgent cases from seeking care in the ER through a high cost of care. Using ER facilities for non-urgent care is also a potential hazard for those actually in need of emergency care. The lag time in treatment created by an overcrowded ER has the potential to result in death or disability of a person truly in need of life-saving emergency care – delaying the diagnosis of heart attack in an individual experiencing chest pains for example.

Those without health insurance include the healthiest demographics, individuals between the ages of 19-26. This age group is particularly sought after by insurance companies because if they were to join the pool they would pay into the system more than they take out. However, those without health insurance also include the least healthy demographics, because insurance companies can deny coverage on the basis of pre-existing conditions. Compelling the healthiest demographics to join the health insurance pool will, “help support the currently uninsured persons who do need care” (Altman 2006, 2094). Although this may not seem fair, the theory of insurance necessitates the

inclusion of individuals the pool that will have a low utilization of services in order to support those in the pool who will have a higher utilization. As the younger demographic ages, they will theoretically reap the benefits.

National estimates of the number of uninsured Americans hovers around 50 million, or about 15.9% of the population (Kaiser Medicaid Fact Sheet 2006). Although health care is an issue of national importance, Washington has remained reluctant to purpose any sweeping changes since the disaster of Clinton's 1994 initiative. The reluctance on the part of Washington to take the first step in finding alternative ways of dealing with the health insurance problem has left the job of innovation up to the states. Massachusetts was the first to step up to the plate with health care reform legislation in April of 2006, followed by California in January 2007.

### **Health Savings Accounts (HSAs) and Single-Payer Alternatives**

Both California and Massachusetts offer "shared responsibility" models of reform which center on an individual mandate. In other words, individuals are mandated to obtain health insurance. However, employers are required to make contributions to their employee's coverage, health plans face certain limitations on the cost of insurance products and the government is responsible for facilitating enrollment and aiding those for whom purchasing insurance in the private market is not economically feasible. The "shared responsibility" model is relatively new and represents a merging of two more traditional ideologies regarding the expansion of health insurance. The two alternatives to "shared responsibility" are Health Savings Accounts (HSAs) which treat the health care system like a market based system, and national single-payer health insurance which is founded on a public-interest model.

HSAs are strongly advocated by the American Medical Association, which would like to see a series of “incremental policy changes” (AMA Goals Pamphlet 2005) leading to a market-based system wherein patients function as consumer and doctors as providers. In a system of HSAs, individuals purchase a high deductible plan (typically a plan with a deductible of \$1000 or more, intended to cover only catastrophic care) and pay for non-catastrophic health care needs through a tax-exempt savings account similar to an IRA. The goal of HSAs is to increase patient awareness of the cost of their medical care, forcing them to become more prudent consumers because the money to pay for care is coming “out-of-pocket”. There is both a practical and an ethical problem in a system dominated by HSAs. First is the assumption that the health care market could ever operate in the traditional supply and demand economic model. Patients can never be truly informed consumers since acquiring medical knowledge requires years of study. Also, HSAs may prove to dissuade individual from seeking routine and preventative care because they may not want to spend their own money (as opposed to the insurance company’s money) on preventive health care. Expecting patients to make informed decisions about their medical care seems inherently naïve and unfair. HSAs provide the wealthy who can afford them with increased means to access health care, but deny access to the middle and lower classes who can not afford the HSA system.

The largest groups in opposition to the “shared responsibility” model of health insurance reform (apart from the business lobby) are groups such as Physicians for a National Health Program. Physicians for a National Health Program advocate the institution of single-payer systems and as staunch advocates of national single-payer health insurance, this group fears that “shared responsibility” and individual mandate

plans will lower the number of uninsured while increasing the number of underinsured. National single-payer health insurance has a major economic benefit over other reform methods stemming from the elimination of the multitude of health insurance companies, each of whom maintain overlapping bureaucracies thus driving up cost through administrative duplication.

Advocating a single-payer system is an uphill battle. Many special interests to which politicians and policymakers are beholden are opposed to a single-payer system, thus making the single-payer model politically infeasible at the present time. However, as health care costs continue to increase, single-payer insurance may become more politically attractive. Also, a successful “shared responsibility” initiative may prove to create a, “constituency for single-payer insurance” (Hogberg 2006, 2). A single-payer system is an anathema to conservatives, but for liberals it is an essential governmental function: to provide equitable health care to all citizens. It is very difficult politically to revoke popular entitlements, and voters may respond more favorably to the idea of single-payer insurance once they have seen the beneficial effects of state health care reforms.

## **CASE STUDY I**

### **MASSACHUSETTS: “WE HAVEN’T ALLOWED PERFECTION TO BE THE ENEMY OF THE GOOD”**

On April 12, 2006 Massachusetts Governor Mitt Romney signed into law, “An Act Providing Access to Affordable, Quality, Accountable Health Care” (known as Chapter 58). Chapter 58 is a proposal for universal health insurance designed to take a comprehensive approach to health care reform with special attention paid to increasing

access to care. The Massachusetts health care reform plan aims to provide coverage to all but about 35,000 residents of the currently 550,000 uninsured through a combination of proposals intended to place the onus of health insurance coverage on the individual – while encouraging employers to continue offering employees insurance products, and providing government assistance where necessary. These proposals include mandating that individuals who can afford to do so purchase private health insurance, expanding state Medicaid benefits to include more indigent persons and creating a new state subsidized insurance coverage for qualified individuals. In addition to provisions targeting increased access to care, Chapter 58 addresses issues of quality through unifying the credentialing process for hospitals and providers, requiring hospitals and providers to collect data on racial and ethnic health disparities and tying increases in Medicaid reimbursement rates to attainment of performance goals in a “Pay-to-Performance” model. Apart from the cost control benefits of nearly universal health insurance coverage, and a streamlining of the credentialing process, Chapter 58 also attempts to control costs of health care through merging the small- and non-group insurance markets.

Massachusetts has often been at the forefront of health care reform. The history of health care legislation in Massachusetts provides a useful road map, plotting the route to the current solution of “shared responsibility. The law will not be fully implemented until July 1, 2007, however there has been vigorous debate over the components of the plan, and substantial polling of the Massachusetts population to determine the plan’s popularity in the early stages of its implementation. A majority of Americans believe that the health care system has serious problems and is in need of reform, a view that is

mirrored in Massachusetts. While it remains to be seen whether the particular policy components of Chapter 58 will be totally successful, it definitely has the potential to bring meaningful reform to health care in Massachusetts.

### **The Massachusetts Health Care Market**

The estimated number of individuals without health insurance in Massachusetts ranges from 550,000 to 715,000, or 10.7% of the population (Kaiser Foundation Key Facts 2006). The legislators behind Chapter 58 expect about 515,000 residents will gain health insurance through the law's various programs while leaving 35,000 people uninsured. The remaining uninsured will be illegal immigrants and under-the-table workers who do not file taxes (tax returns will be a key mechanism for monitoring compliance and assessing benefits or penalties). An individual may also remain uninsured under the proposal if they apply for, and are granted, a waiver from the state signifying that the coverage program the state has deemed affordable for the individual's income bracket in fact will pose the individual a significant financial hardship. Massachusetts has a strong record of employer-sponsored insurance programs with 68% of employees covered by an employer-sponsored plan (Kaiser Foundation Key Facts 2006). By contrast, the U.S. nationally has about 61% employer coverage (Kaiser Foundation Key Facts 2006). The low percentage of uninsured, the high percentage of individuals covered by an employer-sponsored health plan, and presence of certain insurance market provisions (such as guarantee issue and community rating) are all testaments to the relative strength of health care systems in Massachusetts and the reforms instituted by Chapter 58 hope to capitalize on these strengths.

### **Brief History of Health Care Reform in Massachusetts**

Policymaking is most often path dependant, meaning it is, “related in some logical way to whatever has gone before” (McDonough 2000, 247). To any policy problem, there may be many solutions, but the truly viable ones relate meaningfully to what has come before. Therefore, although the Chapter 58 law is thought of as unique, the history of health care legislation in Massachusetts shows that the new legislation does have precedent and is not incongruous with the general path of health care reform in Massachusetts. There were essentially two different roads – one liberal and one conservative – to health care reform in Massachusetts which collided in 1996.

One path represented the legacy of former Massachusetts Governor Dukakis and the 1988 Chapter 23 law. Chapter 23 was an employer mandate intended to provide residents of Massachusetts with universal health insurance and was fated for failure due to bad politics and staunch business opposition. The law required all employers with more than 6 employees to provide family health coverage to their employees, “with employers paying at least 80% of the cost” (McDonough 2000, 248) or employers were to pay \$1,680 per worker per year to the state. Revenue gained from this tax would then be used to finance health care coverage to the employee and his family. Businesses recoiled violently at the costs being imposed on them and in an attempt to compromise with business interests, implementation of the employer mandate was delayed four years. In the ensuing time, the economy entered a severe recession that weakened what support there had been for the employer mandate. Additionally, Dukakis was replaced in January 1991 by Republican William Weld, “who was adamantly committed to repealing the requirement” for the employer mandate (McDonough 2000, 248). With Dukakis gone and the economy in recession, the employer mandate was quickly repealed.

Another path represented Governor Weld's request of the federal government for a Medicaid 1115 waiver, which would enable the state to experiment with its Medicaid design. Weld wished to expand Medicaid coverage to families with incomes below 133% of the federal poverty line. Next there was a program of, "tax credits to employers and subsidies to low-wage workers" (McDonough 2000, 252) provided to workers with incomes below 200% of the poverty level and required employers to provide health insurance paying at least half the cost of care incurred by employees. The financing for this program was to come from the state's Uncompensated Care Pool, which was used to offset debts hospitals and providers incurred from caring for patients without insurance. The legislation also called for, "the reform of the so-called non-group insurance market that exists for individuals who cannot obtain group coverage through employers" (McDonough 2000, 252). These policies represented an incremental approach to health care reform, which attempted to reform the system through slowly implemented changes in particular areas of the health care system. Lastly the legislation allowed for the use of tax-deferred health savings accounts. In 1995, the federal government approved Massachusetts Medicaid section 1115 waiver. The legislation which was to result would be Chapter 203, which included elements of Weld's original plan, plus some more liberal elements from Dukakis' 1988 plan although the employer mandate was completely dropped.

Elements from the current Massachusetts health care proposal are apparent in this brief legislative history. Massachusetts had previously taken steps to expand the number of individuals and families covered by the state Medicare program that would become known as MassHealth. Also both Dukakis and Weld were running, or planning to run, for

the presidential nomination at the time of their health care reform initiatives – a condition reprised by Mitt Romney.

### **Key Components of Chapter 58**

Chapter 58 was approved 154-2 in the state House and 37-0 in the state Senate, a testament to its widespread public support. The law is intended to provide Massachusetts residents with a minimum level of health insurance by July 1, 2007. Chapter 58 can be distilled into six basic components. Most of these policies focus on increasing access to care, while some are tangentially related to the two remaining points of the iron triangle, costs and quality.

1. *Individual Mandate*: All Massachusetts state residents will be required to obtain at least a minimum level of health insurance coverage by July 2007. Health coverage may be obtained through an employer, through the private insurance market, public insurance programs (including Medicare, the Massachusetts Medicaid program called MassHealth, or a new state subsidized insurance program called Commonwealth Care). Compliance with the individual mandate will be tracked through a combination of monitoring state income tax returns and a Health Insurance Responsibility Disclosure (HIRD) form to be completed by employers and employees. Massachusetts residents will place their health insurance policy number on their tax returns and those who are non-compliant will face a series of economic penalties which include certain state income tax penalties and a fine, “not to exceed 50% of minimum insurance premium for credible coverage...” (Chapter 58 Acts of 2006). The HIRD form is intended to monitor insurance provided through the workplace. The Employee HIRD form must be completed if the employee has declined an employer-sponsored health plan and/or if that employee declined to participate in the

employer's Section 125 plan which will allow employees to purchase insurance with pre-tax dollars (Commonwealth Connector 2007, 6). Although the specifics of both tax-return monitoring and HIRD monitoring are still being worked out, the Department of Revenue will be responsible for enforcing the financial penalties incurred by noncompliant individuals.

One year after the passage of Chapter 58, the affordability and coverage requirements that health insurance plans will need to meet are finally being released by the Commonwealth Health Insurance Connector Authority (the Connector). The intention of the Connector has been to raise the floor of health insurance coverage by requiring as many individuals as possible to obtain the highest level of benefits at the lowest level premium cost. The Connector voted in February to, "require all plans to have substantial coverage, including prescription drug benefits" (Belluck 2007), a requirement which raised concerns over the affordability of such plans. However, on March 8, 2007 the Connector board released the details of what average low-cost plans will look like and on April 12, 2007 the affordability requirements were released.

There are two programs included within the Connector, one is called Commonwealth Care and the other is called Commonwealth Choice. Commonwealth Care is the state subsidized health insurance plan created for individuals between 150-300% FPL as an expansion of MassHealth. The Commonwealth Choice program is comprised of commercial health insurance products which will be available for purchase by uninsured Massachusetts residents who do not meet the income eligibility requirements of Commonwealth Care or MassHealth. In order to be offered through the Commonwealth Choice, health insurance plans will need to qualify for a "Connector Seal

of Approval” which will certify these programs as being good value to the consumer – meaning that the product offered is comprehensive and the price low. Employers of small firms can also find low cost health insurance products for their workforce through the Commonwealth Choice.

In a March 8, 2007 press release, members of the Connector board announced that seven insurance companies (including big-time players who had initially expressed concern about being able to come up with low-premium plans such as Blue Cross/Blue Shield of Massachusetts and Harvard Pilgrim Health Care) have earned the “Connector Seal of Approval” and will begin offering these plans to the public on May 1, 2007. The Commonwealth Choice plans will begin at \$175 (if the plan is purchased on a pretax basis the cost is lowered to \$109) per month for the average uninsured individual residing in the wealthiest region in the state (community rating divides Massachusetts into a more expensive eastern region due to the presence of Boston and less expensive western and central regions). Plans offering similar benefits in the central and western parts of Massachusetts will have an average cost of \$154 per month. This represents a premium cost almost \$200 less than the average cost of a high deductible health insurance plan without prescription drug coverage purchased through the non-group market in eastern Massachusetts. While plans will differ in their cost and scope, all plans sporting the “Connector Seal of Approval” include inpatient and outpatient medical care, emergency care, mental health and substance abuse services, rehabilitation services, hospice and vision care. Most plans offer prescription drug coverage, while some do not. Deductibles range from zero to \$2000 per year with intermediate deductibles available. Co-pays also range from zero to \$35. In an attempt to encourage preventative treatment, all plans are

required to provide for at least three preventative care visits for individuals (six for families) before the deductible. The variety in deductible, co-pay and premium costs of these plans is intended to minimize the burden that mandated purchasing of health insurance places on individuals. As one member of the Connector board stated, “the recognition that one size does not fit all will allow individuals and small businesses to choose plans that fit both their medical needs and their wallets” (Press Release, 3/8/07). Providing as much choice as possible within the individual mandate is crucial so that individuals do not feel they are being coerced by the government into spending money on inferior insurance products. The comprehensive nature of the current versions of Commonwealth Choice plans were able to meet indicate that the government is able to effectively partner with health insurance companies in order to develop new, low cost, products. The ability of the government and health insurance companies to partner is crucial to the individual mandate plan, and so far the Connector authority has proven that such a partnership can be successful.

The affordability provisions offered by the Connector in April indicate that the Connector Board took seriously the concerns of individuals that an individual mandate would place too strenuous a financial burden on the lower-middle class – those individuals who would not qualify for state subsidized programs. First, the connector board has proposed raising the income eligibility level for no-premium MassHealth from 100% FPL, where the eligibility line is currently drawn, to 150% FPL. This would allow about 52,000 additional low-income individuals earning up to \$15,315 annually to qualify for no-premium coverage (Belluck 2007). The proposed increase will require an additional \$13 million more than the \$200 million the state was planning to spend on the

program (Belluck 2007), however the cost will most likely be incrementally incurred as individuals slowly take-up enrollment in MassHealth programs and will therefore not be overwhelming to the state. The increase in MassHealth income eligibility levels still needs to be presented at public hearings across the state and face another board vote in June, and if accepted, the expanded program will significantly increase the affordability of health care for near-poor individuals and families.

In addition to the extension of MassHealth, Chapter 58 requires that the Connector come out with an annual affordability scale determining what the maximum level of premium cost the state can mandate an individual to purchase given their annual income level. Under the affordability scale for 2007 released in April, individuals between 100-150% FPL will have no premium costs and will not be expected to share in the cost of their health care premiums. Those with incomes between 151-200% FPL will be expected to pay \$35 in monthly premiums (11.4% their cost of coverage). Individuals with incomes between 201-250% FPL will be expected to pay \$70 in monthly premiums (24.5% cost) and those with incomes 251-300% FPL will be expected to pay \$105 monthly (31.3% cost) (Affordability Scale 2007). Apart from the affordability of subsidized insurance programs, the Connector also provides affordability measures for individuals who are expected to pay the full cost of their own insurance, those above 300% FPL. Individuals who earn between \$30,630 and \$50,001 will not be penalized for noncompliance with the individual mandate if they cannot find health insurance products priced between \$150 and \$300 per month. Individuals earning more than \$50,001 will not have caps on health insurance costs. Additionally, any individual (within the state subsidized income range and outside of it) who feels that they cannot afford health

insurance coverage can make an appeal to the connector for exemption from the mandate. Under the current affordability scale, 80% of the currently uninsured population will be obliged to participate in one of the state's insurance options, while 20% will be able to opt-out based on persistent financial constraints.

The plans currently scheduled for open enrollment in May of 2007 fall well within or below the \$150-\$300 premium levels and those individuals who cannot obtain coverage through a state subsidized program or employers are expected to enroll in the low cost Connector plans. However, what becomes clear in examining the individual mandate closely is that while it may prove an effective means for greatly expanding the number of insured individuals, it is not a truly universal coverage proposal. The success of the new health insurance programs depends on public support and the Connector is therefore rightly worried about mandating individuals purchase insurance coverage which is beyond their financial reach. The addition of an economic hardship waiver to the individual mandate further indicates the need to keep up with the appearance of options within an individual mandate environment. If it turns out that 20% of those currently uninsured do not enroll in any of the new insurance programs then the affordability requirements and insurance products offered will need to be adjusted for 2008. The Connector is committed to maximizing the number of individuals with insurance in Massachusetts, and while it may take several years to iron out the details, the programs will probably end up with high enrollment rates. However, closely monitoring the characteristics of those who obtain waivers or opt-out of coverage will be essential for correcting problems with Connector based insurance programs.

The individual mandate, while often the most discussed aspect of health insurance reform in Massachusetts, is not expected to work in a vacuum. It is one aspect of a “shared responsibility” philosophy which provides the framework for health insurance and health care reform. In fact the Connector Board has stated that, “the fundamental tenet of health care reform in Massachusetts is *shared responsibility*—for government to subsidize coverage for the low-income uninsured, without undoing employer-sponsored insurance” (Executive Summary Affordability 4/12/07). Therefore, after outlining the individual mandate, Chapter 58 turns to a series of provisions intended to reinforce Massachusetts’ strong history of employer-sponsored insurance.

2. *Employer Responsibility*: Employers with businesses of 11 or more full-time workers will be required by Chapter 58 to provide health insurance to those full-time employees. Minimally, one-quarter of a business’ workers must participate in the health plan, or the employer must contribute at least 33% of the employee’s individual premium (Krasner 10/11/06). A “fair share contribution” of \$295 per full-time employee will be assessed annually to employers who do not offer employee health plans or who do not meet the 33% cost-sharing minimum. The contribution is intended to reflect the cost to the state for free care utilized by workers who are not offered employer-based coverage. These requirements will be pro-rated for employers with seasonal or part time employees (Conference Committee Report 4), ensuring that these underserved workers will gain some benefit.

Employers will also be required to set up cafeteria plans under Section 125 of the Internal Revenue Code. The cafeteria plan system, “costs employers nothing, but allows workers who don’t get employer coverage to buy insurance through the Connector with

pre-tax dollars” (Serafini 2006, 24). In other words, employees are able to purchase health insurance from an employer before their income is taxed. In the example of the average Commonwealth Choice plan, the individual purchasing a plan pre-tax can expect to save \$66 a month in premium costs. Lastly, a “free rider surcharge” will be assessed on businesses when an employee and/or their dependents accesses free care more than three times in a year, or when five or more instances of employees receiving free care per year arises. The exact amount of the surcharge will be calculated by the Division of Health Care Finance & Policy (a Division of the Department of Health and Human Services) and will vary based on the number of employees, the frequency of “free care pool” utilization, the percentage of employees enrolled in the employer’s health plan and the total state-funded costs (Commonwealth Connector 2007, 6). It is expected by the Conference Committee that the total employer mandate will generate about the same revenue as the state now spends on health care for the uninsured and will be contributed to the Health Safety Net Fund (which will replace the Uncompensated Care Pool on October 1, 2007). As the number of insured individuals rises, the amount of free care used is expected to decline, therefore the Health Safety Net Fund will eventually transfer funds to the Commonwealth Care Health Insurance Program that oversees the state subsidized care programs.

Businesses and insurance companies each possess their own qualms over the employer mandate. As expected, the business lobby was opposed to the imposition of the “fair share contribution” to such an extent that Governor Romney, in a largely symbolic gesture, line-item vetoed the contribution (a veto overwhelmingly overridden by the Democratic legislature). However, most who analyze the bill note that, “the \$295 charge

is dwarfed by the annual cost of health insurance” (Steinbrook 2006, 2095) and is therefore an ineffective economic incentive for employers to provide health insurance. Although legislators claim that the funding for Chapter 58 will come primarily from the employer mandate, along with a redistribution of funds from free care to subsidized health care, the *New England Journal of Medicine* estimates the revenues are only about \$50 million a year out of at least \$200 billion needed for new coverage initiatives. However, it is not clear if other aspects of the mandate, (including the free-rider surcharge which may prove more costly to businesses than the \$295 per employee per year assessment) are included in this estimate. There is also the “foot in the door” theory, which supposes that once the program is implemented, government officials committed to increasing access to medical care will increase the responsibility placed on businesses.

Health insurance companies are also skeptical of the employer mandate, largely because they feel that the minimum levels of employer participation are too low to be effective. Blue Cross Blue Shield of Massachusetts and Harvard Pilgrim Health Care, the two largest health insurance providers in the state, have both stated that they will not offer insurance to businesses where employers contribute the minimum 33% of employee’s annual premiums, or where less than 50% of employees are enrolled in a health insurance plan. Insurers are typically looking for around 75% participation (contrasted with the 35% required by law) because, “the higher the rate of participation, the easier it is to estimate annual expenses and minimize premium costs” (Krasner 10/20/06, 1). Insurance plans for employees of businesses that are only contributing the minimum will be more expensive and with fewer benefits to make up for the small risk

pool. Therefore, the cost of paying for health care will once again fall on the middle-income worker.

Massachusetts House Speaker Salvatore DiMasi, a Democrat who has been instrumental in promoting the health care compromise, expressed his concern recently that the low standard for businesses “is undermining the legislative intent of the health care law” (Krasner 11/11/06). If the law is in fact one of “shared responsibility” between business, government, and individuals, it is necessary that business hold up its end of the deal. Many employer responsibilities, such as the vague “free rider surcharge” will need to be ironed out once the Commonwealth Connector is fully established. However, the “foot in the door” metaphor is appropriate here – business is rarely interested in regulating itself, and agreeing to initial provisions may create space for subsequent improvement.

*3. The Commonwealth Health Insurance Connector:* Bureaucracy usually follows the institution of new policy, and the Massachusetts case is no different. The Connector was instituted by Chapter 58 to administer many of the new law’s insurance regulations and programs. The Connector is a government-appointed but independently run authority which, as its name suggests, will facilitate connections between uninsured individuals and affordable insurance programs. Defining what policies can be considered “affordable”, as was discussed earlier, the Connector will facilitate the purchase of insurance for those currently uninsured including small-businesses, the self-employed, those who remain without employer insurance (who under Chapter 58 can now purchase insurance with pre-tax dollars), the unemployed, and part time/seasonal employees. The Connector is intended to “make insurance more affordable to individuals by having them

band together to get group rates” (Serafini 2006, 24). The Connector will also be responsible for helping businesses set up cafeteria plans, and will determine what level of premium assistance uninsured residents who fall below 300% of the Federal Poverty Level (FPL) will receive, in-keeping with the proposed expansion of Medicaid benefits to individuals who make between 150-300% FPL

The particular programs currently being implemented under the Connector were discussed in section 1 regarding the individual mandate, and the success these programs have had thus far in implementing (and even expanding) the vision of Chapter 58 is indicative of the Connector’s effectiveness. A well run and committed bureaucratic facilitator is essential to the success of an individual mandate health insurance reform effort and thus far the Connector has proven to be just such a facilitator. It has a clearly defined role as the provider of both state subsidy programs and low cost health insurance products to individuals and small businesses, meaning that none of its functions are redundant or overlapping with the MassHealth Agency Massachusetts Department of Health and Human Services. Thus far the connector has hit all of its target dates for policy implementation, including developing the Commonwealth Care subsidized insurance products and initiating enrollment by January of 2007, awarding “Seals of Approval” to qualifying health insurance plans by March 2007, and is on target to begin open enrollment in Commonwealth Choice programs by May 2007. The policy successes of the Connector can be traced to the political support it received both from the Romney administration and now from the Democratic gubernatorial administration of Deval Patrick elected in November of 2006. Agencies are only as effective as their administrators, and having an political administration dedicated to the successful

implementation of Chapter 58 means that the Connector has thus far received all the support (both monetary and personnel) it has required.

4. *Commonwealth Care Health Insurance*: Individuals who earn more than 150% FPL (the cut off for MassHealth eligibility), but less than 300% FPL will qualify for a new means-tested subsidized insurance program through the Connector known as Commonwealth Care. The subsidies provided will be based on a sliding “affordability scale”, which in turn is calibrated to household income (Conference Committee Report 2). No plans offered through Commonwealth Care will have deductibles, and plans will be offered by managed care organizations with histories of successful Medicaid participation.

So far there are four health insurance providers offering Commonwealth Care insurance plans for different regions of the state. Boston Medical Center HealthNet Plan, Neighborhood Health Plan, and Network Health serve all of Massachusetts, while the Fallon Community Health Plan serves only Central and Eastern Massachusetts. All health plans offered through Commonwealth Care have the same health benefits and copays. Differences include where providers are located (Community Health Centers vs. multi-specialty group practice). There are also limits on how much an individual will have to spend on copays per year depending on their level of income. Individuals qualifying for Commonwealth Care can also choose whether they would like to use a low copay or low premium method of payment. Individuals who see specialists often or have a medical condition necessitating medication may choose a low copay plan under which they will pay less for copays, but pay a higher monthly premium. Alternatively, an individual in generally good health with low utilization of health care services may choose a low

premium plan, where copays range from \$5 more for a visit to a primary care physician to \$200 more for inpatient care than low copay plans. The presence of choice within the Commonwealth Care program is important to its popularity. In order for the individual mandate reform to work, individuals need to feel that the government is aiding them to purchase a health insurance plan which best fits their needs, not that the government is coercing them into paying for something which is not useful to them.

According to an April 12<sup>th</sup> progress report issued by the Connector board, there are currently 62,979 individuals enrolled in Commonwealth Care programs, over 10,000 of whom are of an income level which necessitates a premium contribution (Commonwealth Care Progress Report). The Connector has been running large community outreach campaigns, and the Commonwealth Care call center which has been fielding an average of 1400 calls a day. The enrollment in Commonwealth Care programs is higher than expected at this point in the implementation of Chapter 58 and is indicative of public interest in the health plans being offered, and of the commitment of the Connector board to community outreach.

5. *MassHealth Expansion*: Operating under section 1115 waivers since 1996, which enable the state Medicaid program to vary from that of the federal government, MassHealth will be expanded yet again under Chapter 58. All individuals who earn less than \$15,315 (150% FPL) will qualify for expanded subsidized health insurance products through the connector with comprehensive benefits and premium waivers. Through this expansion childless adults under 150% FPL, who currently do not meet MassHealth requirements unless they are disabled, will be able to obtain health insurance. MassHealth will also expand the eligibility of children, covering children of families earning up to

300% FPL (\$38,500 annually for a family of two). Currently MassHealth only provides coverage to children of families earning up to 200% FPL. There are provisions to allocate about, “Three million dollars for comprehensive community-based outreach programs to reach people who are eligible for Medicaid but not enrolled” (Conference Committee Report 2). The plan calls for increased funding to community action programs, which will attempt to erode the stigma surrounding Medicaid, and will attempt to reduce the bureaucratic barriers to Medicaid enrollment. It is within the Medicaid expansion section of Chapter 58, that linking “Pay-to-Performance” (P2P) is discussed for the first time. P2P touches on the quality component of the health care reform program. Medicaid rates received by hospitals and providers will be tied to achievement of P2P goals. For example, a provider may achieve a P2P goal if a majority of his asthma patients are on a new drug regimen which has been proven effective. The closer the provider adheres to local, state, and national guidelines, the more Medicaid reimbursement they receive. Cost and quality data for physicians will also be collected and made public.

The Section 1115 Medicaid waiver requires that the reforms posed be revenue neutral, and as such limits what Massachusetts can expect the federal government to agree too. The 1115 Medicaid waiver expires in 2008. When the state re-files for its waiver, it will have to demonstrate that the programs it has instituted are working and are remaining revenue neutral in order to renegotiate the waiver. The process of re-filing for a Medicaid waiver is made easier by Massachusetts’ history of effective 1115 waiver programs. However, if the MassHealth expansions prove too costly the federal government might take a harder look at the program before agreeing to share in the cost.

*6. Market Reforms:* The only real attempts at cost containment can be found in the parts of Chapter 58 that deal with insurance market reforms. The non- and small-group insurance markets are scheduled to be merged in July 2007 pending an actuarial study of what effect merging these two markets will have on insurance providers and the overall market. The Conference Committee estimated the drop in non-group premium costs to be about 24% as a result of the market merger. The actuarial study was completed by several consulting firms and presented to the Massachusetts Division of Insurance and Market Merger Special Commissions on December 26, 2006. The study showed that while the decreases in non-group insurance premiums were not as great as the Conference Committee predicted, there was a resultant drop of about 15% (Gorman 2006, 10). However, the effect of the market merger on premium rates was found to vary by insurance carrier and some individuals could experience a drop in premium rates as great as 50% while others experience reductions as minor as 2% (Gorman 2006, 10). The report issued indicates that the merging of the non- and small- group insurance markets will go forward as scheduled and will result in at least a small drop in premium costs for individuals purchasing insurance through the new non-and small-group market.

In addition to the market merger HMO's will be able to offer Health Savings Accounts (HSAs) with high deductible insurance plans for individuals who wish to participate in HSAs. Young adults will be able to remain on their parents insurance plan for up to two years past their loss of dependant status, or until they turn 25. Most insurance plans do not permit students to remain on their parent's plans once they have lost their dependant status. By providing a buffer of two years of insurance coverage, recent college graduates would be able to take entry-level jobs that may not offer health

insurance without fear of losing health benefits. Young adults will also be offered targeted health insurance plans by the Connector, which will have low monthly premiums with higher deductibles and co-pays. Compelling young and generally healthy individuals to join the insurance pool will lower the rates of other members of the pool because young adults will be paying monthly premiums greater than their level of health care services utilization. Lastly, the bill places a moratorium on the creation of new health insurance mandates through 2008, in order to let the dust settle on the new system before making any alterations.

### **Prognosis**

Chapter 58 is a comprehensive plan for addressing the problem of access to health care while making lesser attempts at containing costs and ensuring quality. The first variable is the financial viability of the law which purports to be mainly a redistributive program, gaining the majority of its revenue from shifting existing funding. In the Conference Committee Report, there is only one sentence under the heading funding: “The plan leverages federal dollars to enhance and match state spending and uses revenue generated by employer contributions to fund health insurance coverage” (Conference Committee Report 5). Critics of the plan remain unconvinced. Due to the revenue neutral nature of the Section 1115 Medicaid waiver, the federal government will not be directing more money towards Massachusetts than they would have otherwise. Supplemental revenue to support the program is, “projected to be \$201 million in fiscal year 2008” (Steinbrook 2006, 1) with about \$125 million coming from state revenues, the question becomes whether the employer mandate will realistically be able to make up the difference. When Massachusetts residents were polled about their support of Chapter 58’s

various components, 80% polled in support of the government requiring businesses to facilitate employee purchase of health insurance with pre-tax dollars. There is also 70% support for the employer mandate requiring businesses, “to provide health insurance or pay a penalty” (Blendon 2006, 8). The support of a majority of residents for the employer mandate will give legislators a stake in maintaining, and possibly expanding, the employer mandate. While health care coverage will definitely be expanded by the law, the quality of this coverage remains to be determined.

The individual mandate is the least popular part of the Massachusetts law, with only 52% supporting the individual mandate whereas 70% support the parts of the law related to the employer mandate, and 64% support the law generally (Blendon 2006, 1). The moderate support for an individual mandate represents the public’s willingness to experiment with the new law, but the Connector should, “exercise care when establishing affordability standards ... to ensure that those standards are viewed as fair by the public” (Blendon 2006, 1). The respondents polled as part of a survey on the public opinion and perception of the new Massachusetts law were asked questions related to the prospective affordability of Commonwealth Care premiums as well as Commonwealth Connector offered premiums. Commonwealth Care premiums for an individual earning \$25000 annually (250% FPL) are estimated to fall between \$50 and \$200 per month. Only 25% of state respondents asked felt that the highest price estimate was fair while over 70% believed that monthly premium in between the high and low estimates would be fair (Blendon 2006, 14). The individual premium contributions for those at 250% FPL have now been fixed for 2007 at \$70 per month, towards the lower end of the predicted range. Notwithstanding a drastic shift in public opinion, a majority of individuals feel that this is

a reasonable contribution for an individual to make for the cost of their coverage and bodes well for the popularity of Chapter 58.

The implementation of Chapter 58 has implications for the cost of medical care. On the one hand through increasing the number of insured to near-universal levels, the demand for health care services and procedures will rise, creating a corresponding rise in cost (Steinbrook 2006, 1). However, the increase in individuals receiving routine preventative care and treatment may lead to a corresponding decrease in medical spending as the need for more expensive procedures diminishes (Hoerger and Moore, 2006) due to early diagnosis and treatment of chronic conditions. Preventative screening also serves to ward off potential public health risks from the spread of communicable diseases. Pressure will be relieved in ERs as the uninsured who obtain insurance are able to receive care in a primary care provider's office, thus freeing up emergency rooms to treat actual emergency cases. While time will tell the ultimate prognosis of Chapter 58, the plan has already met its objective of expanding access to health insurance coverage.

### **Conclusion**

When asked about the compromises made in order to get the Massachusetts Health Reform Law passed, Governor Mitt Romney stated: "We haven't allowed perfection to be the enemy of the good." The death of important legislation often occurs as a result of an inability to compromise; when equally powerful special interests compete the result is often deadlock. Sometimes external events enable the political process to move out of the realm of purely self-interest motivated politics and into a realm where self-interest and public-interest combine to produce an innovative change for economic and social justice. With 92% of Massachusetts residents believing the

health care system has at least some flaws (Blendon 2006, 4), Massachusetts seems to have arrived at the point where large policy changes are politically feasible.

At this point in the development of Chapter 58 much of the law that had been vague has been clarified. As the programs promulgated in Chapter 58 continue to take shape, their success will continue to be evaluated. However, at this initial stage in its development, Chapter 58 appears to be on schedule. Through enacting the employer mandate simultaneously with other aspects of the law Chapter 58 will avoid the excessive lag time from enactment to implementation which undermined Dukakis' employer mandate program. Additionally, the all-important Connector has moved from being an abstract concept to a functioning administrative agency.

Chapter 58 does little to address the concerns of cost containment and quality assurance (both of which are an important part of any health care reform proposal) however it does substantially increase access to care - which is the law's primary objective. The aspects of the bill dealing with cost containment and quality, such as insurance market reforms and tying Medicaid reimbursements for both hospitals and providers to P2P hold the possibility for later expansion. The enactment and initial implementation of Chapter 58 has proven that health care problems can be addressed through the political process and it opens the door for a much needed national discussion of finding a socially and economically just solution to health care's iron triangle.

As predicted, legislators in other states have begun to look to Massachusetts as a model for comprehensive and meaningful health care reform policy that is politically feasible. California is one state attempting to fit the Massachusetts model of reform to its very different health care market. The estimated number of uninsured in California is

about equal to the entire population of Massachusetts, and there are easily six times as many residents in California as in Massachusetts. In addition to these drastic demographic differences, health care reform on the West Coast faces the additional obstacles of a large illegal immigrant population, and of a more dysfunctional health care system. However, California is the ultimate laboratory of American policy and has been a legislative trend setter in the past (such as in the national adoption CAFE emissions standards in the 1970s). If the individual mandate and “shared responsibility” policies being implemented in Massachusetts can survive the grueling California legislative process and ultimately be implemented successfully within the state, than individual mandates with shared government and employer responsibility can truly be said to be the future of comprehensive health care reform.

## **CASE STUDY II**

### **CALIFORNIA: “FINDING THE *IT* OF IT”**

The debate surrounding health care reform in California offers a second valuable case study of state-initiated health care reform. Analysis of health care reform in California – which is not only the largest and richest state, but also serves as a legislative trendsetter for the nation as a whole – has the seductive appeal of applicability to other states and to the entire nation. Whereas any health care reforms enacted in Massachusetts may be written off by critics as the efforts of a relatively liberal and affluent state to introduce socialized medicine, the institution of major reform in California will not be able to be so easily ignored or stigmatized. The successful implementation of health care reform in California will require a massive commitment to the success of the undertaking

by many varied stakeholders. These stakeholders include the uninsured and underinsured, undocumented workers and their dependents, the county health systems, both large and small business interests, the health insurance lobby, and health care provider associations. Each of these stakeholders has a different capacity to effect the legislative process and each wish to shape any health care reform to their benefit. The interplay between these stakeholders throughout the legislative process and the way in which they are able to negotiate and compromise will be crucial to the success of health care reform in California and is indicative of the ways in which national health care reform efforts could be instituted.

While Massachusetts' Chapter 54 was able to build on previous legislative health care reforms, the current attempts to reform California's health care system follow a long lull in reform legislation efforts. As a result, much of California's health care delivery system has been slowly eroded by years of neglect and increasing costs that have rapidly outpaced increases in wages and general economic growth. Rising health care costs in California are further accentuated by the way in which public insurance programs reimburse providers and hospitals. California's state Medicaid program (Medi-Cal) and California's State Child Health Insurance Plus program (Healthy Families) have the lowest health care provider reimbursement rates in the nation. The very low rate of reimbursement to health care providers and hospitals has left California's health care system in need of urgent reform.

Additionally, predictors of the success of health care reform in Massachusetts, including a strong tradition of employer-sponsored health insurance, are not present in California. The number of employers who offer insurance to their employees has

decreased steadily in recent decades and is worse than the national average. The reimbursement to health care providers offered by Medi-Cal pales in comparison to those offered by MassHealth (Massachusetts's state Medicaid program) even before the Chapter 58 reforms. Health insurance companies were already required to guarantee issue and offer community rating in Massachusetts prior to the passage of Chapter 58, making the health insurance market more equitable and efficient than California's. Medi-Cal does not cover as many indigent adults or children as MassHealth did even before the Chapter 58 reforms. As in the Massachusetts case study, looking at the history of health care reform legislation in California provides an important entry into the discussion as to how meaningful health care reform can take place given California's currently inefficient health care system. It is in this context that the health care reform in California will be addressed.

Part of what is so interesting about the California case is that several of the proposals on the table have not yet been drafted into legislation. Whereas in Massachusetts, the path of former Governor Mitt Romney's health care reform proposal took into law followed the well charted path most legislation faces – from Assembly to Senate to Conference Committee and finally to the Governor's desk – California is taking a different track. This unorthodox means of drafting legislation is in part because the threat of referenda which looms large in California. Therefore, the focus in analyzing California's response to health care reform will center on Governor Schwarzenegger's proposal, in spite of the fact that it is not in the form of legislation.

There are bills before the California's Assembly and Senate that address health care reform. These bills largely fall in line with Governor Schwarzenegger's individual

mandate model. For this reason, special attention will be paid the Governor's proposal at the expense of analyzing each similar piece of legislation. Two other plans worth mentioning because of the radically different way in which they take on health care reform are Senator Sheila Kuehl's universal health care bill (S.B. 840) which provides for a single-payer alternative, and the Republican Party caucus's proposal for health care reform. Senator Kuehl's health care bill was passed through the legislature last year and was vetoed by the Governor. The plan offered by the Republican caucus is less of an integrated or comprehensive solution the health care reform, but represents an affirmation of utilizing conservative market principles (e.g., Health Savings Accounts and tax credits) in order to expand coverage. In discussing her misgivings over the Governor Schwarzenegger's proposal, State Senator Sheila Kuehl stated that in devoting so much of the proposal to increasing access to health insurance the Governor was ignoring the fact that health insurance in and of itself is not, "the 'it' of 'it'" (CA Health Committee Hearings, 2/15/07). In other words, simply having insurance coverage does not automatically mean that you will be healthier, that your care will be more reasonably priced, or that you will not experience inadequate medical services. While the Governor's health care reform plan does focus on increasing health insurance coverage, it also makes a real attempt to find the underlying "'it' of 'it'" in order to form a truly comprehensive health care reform strategy.

### **Brief History of Health Care Reform in California**

The legislative path which California has taken to health care reform has not only been rocky, it has been obfuscated with false starts, dead ends, and cyclical policy paths. History of health care legislation in California can be characterized by two phases. The

first phase was the evolution of managed care and the subsequent attempts to regulate and streamline the resulting managed care health insurance plans. The second phase, begun in earnest in the early 1990s, was an attempt to remedy the health care system with a “Pay-or Play” employer mandate.

### *Phase I: Insurance Development and Regulation*

The problems with Medi-Cal which are central to all current discussions of health care reform can be traced to the first phase of health care legislation. Health insurance plans as we know them today began to evolve in the late 1930s. In California, the first hospital association health insurance plan (later Blue Cross) was legislated in 1937. The hospital insurance plan was followed two years later when the California Medical Association’s founded California Physicians Service (later Blue Shield). The evolution of Blue Cross and Blue Shield represented the first prepaid health insurance plans, which provided, “specific services for a fixed monthly fee through more tightly organized networks” (Roth and Kelch 2001, 6). Health insurance grew rapidly during World War II when wages were frozen, but benefits were not (Roth and Kelch 2001, 7) leaving many employers offering more extensive benefit packages in order to entice and retain workers. By the 1950s, health insurance was offered through most workplaces with about 80% of the workforce in California covered through their employer by some type of health insurance plan (Roth and Kelch 2001, 7). The attraction of prepaid health plans grew, particularly among members of government who saw prepaid health plans as a means for assuring cost reduction in government sponsored health plans.

In 1971 Governor Ronald Reagan proposed to integrate prepaid health plans with the Medi-Cal program in order to drive down Medi-Cal costs. These reforms were

enacted through Assembly Bill 949 and, in part, authorized prepaid health plans to serve Medi-Cal beneficiaries on an individual basis. Under AB 949 the prepaid health plans contracted with the California Department of Health Services (DHS) to provide Medi-Cal patient's their entitlements. By December of 1972 about twenty-two prepaid health insurance plans had contracts with 132,668 Medi-Cal enrollees (Roth and Kelch 2001, 28). However, in the absence of rigorous government regulation abuses of the Medi-Cal prepaid health insurance plans occurred. Fraudulent enrolment in Medi-Cal programs, inadequate care, and limited physician availability, were among some of the initial abuses. In the wake of these abuses the Waxman-Duffy Prepaid Health Plan Act of 1972 set new standards for Medi-Cal which required increased regulation by the Department of Health Services. However, abuses persisted and as The New York Times reported in 1974, only \$56.5-million in payments made by State Health Dept to 15 prepaid health contractors surveyed, only estimated \$27.1-million was spent directly on the provision of health care services. The remaining funds went to administrative costs and profits to the contractors (Roth and Kelch 2001, 28). Investigations into malfeasance of the Department of Health Services found that its officials "had shown favoritism to plans represented by former DHS staffers and had renewed licenses even where quality of care problems had been documented" (Roth and Kelch 2001 8). Distrust of the government's ability to oversee and ensure adequate health insurance care coverage had its beginnings with these transgressions. In 1975 the Knox-Keen Health Care Service Plan Act was passed in order to regulate Medi-Cal prepaid plans and to establish some basic Medi-Cal requirements. Knox-Keene, which is still in effect today, sets rules for mandatory basic services, accessibility of providers, consumer disclosure and grievance requirements.

As managed care became the health insurance mechanism of choice for Medi-Cal enrollees, managed care organizations began to increase their penetration into the private health insurance market. After the 1973 Federal HMO act, managed care health insurance products increasingly became the method of providing health insurance by employers to their employees. However, although managed care promised cost savings through the prepaid system, it also offered incentives for, “private insurance companies to drop coverage or raise premiums for small, high-risk groups of employees” (Oliver and Dowell 1994, 124), which made offering health insurance benefits to employees increasingly difficult for employers. Therefore, from its high of 80% of employers who offered health insurance in 1950, employer-sponsored health insurance continued to erode through the late 1970s and the duration of the 1980s until by the early 1990s only 56% of Californians (compared with over 60% nationally) were covered by an employer-sponsored health insurance (Brown 1996). With notably fewer individuals covered by employer-sponsored health insurance, and about 23% of the population entirely without insurance coverage, the impetus for health care reform has been revived.

### *Phase II: Employer Mandate*

The 1992 attempts to ensure a basic level of employer-sponsored health insurance began with a Senate bill and a ballot proposition which indicated the first “sea-change” in health care reform legislation in California. The second wave of employer mandate legislation came in the Health Insurance Act of 2003 (S.B. 2). Instead of focusing reform efforts on insurance companies and the health insurance plans themselves, legislators and interest groups addressed the problem of increasing number of the uninsured among working Californians. Due to legal restrictions placed on government regulation of

employee health insurance benefits by the Employee Retirement Income Security Act of 1974 (ERISA), employer mandate proposals are often coupled with a “play-or-pay” program<sup>2</sup>. “Play-or-pay” gives employers the flexibility to opt out of offering health insurance coverage in favor of paying a “fee” intended to cover those workers not receiving health insurance.

As employers have traditionally served as the connector between the labor force and their dependents and health insurance, it makes sense that reform efforts should build on this existing relationship in order to facilitate reform. Employer mandates are all similar in requiring employers to insure their employees but the variation between employer mandate policies becomes evident in the details: Who counts as an employee? How many employees constitute a firm? Which firms are subject to the mandate? What is the minimum benefit package? How much of the cost of coverage can be shared with the employees? How politically feasible is enactment of an employer mandate? Some employer mandates make provisions for seasonal or part time workers, the unemployed, those employed by businesses exempt from the mandate. Despite these variations, the basic purpose of employer mandate is to provide health insurance to the working-middle class. The working-middle class is an important and powerful political demographic whose support is essential for change.

The addition of a “play-or-pay” proposal to an employer mandate generally makes the proposal more palatable to businesses (as well as less subject to legal challenge). With a “play-or-pay” proposal, employers can either “play” by offering their employees health insurance compliant with the mandate, or “pay” a tax (usually some

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<sup>2</sup> Hawaii is the only state whose employer mandate program is exempt from ERISA requirements because Hawaii’s employer mandate program was enacted prior to the passage of ERISA.

percentage of payroll), which is intended to cover employees whose employers opt out of the mandate. These funds raised by the state are then used to cover employees with some type of state sponsored health insurance pool. The “pay” component of “play-or-pay” is indicative of how serious the legislators are about offering coverage. Typically it is estimated that employers would have to pay about 7-8% of their gross payroll to substantially be able to offset the costs of providing health insurance for employees through a state pool. However, proposals are rarely drafted with gross payroll taxes greater than 5% because of the difficulty in getting businesses to accept any gross payroll tax at all. As was shown by the Massachusetts example, the amount that businesses agreed to pay was nominal compared with the cost of employers having to provide health insurance coverage, or with the cost the state will incur in providing a pool of subsidized health insurance for the employees of non-playing employers. While Massachusetts offers a weak example of an employer mandate as part of its reform proposal, it is worth noting that the health care reform legislation was actually enacted in Massachusetts. Several employer mandate reform proposals have been proposed in California, yet none have been enacted. The two most interesting attempts at increasing access to coverage through an employer mandate were the 1992 ballot proposition 166 sponsored by the CMA which would have required a straightforward employer mandate without “play-or-pay provisions”, and S.B. 2 an employer mandate with a “play-or-pay provision” that was narrowly defeated by referendum.

The 1992 employer mandate ballot initiative provides an introduction to the key interest groups responsible for making or breaking health care reform proposals in California. These interest same groups have been present in each of the subsequent

manifestations of health care reform in California. They include most notably: provider groups (the CMA, the California Hospital Association, the California Nurses Association), the health insurance industry (the California Association of Health Plans well as powerful individual health plans such as California Blue Cross and Blue Shield), business interests (the California Manufacturing Association, the California Restaurant Association, and the California Chamber of Commerce), labor unions, consumer advocacy groups (such as Health Access California) as well as county and local governments. Each of these interest groups feels the effects of health care reform policy directly and therefore has a large stake in the outcome of legislation. As the interest group theory of politics tells us, those with large stakes in the outcome and with a great capacity to organize are the most influential.

The CMA was the primary driver behind California's 1992 reform efforts. The Care Initiative of 1992 (Prop 166) mandated that all employers provide a basic level of health care coverage and be responsible for paying at least 75% of the premium rates to eligible employees and their dependents. It also required insurers provide community ratings to employers, meaning that they offer employers within the same geographic regions the same premium rates. Only employers with less than 100 employees would be exempt from the community rating requirement but health plans would only be able to charge smaller employers up to 30% more than larger employers (Oliver and Dowell 1994, 126). Most of the components of the reforms offered by Proposition 166 were also presented in a complimentary Senate Bill. However when the bill stalled in assembly and took a back seat to California's increasing fiscal crisis, efforts shifted to a ballot initiative.

Provider associations, particularly the CMA and Hospital Associations, are not typically supporters of health care reform. Thus having powerful provider lobbies behind a health care reform effort made the passage of that reform seem inevitable. However even adding the presence of public support for the proposed health care reform to the CMA, “the opposition of other important interest groups and a foundering economic created insurmountable obstacles to a significant change in public policy” (Oliver and Dowell 1994, 125). The opposition groups turned out to be a strange mixture of the health insurance lobby, business interests who routinely reject health care reform efforts, and more progressive lobbies, such as the California Nurses Association and Health Access California. A typical complaint against the employer mandate reform is that it would prove too costly for business. Employers with interstate operations were, “unsupportive of state-by-state solutions and preferred to let momentum build for national reform” (Oliver and Dowell 1994, 131) since such employer mandate reform would place them at a disadvantage with competitors in states not having such an employer mandate reform. Progressive opponents of Proposition 166 expressed similar sentiments for national health care reform, though for slightly different reasons. Health care reform was a major issue in the 1992 campaign<sup>3</sup> and it seemed that national health care reform was imminent. Thus, national politics played a role in the defeat of Prop 166.

The fickle nature of public opinion regarding health care reform in 1992 also contributed to the defeat of the California ballot initiative (Proposition 166). In the months leading up to the November election, health care reform in national polls moved

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<sup>3</sup> After the November 1991 election of Harris Wofford as United States Senator from Pennsylvania, who ran on a platform of universal health insurance, it “increased the confidence of consumer advocates and produced a greater commitment to waiting and working for a national solution” (Oliver and Dowell 1994, 132).

from 55% in favor in September of 1992 to 46% against by late October of 1992 (Oliver and Dowell 1994, 135). The factors accounting for this drastic change in voter opinion regarding health care reform was do in some part to the nature of the economy. The state of the economy is one of the best indicators of voting patterns both nationally and at the state and local level. Since national health care reform was believed to be on the horizon, voters worried about unnecessarily spending state funds since the federal government would soon be spending federal resources. Also, voters had considerable help in forming opinions about health care reform. Business organizations ran a blitzkrieg advertising campaign, inundating voters with the message that small businesses would close and more people would be unemployed if Proposition 166 passed, causing a worsening of the state's economy. California voters defeated Proposition 166, electing instead to wait – in vain – for an answer to the health care problem to come from Washington. When none came it took almost 10 years for another health care reform proposal to be seriously considered.

The story of The Health Insurance Act of 2003 (S.B. 2) is in many ways a repeat of Proposition 166, only the struggles with this act occurred *after* its passage. S.B. 2 mandated that firms with more than 50 employees provide their employees and their dependents with health insurance coverage, with employees sharing in up to 20% the cost of coverage. S.B. 2 also provided a “pay” option for employers whereby employers could pay into a state health insurance pool managed by the Managed Risk Medical Insurance Board (MRMIB) which would, in turn, provide some minimum level of benefits to employees. The MRMIB was founded in 1990 and is responsible for administering several health insurance expansion programs including Healthy Families which provides

health insurance to low income children and families who are above the income eligibility requirement for Medi-Cal. According to S.B. 2 the MRMIB would have the responsibility for determining the fee paid by non-participating employers by, “determining the total amount necessary to pay for health care for all enrollees, and, if applicable, their dependents eligible for the program” (Proposition 72 Chapter 4 Section 2140.1). The primary criticism of S.B. 2 was that the state health insurance purchasing pool created by the legislation would not have been able to support all the employees of employers who chose to “pay” rather than “play”. Additionally, because the legislation would not have permitted the new purchasing pool to self-insure, as is the case for California’s health insurance program for state employees (CalPERS), the “health plans would be unlikely to offer the pool better rates than they offer to employers directly” (Institute for Health Policy Solutions 2005, 38). This meant that the pool would not be able to self-sustain financially and would thus provide health insurance at a greater cost, negating the very purpose of the bill. It was estimated that under S.B. 2 17.8 million Californians would be covered by the act. Out of those 17.8 million individuals covered, only about 1.9 million would be uninsured and thus in the pool (Yelowitz 2005, ii). Thus, according to this calculation, S.B. 2 would only provide coverage to a small percentage of Californians. Thus, while the law would not have wide reaching implications for the uninsured, it would have an effect on firms where employees were being asked to share in more than 20% of the cost of their coverage.

The legislature approved S.B. 2 and Governor Grey Davis signed the bill into law in 2003. However, powerful interest groups that opposed to employer mandated coverage put Proposition 72, a referendum on S.B. 2, on the ballot for the November 2004 election,

thus halting the implementation of S.B. 2. The opponents to employer mandated reform were largely the same as in the 1992 example cited above. While provider associations were generally in favor of S.B. 2, business associations, particularly the California Restaurant Association, opposed the bill claiming it would place a burden on restaurants, which are typically firms having high labor costs and a low profit margins. Labor organizations supported S.B. 2. Consumer advocacy groups remained wary of the ability of the state's health purchasing pool; however they also supported the bill because it represented a step in the right direction. Whereas in 1992 progressive organizations were inclined to wait for an answer to health care reform from the federal government, the dismal failure of Clinton's 1994 health care proposal coupled with a federal government under Republican control removed the likelihood that the federal government would step in with some version of national universal coverage. Therefore, the ideological division over S.B. 2 and Prop 72 were more traditional, with business against reform and consumer advocates in favor. In order for S.B. 2 to go into effect, the voters would have to approve it by a vote of "yes" to Prop 72. Theoretically, the fate of employer mandated health insurance reform now lay in the hands of the people of California, and the interests on each side of Prop 72 began an intense media campaign to bring the voters to their side.

As in 1992, the public generally favored Proposition 72. In June, 2004, 50% of likely voters said that they were currently inclined to vote yes on Proposition 72 (Field Poll June 2004). However, the same poll recognized that the voter awareness of the referendum was at a relatively low level, with only 23% of voters saying they had prior knowledge of the Proposition. In the campaign leading up to the 2004 election, the key interest groups on both sides poured money into a mass media campaign. According to

the California Health Care Foundation, the three largest groups in favor of Proposition 72 were the California State Council of Service Employees Issues Committee (contributing \$3,131,879), the California Teachers Association Issues PAC (contributing \$1,057,696) and the United Food and Commercial Workers International Union (contributing \$1,030,000). Those groups opposed to Against Proposition 72 included the California Restaurant Association (contributing \$5,042,000), WAL-MART Stores, Inc. (contributing \$648,449) and McDonald's Corporation (contributing \$471,250). The key interest groups broke down along the traditional labor vs. business divide with those businesses most vehemently opposed to the employer mandate being the very ones offering their employees minimal or no health insurance benefits. All told, those interest groups contributing money to defeat Proposition 72 out spent those groups contributing money to support Proposition 72 roughly 4 million dollars (California Health Care Foundation S.B. 2 Retrospective). In the final election, the Proposition was defeated by a surprisingly narrow margin of 50.9% to 49.1%. Among those who voted against the proposition, “43 percent, say the main reason for opposing Prop. 72 is ‘it would increase the cost of doing business in California / makes business less competitive / would be bad for business’” (California Health Care Foundation Press Release 2004). Each of these reasons for voting “no” had been a prominent message of the media campaign presented to the public by the business associations and their supporters. This confirms the particular susceptibility of voters to political advertising where health care politics is concerned. Although a majority of Americans consistently support health care reform, once subjected to effective media campaigns by special interest groups, public support proves malleable. It is important to keep this in mind when discussing the current health

care reform proposals in California that any legislation which eventually passes the legislature and is signed into law by the governor will likely have to survive a similar referendum.

### **Profile of California's Economy and Population**

With a gross state product of \$1.6 trillion, California not only represents the largest economy in the nation, but consistently ranks among the top ten economies in the world (*LAO Cal Facts*). Apart from its enormous size, the California economy is also highly diversified with the largest employment sectors in trade, transportation and utilities, government, and professional and business services. Mining and agriculture also represent an important part of California's economy. California's large and diversified economy necessitates a large and diverse labor force which is reflected in the demographics of the state.

California has a population of about 36 million residents with approximately 1 million more individuals residing within the state without documentation. California has a large percentage of foreign born residents, 28% compared with only about 12% nationally (*LAO Cal Facts*). Mexico contributes the most to California's immigrant population with about 4.6 million, or 46% of foreign-born Californians coming from Mexico (*LAO Cal Facts*). About 16.9% of individuals living in California are non-citizens. Non-citizen populations without health insurance coverage contribute to both the problems and inefficiencies of California's health insurance market.

### **Profile of California's Uninsured**

The estimates of California's uninsured vary. However, according to the California Health Care foundation, the average percentage of Californians without health

insurance is 20.8% or 6.6 million people (CHCF 2006, 3)<sup>4</sup>. This number represents the seventh largest proportion of uninsured in the nation but the largest number of uninsured residents of any state. The proportion of uninsured is about twice as much as the proportion of uninsured in Massachusetts (10.7%) and is significantly greater than the percentage uninsured nationally (17.7%).

Current analysis of health insurance coverage patterns in California reveal that the majority of non-Medicare covered persons are insured through an employer (54.7%). However, this percentage represents a drop from 2000 when the proportion of Californians insured through their employer was 59.1%. This declining percentage of Californians covered through their employer is not an isolated trend, but demonstrates the slow erosion of employer-sponsored health insurance that has occurred since the 1980s. Employer-sponsored health insurance coverage has fallen 10 percent in California between 1987 and 2005 (CHCF 2006, 6). National trends in employer-sponsored health insurance coverage parallel those in California with the proportion of individuals insured by their employer falling from 70.1% in 1987 to 62% in 2005. Therefore, the problem of the decline in employer-sponsored health insurance that is being felt across the nation is more dramatic in California, where fewer individuals started off with employer-sponsored health insurance, thus magnifying the decline.

When discussing employer-sponsored health insurance coverage it is important to note that there are two ways in which an employee can be covered. The first is through primary coverage, where the only the employee receives health benefits. The second, and

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<sup>4</sup> Most estimates of the uninsured only include those who are classified as non-elderly. The non-elderly population is that between 0 and 64, with the assumption being that those over 64 qualify for Medicare. While the problems facing Medicare are vast, my analysis focuses on problems facing the non-elderly uninsured populations and therefore any estimates of the uninsured population or of the breakdown in insurance coverage will only include those up to age 64 unless otherwise noted.

more traditional, is dependant coverage where the employee, spouse, and any dependant children all receive health benefits. The well documented drop in employer-sponsored health insurance is in dependent coverage, although primary coverage has experienced a decrease as well. In 2003, for example, 14.5% of adults had employer-sponsored health insurance as a dependant, down from 16.7% in 2001 while the rate of employer-sponsored primary health insurance coverage remains statistically unchanged (Brown 2005, 3). Only 5.8% of employees decline coverage because they are able to obtain coverage as a dependant through a spouse's employer, and many adults who previously would have been able to obtain coverage as a dependant have had difficulty obtaining coverage at all. The decrease in dependant coverage has also led to an increase in child enrollment in the state-sponsored Medi-Cal and Healthy Families programs. Of the approximately 4.4% of Californians who lost employer-sponsored health insurance between 2000 and 2005, almost half (about 2.3%) were able to qualify and obtain coverage from Medi-Cal or Healthy Families. Additionally, because low wage jobs are less likely to offer dependant coverage, and more likely to offer coverage with prohibitive annual premiums, a large proportion of those who are affected by the loss of employer-sponsored health insurance are able to meet the income eligibility levels imposed by the Medi-Cal and Healthy Families programs. However, the rising percentage of the uninsured indicates that not all of those losing employer-sponsored health insurance can find alternatives. These individuals are most often the lower-middle class or the working poor.

Another important contributing factor to the decline in employer-sponsored health insurance is the continuing rise of premiums and the increasing share of those premiums

employers shift to employees. Between 2001 and 2003 the average total cost of primary coverage in California rose 31.6% and the average cost for dependant coverage rose 36.1% (Brown 2005, 28). To offset the increased cost, some employers increased the amount of employee contribution to nearly 80% of the cost of premiums. In dollar terms, the average employee contributed \$2,452 annually for family coverage in 2003 (Brown 2005, 28). While this may not seem like a prohibitive contribution for employees with dependant coverage, many workers with lower wage jobs are actually expected to contribute more for their coverage because employers generally give more generous benefit packages in order to recruit and retain high-wage workers. Also, both the cost of premiums and the percentage of employee contribution have continued to rise since the last California-specific study of employer benefits. The average cost of a dependant health insurance plan nation-wide is \$11,480 annually, and the average worker contribution to that average plan is about \$3,000 (Kaiser Foundation 2006, 2). Keeping in mind that California has a lower rate of employer-sponsored health insurance than the national average; it is safe to assume that the average rate of worker contribution is currently higher in California.

Coverage by firm size is another important trend in employer-sponsored health insurance because health care reform proposals typically seek to require firm participation. It is no surprise that firm size is inversely related to insurance coverage, with larger firms being more likely to have insured employees. The larger the pool of individuals covered, the lower the risk and the lower the premiums. However medium-sized firms, with 100-499 employees have experienced the largest increase in uninsured employees, going from 17.5% uninsured in 2000 to 20.9% uninsured in 2005 (CHCF

2006, 7). This increase in the number of uninsured employees in medium-sized firms paralleled an increase from 15.1% in 2000 to 18.7% in 2005 in the number of uninsured individuals with annual family incomes between \$50,000 and \$74,999 (CHCF 2006, 9). This demonstrates the increasing lack of coverage for lower-middle and working class families. These families are a politically important group on any issue but particularly in the realm of health care reform. To pass health care reform legislators have the difficult task of convincing their constituents that health care reform is in their interests and is not just a problem effecting others (e.g., uninsured and the poor). Current efforts to convince the currently insured that health care reform effects them have focused mainly on the “hidden tax” (an ingenious rhetorical ploy which will be discussed later) and the economic burden everyone suffers because the uninsured.

Another important aspect of employer-sponsored insurance is how often firms offer health benefits to their employees (offer rate), how many employees qualify for these health benefits (eligibility rate), and how many employees accept employer based insurance (take-up rate). Generally firms have been increasing their offer rate, and employees have a very high take-up rate, so the resulting lack of insurance experienced by employees and dependants has to do with falling eligibility rates (Brown 2005, 3). Who qualifies for employer-sponsored health insurance (eligibility rate) reflect both employer deniability (e.g., due to a pre-existing medical condition such as cancer) and any barriers erected by the employer as a means of decreasing the take-up rate (e.g., long waiting periods before coverage takes effect). In situations where a firm offers insurance and an employee is eligible, the take-up rate consistently over 80% (Brown 2005, 3). Therefore, uninsured employees most often work for non-offering firms 57.2%, while

about 25% work for firms which deny coverage because of eligibility issues (Brown 2005, 35). Consistent with the high cost of coverage, the failure of employees to take-up coverage which they are eligible for is most often (44.3%) attributed to their inability to afford coverage due to the high cost of their contribution to the insurance (Brown 2005, 38). A small percentage of employees reported trading health benefits for increased wages while another small percentage reported declining health insurance because, “they did not need or want health insurance” (Brown 2005, 38). Some workers received coverage from a dependant spouse, thus the number of individuals declining employer-sponsored health insurance because they are healthy may in fact be negligible.

The decline in employer-sponsored health insurance has not been accompanied by a point-for-point increase in the percentage of the uninsured. While the proportion of those without insurance has been steadily rising with the decline in employer-sponsored health insurance, the proportion of uninsured is not as high as it might be expected because of an increase in the number of individuals enrolled in the Medi-Cal and Healthy Families, and an increase in the number of individuals finding insurance through the individual health insurance market. From 2000 to 2005 the percentage of individuals enrolled in some form of public insurance program rose from 13.7% to 16%. Over the same period of time individually purchased insurance rose from 20.6% to 21.4% (CHCF 2006, 4). Thus, those who have lost employer-sponsored health insurance are not *all* becoming uninsured.

The low percentage of Californians covered by employer-sponsored health insurance has to do in part with the nature of California’s workforce. Non-citizens workers who work low wage jobs are more likely then other workers to drop health

insurance coverage when faced with increasing health insurance premiums. Many non-citizen workers do not have any health insurance benefits at all. These workers end up in public insurance programs such as Medi-Cal and Healthy Families or join the ranks of the uninsured. While some may see the high rates of participation in public insurance programs in California as a positive development, it may in fact reflect a large indigent population, not a particularly successful public insurance. This presents health care reform in California with several particularly difficult problems to solve.

The first problem is the well-documented low reimbursement rates to health care providers and hospitals from Medi-Cal. Cutting hospital and provider reimbursement rates is a time-honored way to save public health insurance programs money and is particularly popular in years where there is a budget shortfall. Medi-Cal rates are, “among the lowest of any Medicaid program in the country” (Prestowitz 2000, 17) and reimbursement for provider office visits remain at about 40% of other payer’s reimbursements (e.g., commercial health insurance plans and Medicare). The majority of Medi-Cal patients are concentrated in a few practices and hospitals threatening to the fiscal security of these practices and hospital due to low reimbursement. When this low reimbursement from Medi-Cal is combined the cost of caring for the uninsured, the result is, “tremendous pressures on our emergency rooms” as Kim Belshe, California’s Secretary of Health and Human Services noted in a presentation to the California Health Committee in February 2007. The low Medi-Cal reimbursement rates and the effects of the uninsured population of Californians results in the practice of “cost-shifting”, that has been occurring in California for years.

In the health care market “cost-shifting” manifests itself by, “the allocation of unpaid costs of care delivered to one patient population through the above-cost payments collected from other patient populations” (Dobson 2006, 23). Therefore, those persons with insurance are billed at a higher rate that is intended to offset the losses incurred for providing care below cost (e.g., Medi-Cal patients) or at no cost (e.g., the uninsured). Thus, “cost-shifting” places hospitals and providers in the role of, “private-sector tax collectors” (Dobson 30). It can therefore be argued that individuals with health insurance coverage are already paying, through “cost-shifting”, for the health care of the under-insured and the uninsured. The theory of “cost-shifting” is difficult to prove, although it is an observable fact that, “Hospitals with a bigger decrease in average payments from Medicare in a given year tended to have a bigger increase in their private-pay prices” (Zwanzinger 2006, 201).

“Cost-shifting” is at the center of Governor Schwarzenegger’s health care reform proposal. The Governor argues that “cost-shifting” results in a “hidden tax” which Californian’s are already paying to shoulder the cost of services used by the uninsured. The term “hidden tax” was coined by the New America Foundation in a December 2006 issue brief on the nature of the health insurance problem in California. Founded in 1999, the New America Foundation is a Washington D.C. based public policy institute with a large presence in California whose mission statement declares that the foundation is, “post-partisan”. Governor Schwarzenegger picked up on the term “hidden tax” and has been able to successfully use it to reframe the problem of the uninsured.

First, the New America Foundation estimates that about 10% of California premium costs reflect the “hidden tax” imposed by the uninsured on the insured by “cost-

shifting” which translates into an increase in average annual health insurance premium by \$1,186 for a California family by and \$455 for an individual (Harbage 2006, 2). The “hidden tax” is worse in California because California has a lower percentage of persons covered by insurance than the national average. In addition to the “cost-shift tax” imposed by the uninsured, there is the notorious under compensation for services by Medi-Cal. The Governor’s office has estimated the “cost-shifting” caused by under-compensation to be about 7% of health insurance premiums. Therefore, the Governor’s health reform proposal assumes that there is already a 17% shift of cost from the uninsured and underinsured to the insured.

In presenting the nature of the problem the uninsured pose in California, the Governor and his health care team lean heavily on the concept of a “hidden tax.” Secretary Belshe mentioned the “hidden tax” frequently during her presentation to the California State Senate Health Committee (about 15 times in the space of a 30 minute presentation), and tended to relate the “hidden tax” to nearly every question asked of her by members of the committee. Traditionally the domain of liberals and progressives, reliance on “hidden tax” rhetoric has enabled the Schwarzenegger administration to reframe the issue of universal (or at least expanded) access to health care in manner palatable to conservatives. Not only are the costs imposed by the uninsured framed as a tax, which is antithetical to conservative public policy, but it is a “hidden tax”. This “hidden tax” “is paid by families, individuals, employers...” (Senate Health Committee, February 2007) who are the hardworking people of California. In order remove this “hidden tax” Governor Schwarzenegger has proposed a version of the, “universal

coverage program with comprehensive care and appropriate provider rates” (Harbage 2006, 3) which he hopes will bring the cycle of “cost shifting” under control.

The “hidden tax” rhetoric appeals to the economic self-interest of a broad range of individuals, thus ensuring the broad range of political support that is necessary for the success of any large-scale health care reform. By stressing the economic benefits of universal health care, the politics of health care reform is shifting towards the middle of the political spectrum, thus enhancing the appeal of health care reform to a politically sizable group of Americans. Governor Schwarzenegger’s health care reform plan thus no longer depends on what is best for society (the traditional liberal social justice argument for health care reform), but rather what is in the individual’s economic self-interest namely removing the “hidden tax” driving up the cost of health insurance.

### **Governor Schwarzenegger’s Health Care Proposal for 2007**

In a document released in early January 2007, Governor Schwarzenegger laid out the framework for health care reform in the state of California. Although the proposal has initially been presented as a document written in lay terms describing the means which should be used to achieve reform, this does not indicate that the proposal should be taken lightly. On the contrary, this unorthodox means of arriving at legislation is indicative of the need to get all of California’s powerful special interest groups behind the reform plan before it passes the legislature and is signed into law. As California’s Secretary of Health and Human Services Kim Belshe stated in her presentation to the Senate Health Committee,

“the governor didn’t start this process by seeking that a bill be introduced, and that reflects and that reflects [Governor Schwarzenegger’s] recognition that change of this complexity, change of this magnitude, really does require a change in the way of doing business ... we need to reach consensus around some of the fundamental issues in

the context of coverage for all and health care affordability” (California State Senate Health Committee Hearing, February 2007).

Although the motives behind Governor Schwarzenegger’s introduction of a health care reform proposal rather than a bill may not be as indicative of a commitment to consensus politics as his office suggests, getting most special interest groups on board with the proposal prior to its authorization goes a long way towards allaying a future law’s defeat by referendum.

The Governor’s health care reform proposal is comprehensive in that it focuses simultaneously on several aspects of the health care system as means of driving down costs, increasing access to care, and improving the quality of care and the overall public health rather than choosing one problem area in isolation. The benefit to approaching health care reform in this manner is that it recognizes the nebulous nature of health care systems and that one aspect can rarely be effectively reformed in isolation. While the majority of the attention given to Governor Schwarzenegger’s plan by the media and legislators focuses on the way he intends to expand health insurance coverage, the components of the plan are meant to be taken as a whole package. The metaphor most commonly used by the legislators is that of a puzzle, in which each of the pieces has to be correctly connected to the other in order for the picture to make sense. And the spokespeople for Governor Schwarzenegger’s plan frequently comment that the plan is, “comprised of a number of components which... in isolation are problematic if not unworkable” (CA State Senate Health Committee Hearing, February 2007). The individual mandate proposal, which is the method chosen by the Governor for ensuring expanded coverage, is the aspect of the overall plan that most often elicits this caveat.

There are three main components to the Governor's comprehensive plan. The first relates to prevention, health promotion and wellness, the second deals with increasing access to health insurance coverage, and the third deals with ensuring affordability. There is overlap between each of these components, which are intended to be implemented in an integrated manner such that reforming one area positively impacts reform in other areas. The middle component, dealing with universal coverage, is the largest and has consequently drawn the most attention. However, the proposals offered on prevention and cost containment are also innovative and may prove more beneficial to the health care system in California beyond a simple expansion of the number of insured individuals. Within each of the components of the plan there is a strong commitment to reforming health care through reforming the health care market. The success of this market based approach will depend on how much of the currently inefficient the health care market can be reformed. The emphasis on market reform throughout the plan is consistent with the Governor's conservative political ideology, and has shifted the focus from the social good of health care reform to its increasing economic necessity. Another buzz-word present throughout the Governor's proposal is "individual responsibility". Repeated mentions of individual responsibility appeal to conservative voters and are representative of the way in which universal health coverage and health care reform, once the purview of progressives, is being recast in a manner palatable to conservatives. There has been a "sea-change" in health care reform policies, and Governor Schwarzenegger's proposal is typical of a comprehensive conservative health care reform effort. It remains to be seen if these conservative ideologies, once implemented, will prove beneficial to the

health care system, or whether the economic emphasis will do more harm than good. The following is an analysis of each component of Governor Schwarzenegger's proposal.

*Part A: Prevention, Health Promotion and Wellness*

The Governor begins his proposal with a discussion of decreasing the prevalence of preventable disease as a means of promoting a healthier California and controlling growing health care costs. The first, and most innovative, proposal is to restructure economic incentives and benefits so that individuals will have an increased motive to make healthy lifestyle choices. Chronic diseases (such as type II diabetes) and preventable diseases (such as smoking induced emphysema or lung cancer) have a long lag time between when an individual makes an unhealthy choice when the ill effects of that choice are felt. Conversely, while maintaining a healthy lifestyle may decrease an individual's chance for developing chronic or preventable diseases, an individual will rarely see benefits of their healthy lifestyle choice directly. The Governor's plan attempts to decrease the amount of time between an individual's health relevant lifestyle choice and the potential ill effects of that choice through a "Healthy Actions Incentives/Rewards Program". Public and private health plans will be required to implement Healthy Actions programs that, "will reward Californians for participation in evidence-based practices and behaviors that have been shown to both reduce the burden of disease and are cost-effective" (Governor's Health Care Reform Proposal 2007, 1). The Healthy Actions program is modeled on deductions offered on car insurance premiums through participation in defensive driving courses. Individuals will receive incentives for taking proactive steps to improve their own health such as quitting smoking, maintaining a healthy weight, or having routine cancer screening. The benefits an individual gains from

the Healthy Actions programs will be tied to a Health Risk Assessment completed by the individual and a follow-up visit with a health care provider. Individuals with private health insurance plans or with employer-sponsored health insurance will mainly see rewards for healthy behavior through a reduction in premium payments. For those individuals with public insurance plans who may not pay premiums, the Governor's proposal will offer such incentives as free gym membership.

The Healthy Actions proposal attempts to reform the health care market from the demand side –assuming that a healthier population will decrease the demand on health care services and thus result in lower insurance premiums. Given that a large portion of the Governor's plan deals with instituting a universal health coverage program, containing costs by promoting prevention and thereby decreasing the actuarial risk incurred by the population is an important provision. However there are several potential problems with the proposal. The first is the presence of the term “cost effective” in the definition of what constitutes a healthy practice or behavior. For example, in the case of smoking cessation it has been demonstrated that some cessation aids are more helpful than others. However, which smoking cessation aids will be considered cost-effective? Since it is possible to quit without the use of aids why should aids be paid for? A similar argument could be made for some weight management programs. The question of what will constitute a “cost-effective” practice is particularly troublesome when it comes to poor communities that are more likely to have preventable and chronic conditions but less likely to have the resources to make healthier lifestyle choices. For such communities the incentives provided by a Healthy Actions program (e.g., a free gym membership) may

not be sufficiently appealing. A Medi-Cal recipient, for example, may not be able to take advantage of a free gym membership.

Restructuring incentives to positively impact the demand-side of the health care market are worthwhile and necessary, although some communities will receive better incentives than others. The Healthy Actions proposal has met no criticism from legislators, and as such will likely be implemented as it stands in the proposal. If the Governor's proposal for Healthy Actions programs were implemented in an efficient manner that did not add to the paper-work problems already encountered by health plans and providers, it is reasonable to expect the program could have a positive impact on the overall health of Californians.

Apart from the Healthy Actions program, the Governor's health care proposal identifies other ways in which the negative economic and health effects of diabetes, obesity and smoking should continue to be addressed. A new Medi-Cal initiative to institute diabetes interventions statewide, continued support of the California Smokers' Helpline, a media campaign to encourage healthy eating habits as well as, "community based activities to increase access to healthy food and physical activity in stores, schools, and neighborhoods" (Governor's Health Care Reform Proposal 2007, 2) are among the programs proposed.

The final aspect of Prevention, Health Promotion, and Wellness is a proposal for preventing medical errors and health care acquired infections. Stating that medical errors, "cause an estimated 23,000 hospital deaths and untold numbers of injuries each year in California and costs over \$4 billion annually" (Governor's Health Care Reform Plan 2007, 1) the Governor's health care reform proposal presents several solutions. The first

is to require the institution of electronic prescribing by all facilities and providers by 2010. Electronic prescribing enables physicians to send a patient's prescription to a pharmacy electronically and can, "improve patient safety by decreasing prescription errors due to hard-to-read physician handwriting ... automating the process of checking for drug interactions and allergies and eliminating duplicative laboratory and diagnostic tests" (Health and Human Services Press Release, 2006). Apart from limiting the number of medication errors through electronic prescribing, the Governor's proposal will require California's health facilities to decrease the number of hospital acquired infections by 10% over 4 years. The specific proposal regarding electronic prescribing combined with general directive for decreasing hospital acquired infections are examples of demand-side reduction in health care costs. By combining preventative healthy lifestyle provisions with such measures as electronic prescribing, the Governor's health care reform proposal shows the role of demand-side health care costs as an important component of ensuring the affordability of universal health insurance coverage.

*Part B: Cover All Californians*

In keeping with the philosophy of "shared responsibility" for health insurance coverage, the second part of Governor Schwarzenegger's health care reform proposal lays out some specific responsibilities of individuals, employers, providers, health plans, and the government for ensuring all Californians receive a minimum level of coverage. While about 6.5 million Californians are uninsured for all or part of a given year, Governor Schwarzenegger's health insurance expansion proposal operates under the assumption that at any given time only 4.8 million individuals are without insurance. The policy for expanding insurance coverage is unusually specific in the Governor's proposal

due to the fact that it is not yet in bill form. Policy presented in bills is often watered down due to the nature of the legislative process, and the details of legislation are worked out either by government agencies or over subsequent legislative cycles (as the Massachusetts case study illustrated). However, the Governor's policy proposal allows for an unusual level of specificity.

The crux of "shared responsibility" for Governor Schwarzenegger's health care reform plan is the individual mandate. Similar to Massachusetts, all California residents will be required to purchase a minimum level of health insurance coverage (or otherwise obtain coverage through an employer or public insurance program) or face an economic sanction. While the Governor Schwarzenegger's health care reform proposal does require more from employers, providers and health plans than the Massachusetts plan, it does call for the institution of some reforms to the California health care market that were already in place in Massachusetts.

One initial criticism of Massachusetts' individual mandate was that it compelled individuals to participate in the plan before a minimum level of coverage was stipulated. In California, the minimum level of coverage is explicitly stated in the Governor's plan. Minimum coverage in California under the Governor's plan will be defined as a \$5,000 deductible plan with maximum out-of-pocket limits of \$7,500 per person and \$10,000 per family (Governor's Health Care Reform Proposal 2007, 6). Although a high deductible health plan such as this offers low premiums (the Governor's health care team estimates premiums to be about \$100 per person per month) it also comes with limited options for care. The Governor does propose excluding preventative care visits to a primary care physician from the \$5000 deductible from the version of high-deductible. However,

having to pay costs out-of-pocket up to the \$5000 deductible would be impossible for most families making just above 300% FPL. Thus, the minimum-level offered is necessarily bare-bones because of the large number of individuals who will need to be covered by this new high-deductible plan.

Several legislators have raised concerns about the high-deductible plan offered by the Governor, especially given the individual mandate. Having a state government mandate individuals purchase insurance that does not provide them adequate coverage while still imposing an economic tax is a persistent fear of legislators which was addressed in a State Senate Health Care Committee hearing on the Governor's health care reform proposal. The Chairman of the Committee Senator Sheila Kuehl (who is herself the author of a universal single-payer health insurance reform proposal which was vetoed by Governor Schwarzenegger in 2006) expressed concern, as did Senator Elaine Alquist, a Democrat representing Santa Cruz. Senator Alquist asked both Secretary of Health and Human Services Belshe and other members of Governor Schwarzenegger's health care team how they intended to ensure premium costs would stay at a reasonable level five times without ever receiving an answer she considered acceptable (CA Health Committee Hearings 2007). Senator Darrell Steinberg, a Democrat representing Sacramento, also expressed concerns over the affordability of the plan and wanted to see the addition of language within the proposal which would ensure, "a trigger of some form within an individual mandate concept... which says that if the premium rises to some point which is beyond their ability to afford it out of pocket that there is some relief" (CA Health Committee Hearings 2007). The limited care and high deductible of the proposed minimum level will be the subject of future debate as the proposal is worked into law.

In designing the specifics of the individual mandate, Governor Schwarzenegger's administration relied heavily on policy modeling provided by Jonathan Gruber, a health economist at MIT. Gruber provided health reform policy modeling to determine the effects of tax-credits on health insurance coverage for George W. Bush during the 2000 presidential campaign. More recently, Gruber was closely involved in the process of developing an individual mandate program in Massachusetts and is now a member of the administrative board in charge of overseeing the Commonwealth Connector Authority. Therefore, similarities between the approaches to universal health care coverage utilized by former Massachusetts Governor Romney and Governor Schwarzenegger are not coincidental, but the result of the application of the same model and the same ideology to the problem of instituting a universal health insurance program in both states. All of the numerical assessments in the following analysis of the Governor's health care reform proposal indicate the results of Gruber's modeling of the individual mandate reform.

The expanded health insurance coverage of Californians under the Governor's plan calls for "shared responsibility" between the individuals, employers, health plans, and providers. While the individual mandate focuses on the individual, the Governor's plan stresses the importance of the reform efforts which will be mandated from the other groups. Therefore, in analyzing the components of the Governor's plan, it is helpful to separate the requirements each separate group will face.

#### *Individual Responsibility*

I) CHILDREN: Governor Schwarzenegger's plan calls for the coverage of uninsured children, who account for about 750,000 of California's 4.8 million uninsured. All children under 300% of the federal poverty level will become eligible for state-subsidized

insurance coverage through the Governor's reform plan. This includes the expansion of Medi-Cal to an additional 220,000 uninsured children below 100% FPL, and the expansion of Healthy Families to cover 250,000 additional children between 101-300% FPL. Coverage will be extended through these programs to children regardless of their residency status. For those children above 300% FPL parents will be responsible for purchasing a minimum level of coverage for their child either through employer-sponsored health insurance (210,000 children), or through private health insurance (50,000). The estimates of coverage for children just above 300% FPL are potentially problematic because they would rely on an employer-sponsored dependant insurance which may not be offered. Once the Governor's plan is actually in place, it is possible that employers may react to the new insurance mandate by scaling back insurance.

Currently, because of their illegal immigration status the children of California's more than 1 million undocumented residents can not receive health insurance coverage through public programs. Despite the unpopularity of the proposal to extend public health insurance benefits to undocumented individuals (particularly in counties close to the Mexican border or with large proportions of illegal residents) the Schwarzenegger administration has pledged its support to covering undocumented children.

Schwarzenegger has argued that expanding health insurance coverage to the children of illegal immigrants is in the self interest of legal California residents. Rather than arguing that covering all children within the state is a social responsibility that Californians owe these children, the Governor has relied on appeals to the self interest of parents whose children have insurance coverage by stating that covering all children will decrease the likelihood of an uninsured child infecting a school or community from an undiagnosed

and untreated communicable disease. Therefore the Governor's plan does not make a distinction in the coverage of children based, "on immigration status just as communicable disease does not make a distinction" (CA Health Committee Hearings, February 2007).

II. ADULTS: Governor Schwarzenegger's health care proposal calls for a dramatic increase in the number of insured adults. As in Massachusetts, it has been impossible for California's poor and near-poor adults to access Medi-Cal benefits. The Governor's plan allows for a change in Medi-Cal policy to provide coverage to an additional 630,000 adults below 100% FPL at no cost to the individual. In addition to expanding Medi-Cal, adults between 101-250% FPL will be eligible for subsidized coverage through a new state purchasing pool. The purchasing pool will be operated by the Managed Risk Medical Insurance Board (MRMIB), the same institution responsible for Healthy Families and California's WIC program.

The MRMIB will offer high-deductible, low premium plans to individuals and families for percentages of their gross income. An individual or family making between 101-150% FPL will have to contribute 3% of their gross income, individuals or families between 151-200% FPL will have to contribute 4% of their gross income, and individuals or families from 200-250% FPL will have to contribute 6% of their gross income. An individual making between 101 - 150% of poverty with income of about \$12,250 annually (Kingsdale Memo 2006) would contribute 3% of their gross income (\$368 annually). As a point of comparison, subsidized high-deductible plans for individuals in the 101-150% FPL bracket are offered through the Commonwealth Health Insurance Connector in Massachusetts has a lower percentage of contribution (1.76% FPL or \$216

annually). The monthly contribution in California (\$30) will therefore be a little less than twice the level of monthly contribution in Massachusetts (\$18) for individuals making the same median level of income. California's subsidized plans are less generous both out of necessity (due to the sheer number of individuals they expect to enroll) and out of conservative political design. It is likely that once this measure makes its way through the democratic controlled legislature that the level of contribution expected from individuals will decrease. Of the 1.2 million adults with incomes between 101-250% FPL, it is estimated that 1 million will enroll in the new state subsidized health insurance pool through the MRMIB. The additional 200,000 are expected to gain coverage through an employer. Individuals between 101-250% FPL who enroll in employer-sponsored health insurance will be eligible for government assistance.

The approximately 1.1 million legal California residents above 250% FPL who are currently lacking health insurance will be required to purchase and maintain insurance coverage without any government assistance either on their own or through an employer. 370,000 are expected to find insurance through an employer while 730,000 will purchase individual insurance coverage. The estimated number of individuals who will have to find insurance through the private market is substantial, and raises serious questions about the fairness of the individual mandate. While in Massachusetts these individuals could receive some government assistance in finding low-cost plans or in forming groups in order to obtain group coverage rates and privileges, Governor Schwarzenegger's plan currently has no such provisions. Individuals have the option of accessing the mandated minimum plan, but will not be given assistance in finding other coverage options. Individuals will be able to purchase health insurance plans using pre-tax dollars, resulting

in some cost reduction. While the Governor's office maintains that California's individual health insurance market will experience a decrease in insurance premiums due to the inclusion of so many additional residents, some legislators have remained skeptical. When pushed on the figures, it becomes clear that the economists such as Richard Figeroa who have worked on the Governor's proposal can really only guarantee that when, "you're doubling the size of the pool... even given if 20% of [the newly enrolled] had a deniable condition, you're only talking about a very small push, one way or the other on individual market rates" (CA Health Committee Hearings, February 2007). E. Richard Brown from the UCLA health policy institute who has been instrumental in analyzing the health care market and potentials for health care reform in California for decades also expressed grave misgivings over leaving individuals to, "shop for comprehensive coverage in the private individual marketplace...not a very friendly marketplace for most individuals" (CA Health Committee Hearings, February 2007). The governor's office is therefore relying on market reforms presented later in the proposal to hold health insurance premiums to a reasonable rate in the private market, where many individuals will need to go to satisfy the individual mandate. However, legislators expressed considerable doubt that the market reforms would prove sufficient to validate the imposition of an individual mandate on working class individuals who do not have much discretionary income. Given the nature of discomfort regarding this aspect of the proposal, it is reasonable to expect that as Governor Schwarzenegger's proposal works its way through the legislative process legislators will attempt to adjust the individual mandate in order to make it more reasonable for working class individuals.

California's large population of residents who do not have "green cards" presents a barrier to any universal coverage plan. There are an estimated 1 million uninsured illegal immigrants residing in California at any given time. Of this amount the Governor's plan expects 40,000 to enroll in employer-sponsored health insurance and 160,000 to purchase health insurance through the individual market. Some uninsured and illegal individuals may obtain health insurance through an employer or through the individual market; however there will be no way for the state to keep track of how many illegal residents are insured and how they obtain their insurance. Thus, while the individual mandate extends to all individuals, even those who are illegal, over 250% FPL, there is no mechanism which the state government can employ to enforce enrollment. Well over half of these illegal residents (about 750,000) who are under 250% FPL will remain uninsured. These individuals will continue to receive health care services from local governments, as is currently common practice. To appropriately offset the cost of those who remain uninsured, localities will retain \$1 billion in current funding for outpatient services incurred by this population. An additional \$1 billion will be retained in federal Disproportionate Share Hospital (DSH) funds. The Governor claims that under his proposal the localities will be able to retain 80% of their current funds while only having to care for about 20% of their original population providing a strengthened safety net for those individuals who remain uninsured.

The success of Governor Schwarzenegger's individual mandate will depend largely on the success of the reforms discussed in subsequent sections of the proposal. Strengthening employer-sponsored health insurance while enacting some reforms in the health insurance and health care market should positively impact the system as a whole

and make an individual mandate more palatable. Governor Schwarzenegger's health care team is well aware of the interdependency of the individual mandate on other aspects of the reform proposal and it is for that reason they keep emphasizing how essential it is for all elements of the Governor's plan to be implemented simultaneously so that they can "hang together".

### Employer Responsibility

Although Governor Schwarzenegger's health care reform proposal emphasizes the responsibility of the individual to find and retain health insurance coverage, the proposal does require some contributions from employers. First, in keeping with the conservative belief in tax-breaks as a means for reducing costs, all employers offering health insurance to their workforce must do so using a Section 125 cafeteria plan. As in Massachusetts, the 125 plan reduces the cost of insurance for both employees and employers by allowing contributions to coverage to be made before taxes. Mandating a Section 125 plan offers the conservative Schwarzenegger administration a means for easing into an employer mandate with a proposal which is politically popular.

Apart from the institution of cafeteria plans, businesses with 10 or more employees will be required to offer insurance. If firms with more than 10 employees choose not to offer insurance they will be required to contribute an "in lieu" fee of 4% of payroll to the MRMIB in order to offset the cost of providing insurance for those employees through the mandated minimum high deductible plan offered through the MRMIB. Additionally the Governor's proposal would add a provision to the Labor Code, "making it an unfair business practice for an employer to differentiate the employer premium contribution by class of employee" (Governor's Health Care Proposal 2007).

Although Secretary Belshe claims that the employer mandate is an essential part of the Governor's health care reform proposal because, "This is a policy that establishes a more level playing field between offering, and non offering employers" (CA Health Committee Hearings 2/15/07).

While this proposal sounds like a traditional employer "pay-or-play" mandate, it is never referred to as such by Governor Schwarzenegger's health care team. The minimum number of employees is lower, and the contribution from employers is higher, than any employer mandate plan offered before. If Californian voters and businesses could not accept lesser employer mandates in the past (e.g., S.B. 2), it is difficult to see how the Schwarzenegger administration hopes to convince these same interests of the palatability of more demanding reform. The reluctance to call the "in lieu" fee a mandate has to do both with a desire to avoid potential legal challenges under the ERISA statute and Governor Schwarzenegger's past public statements against employer mandates<sup>5</sup>. A recent Federal Court of Appeals decision in Maryland struck down a "pay-or-play" employer mandate on the grounds that the law was contrary to ERISA's intent to provide, "a uniform regulation over employee benefit plans" (Butler 2007, 3). The court found that allowing an employer mandate which specifies the level of benefits an employer in the private market could offer would lead to a balkanization of employer entitlements. California's secretary of Health and Human Services remains optimistic that California's employer mandate would survive a legal challenges saying, "our initial assessment is that it really isn't relevant to California" (CA Health Committee Hearings 2/15/07) both

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<sup>5</sup> In an Associated Press article from September 10, 2004, about two months prior to the vote on Proposition 72 to repeal SB 2, Governor Schwarzenegger expressed his disapproval of the employer mandate stating, "Californians without health insurance [is] a positive goal, however we must find a better way than doing so at the cost of putting employers out of business."

because a federal court ruling is not binding across districts and because Maryland's law seemed to target one particular corporation (Wal\*Mart) while California's employer mandate provision is broader. Not all maintain optimism over the ability of an employer mandate in California to withstand a similar legal battle and the Legislative Analyst Office is withholding judgment on questions of legality until after the proposal is drafted into legislation. Regardless of how the proposal is presented to the public it is an employer mandate, and as such the Governor will have to carefully develop the support of valuable interests.

It is worth noting that the employer mandate is stronger in California than the one which appears as a part of Chapter 54 in Massachusetts. The more stringent employer mandate is likely due to the fact that the Governor's plan has not yet been run through the legislative ringer. Legislators in Massachusetts pushed for a more stringent employer mandate, but ultimately had to override Romney's veto in order to pass a modest one. In California, the employer mandate has predictably become one of the more controversial aspects of Governor Schwarzenegger's plan. The business community, most notably the California Restaurant Association, has already begun publicly opposing the 4% "in lieu" fee while consumer advocate groups and some health policy analysts point out that even 4% of payroll will not be enough to cover the costs incurred by employees of non-offering firms.

Even in the initial stages of Governor Schwarzenegger's reform proposal the California Restaurant Association has been the vanguard of business interests opposed to employer contributions in any form. Jot Condie, the current president and CEO of the California Restaurant Association, has been active both in lobbying the legislature and

the public and in so doing made several appearances of California public radio stations in the weeks after the Governor unveiled his proposal. Condi claims that the 4% payroll tax, “is a problem for the restaurant industry, and small businesses in the retail industry... in particular because profit margins average from 3-5% and in the restaurant industry and the labor costs account for about a third of the costs of doing business” (KQED 1/18/07). Many businesses have the option of dealing with the increased labor costs incurred because of a mandate to offer health insurance by shifting the cost to consumers or by lowering the wages of employees. However, Condi argues that restaurants do not have that option because, “the restaurants serve, in many cases, as the point of entry for the work force. You have a lot of entry level workers...getting paid minimum wage (\$7.50 or \$8.00 and hour) so there’s not a lot of room for cost shifting” (KQED 1/18/07). According to this picture, a payroll tax of 4% for a firm with small profit margins and high labor costs would tax such a firm out of existence.

What the California Restaurant Association does not take into account when opposing the payroll tax is that 4% of payroll is that this tax is less than the cost of providing health insurance coverage to all their employees. Thus, paying 4% of payroll because it is less than what employers can expect to pay for health insurance coverage could lead to employers continuing to drop employee coverage. While it is true that small restaurants and small retail stores may be adversely effected by payroll tax, it does not hold that larger restaurant and retail chains can make the same claims. Retail and restaurant behemoths such as Wal\*Mart and McDonalds will undoubtedly be among the largest opponents of any employer contribution. Increasing the level of employer contributions for employee health insurance in these large firms would not put them out

of business. However, they will utilize the same arguments as small businesses for opposing employer mandates to protect their high profits.

In order for an individual mandate to work it must be joined with some kind of employer mandate to prevent employers from dropping coverage altogether. However, when the provisions of employer contributions are set too low, it is likely that employers will continue to drop coverage. As was discussed in the Massachusetts case study, it is possible that the employer contribution could eventually be expanded through subsequent legislation. Because Governor Schwarzenegger's proposal has yet to be drafted into legislation, it is equally likely that the employer contribution which results from the legislative process will be even less than 4% payroll. One option that has not yet been considered would be requiring different contributions from different types of businesses so that the contribution does not have a disproportionate impact on small businesses. Governor Schwarzenegger's employer mandate also does not address the issue of employers dropping dependant coverage. Only having employer mandates relating to primary health insurance leaves the majority of individuals affected by the decreasing scope of employer benefits to fend for themselves in the private insurance market. As a point of comparison, the bill being offered by Senator Don Perata, the President Pro Tempore of the California Senate, which is another version of a "shared responsibility" plan would mandate insurance coverage for employees AND their dependants. Although an employer mandate is a necessary component of a "shared responsibility" health insurance reform effort, the specifics of employer mandates are difficult to legislate because of the strengths of the interests involved and the level of contribution necessary

to make a mandate worthwhile. Governor Schwarzenegger's proposal will come out of the legislative process looking different from its current form.

### Government Responsibility

Increasing Medi-Cal reimbursement rates and organizing the new insurance program for adults up to 250% FPL are the primary responsibilities of the government under Governor Schwarzenegger's health care reform proposal. The Governor intends to provide for a \$4 billion increase in rates the state pays in reimbursements to Medi-Cal providers and hospitals. These increased rates are intended to, "adequately and competently align compensation to actual costs and in so doing further diminish any need for providers to shift costs from the uninsured to the insured population" (CA Health Committee Hearings 2/15/07). The local and county governments, through health centers and hospitals, will provide care for those who remain without insurance. Local and county governments will also retain 80% of their funding to care for those who still cannot find coverage under the plan. The hope is that through adequately funding indigent services, there will be a lesser need for providers and hospitals to cost-shift.

Government is also to facilitate the enrollment of individuals in various insurance programs and to police potential non-compliance. First the government is expected to streamline the various state-subsidized programs through establishing a "bright line" between Medi-Cal and other subsidized insurance programs. In other words individuals will have to be enrolled in only one state subsidized insurance program. This reform will mainly effect the 680,000 children and 215,000 adult Medi-Cal recipients who will switch to enrollment in Healthy Families. The "bright line" will help to bring families under the same coverage plan, so that resources are not wasted through having family

members insured in different programs. Next, the Governor's plan calls for government agencies to partner with each other in to maximize enrollment of uninsured persons. Hospitals will be asked to do outreach to their uninsured patients to facilitate their enrollment in health insurance plans. The Governor's proposal also foresees schools being of particular importance for facilitating the enrollment of children in programs for which they are now eligible. Although a system of monitoring non-compliance has not yet been determined within Governor Schwarzenegger's proposal, one idea offered by Secretary Belshe for identifying non-compliant individuals has been to require employers to report whether an employee is covered by insurance to the Employment Development Department when they submit their payroll tax withholding forms. If an individual were non-compliant in finding insurance coverage, "that information would be provided to EDD and the state purchasing pool would follow up with an engagement of that individual" (CA Health Committee Hearings 2/15/07). However, no enforcement mechanism has been definitively set up by the Governor's proposal which will likely be developed in the legislative process. The enforcement mechanism ultimately decided on will probably be tied to an economic disincentive for non-compliance, as is the case in Massachusetts.

#### *Health Care Providers and Health Plans Responsibility*

Under the principle of "shared responsibility" health care providers and health plans are required to contribute to health care reform in order to reduce health care costs and promote quality. The Governor's plan assumes that an increase in Medi-Cal reimbursement rates plus compelling all state residents to purchase insurance will result in a substantial increase in physician and hospital revenue. Governor Schwarzenegger's

health care team is expecting physicians and hospitals to gain \$10-15 billion in revenue from the increased coverage and increased Medi-Cal rates and therefore feels justified in requiring providers and hospitals to contribute to the cost of increased coverage in the form of a “coverage dividend”. Physicians will be required to contribute 2% of payroll while hospitals will be required to contribute 4% of payroll to supplement the funds for increasing Medi-Cal reimbursement as well as for funding the new state purchasing pool. California Secretary of Health and Human Services Kim Belshe has stated that the tax on providers and hospitals (which the Schwarzenegger administration is careful to persistently call a coverage dividend) will not prove unwarranted because, “simply put as a result of the governor’s plan doctors and hospitals will realize far more in new revenues than they are asked to contribute” (CA Health Committee Hearing 2/15/07). However, there are some flaws in the administrations formulation of the provider and hospital tax and The California Medical Association (CMA) and the California Hospital Association (both major interests which have had considerably influence over health care reform proposals in the past) are quick voice their opposition.

Medi-Cal patients, patients lacking insurance coverage, and their health care providers are not equally distributed throughout California. Thus, while some providers and hospitals will see a revenue increase from an increase in reimbursement rates and a reduction in the uninsured many others will not. Furthermore, the proposed Medi-Cal rate increases will not raise reimbursement rates enough to cover costs of providing care. The Governor’s proposal calls for increasing Medi-Cal reimbursement rates from 40% to 80% of current Medicare reimbursement rates. As a spokesperson for the CMA stated by way of summing up the association’s disagreement with the provider tax, providing services

to Medi-Cal patients, “was a below cost service. It’s now going to be an at cost service. So physicians get the joy of providing and in return for that we’re going to be taxed 2% on every dollar that comes in the door” (CA Health Committee Hearings 2/15/07). The provider tax is unlikely to survive the legislative processes. The support of the CMA is essential for the success of health care reform in California, and the association is vehemently opposed to a provider tax.

The Governor’s proposal also includes a provision intended to streamline hospital and health plan administrative costs though providing that 85% of every premium dollar and 85% of hospital payment is spent specifically on patient services. It has been posited in the past that the largest inefficiency in our health care system is related to the money lost in administration. According to a 2005 study of the nature of administrative health care costs as a percentage of overall cost published in *Health Affairs*, acute care hospitals in California report spending 20.9% of revenue on administration. Administrative costs count for 9.9% of private insurance premiums, 11.4% of Medicaid premiums and 4.5% of Medicare premiums (Kahn 2006, 1631). With the administrative costs of commercial insurance already below 15% of premiums, and the administrative costs of hospitals only slightly above the proposed limit the proposal may not impact the overall cost of health care as the Governor’s proposal intends. Additionally, administration is a vital aspect of health care delivery – ensuring that hospitals have adequate staff and supplies is arguably as important a task as those providers perform. The California Association of Health Plans and the California Hospital Association have both expressed concerns that they will be forced to cut programs which are beneficial to their consumers, but are not considered “patient care” services. The costs incurred through the health care bureaucracy can be

attributed more to the system of multiple payers than health care administration<sup>6</sup> and it seems unlikely that a program mandating 85% of hospital revenue and insurance premiums be contributed directly to patient care will be enforceable, or effective in significantly cutting health care costs.

Governor Schwarzenegger's proposal does contain two insurance market reforms which, if instituted, could drive down the cost of premiums and increase equity. The two reforms work together and have are usually instituted simultaneously. The first requires that all California insurers "guarantee issue" to all Californians. The second requires a system of "community rating". Health plans and private insurers have traditionally been able to "cherry-pick" individuals at relatively low risk while leaving individuals with pre-existing conditions ineligible for insurance products. Alternatively, health plans and insurers attempt to influence the makeup of their insurance pools through setting different premium rates based on an individual's perceived risk. For example, an individual with diabetes (a chronic condition) may experience prohibitively high premium rates as a barrier to adequate insurance coverage. "Guarantee issue" ensures that health plans and insurers cannot deny any person coverage on the basis of pre-existing health conditions, while "community rating" ensures that health plans and insurers can only differentiate between individuals on the basis the geographic area in which they live. "Guarantee issue" and "community rating" are extremely unpopular proposals with the health insurance industry. Health plans and private insurers are for-profit industries, and as such

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<sup>6</sup> Our system, with its multiple insurers, "means multiple duplicative claims-processing facilities and smaller insured groups, both of which increase overhead" (Woolhandler 2003, 773). Additionally, multiple insurance products raise costs for providers, "who must deal with multiple insurance products ... forcing them to determine applicants' eligibility and to keep track of the various co payments, referral networks, and approval requirements" (Woolhandler 2003, 773). It is for these reasons that single-payer systems incur fewer administrative and bureaucratic costs than multi-payer systems.

constantly attempt to minimize the risk in their insurance pools. However, the Schwarzenegger administration hopes to win the support of the insurance lobby through reminding the industry that the employer mandate will add about a million individuals to the insurance pool and that these individuals are estimated to be, on average, healthy. Secretary of Health and Human Services Belshe reminded the State Senate Health Committee that, “guaranteed access without an individual mandate to ensure the broadest, healthiest pool possible, is another example of a proposal which, on its own, is destined to fail...” (CA Health Care Committee Hearings, 2/15/07) and it is the hope of the Schwarzenegger administration that the health plan lobby can be persuaded accept the new insurance market regulations on the grounds of the individual mandate.

#### *Part C: Affordability and Cost Containment*

Due to the integrated nature of the Governor’s proposal, several of the key cost-containment provisions of the Governor’s proposal were already mentioned as a part section dedicated to insurance coverage. Increasing Medi-Cal reimbursement rates, making provisions for e-prescribing, streamlining health care delivery through mandating 85% of premiums to be spent on patient care, are all examples of previously mentioned cost containment strategies. Additional proposals include setting a goal of 2007 for 100 percent electronic health data exchange and appointing a Deputy Secretary of Health Information Technology who could coordinate this effort. County governments will be charged with piloting Electronic Medical Records systems which would improve the quality of patient records and eliminate the cost involved in shuffling paper records around with the patient. The Schwarzenegger administration expects that through the institution of insurance market reforms, individual mandate proposal, employer and

provider contributions, and the various other proposals (such as improving health information technology and continuing community based prevention efforts) an overall reduction in health care costs will occur. However, it remains to be seen whether the Governor's proposed funding sources will be adequate to cover the expenses incurred by the new program.

The provisions for funding within the Governor's proposal rely heavily on reallocating resources already available, and on securing new funds from the federal government. The plan is estimated to cost 5.4 billion dollars, 3.7 billion of which will have to be accounted for by new funds. The Schwarzenegger administration is counting on 3.45 billion from the federal government in matching funds in order to finance the increase in Medi-Cal reimbursement rates and the increase in indigent adults coverage (CA Health Committee Hearing, 2/15/07). As in Massachusetts, the increased federal government funding will be contingent upon California's application for a Section 1115 waiver which will permit expansions and innovations in the state Medicaid programs. Additional funding will come from the employer payroll tax, the 2% provider and 4% hospital tax, and the redirection of \$2 billion in medically indigent care funding. While the Schwarzenegger administration maintains a high level of confidence that the federal government will come through on granting the waiver, policy analysts from the Legislative Analyst's Office (LAO) remain skeptical.

The LAO is a governmental office which provides non-partisan analysis of bills and legislative proposals (as well as referenda) for legislators and the public. The concern over funding lays primarily with the federal government's extension of Medi-Cal and healthy families programs. Both Medi-Cal and Healthy Families are run as part of the

joint federal-state Medicaid and State Child Health Insurance Program (SCHIP) respectively. While the Medicaid section 1115 waiver is relatively certain, the proposed extensions to healthy families will meet more resistance. The current SCHIP program will come up for reauthorization in congress in 2007, and it is likely that reauthorization will mean a cut in funding. Congress will need to reauthorize SCHIP at a higher funding level than it currently in order to satisfactorily meet the requirements necessary for Governor Schwarzenegger's proposal. The LAO estimates that, "350 million in state funds will be needed to pay for program expansion if federal government falls through" (CA Health Committee Hearings 2/15/07). California is therefore at the mercy of the federal government when it comes to securing financing for Healthy Families extensions.

### **Public Opinion in California**

Although 51% of Californians report they are generally satisfied with the state's health care system (The Field Poll January 3, 2007), this should not be taken to mean that the public will not support reform efforts by legislators. While Californian's express content with the system as it stands now, 39% believe the system will be worse five years from now, 40% believe the system will remain unchanged, and only 12% who believe the system will improve (The Field Poll January 3, 2007). Additionally, while only 10% of voters reported being uninsured, 39% expressed they are very concerned that they or someone they are close to will lose coverage in the near future (The Field Poll January 3, 2007). Concern over loss of coverage indicates that while individuals themselves may not be affected by the rate of decreasing employer coverage, they do see the trend effecting them or someone they are close to in the near future. The Californian public is becoming, in Douglass Arnold's words, a more attentive public and, "it is easier to activate attentive

publics when those publics bear large and direct costs” (Arnold 1990, 70). Individuals are risk-averse in their political decision making, so the fact that a significant number of Californian voters see the system as getting worse and not improving while they fear for losing coverage indicates individuals may be ready to support comprehensive health care reform legislation.

*The Field Poll* makes clear that a majority (81%) of individuals feel the government should, “be responsible of assuring that all Californians have access to affordable coverage” (The Field Poll January 3, 2007). Although individuals feel that the government should be responsible, they do not generally support a government single-payer system (which would place the ultimate responsibility of health care costs and coverage in the hands of the government). 24% of voters support a single-payer system, compared with 52% who favor a “shared responsibility” plan which includes provisions for government, individuals and employers while only 18% of voters favor relying on market competition in the current system (The Field Poll January 4, 2007). Support for single-payer systems is highly politically polarized, with Democrats supporting single-payer 61% and Republicans supporting single-payer 26%. The same polarization is present when voters are polled about instituting tax-based reform strategies (such as a Health Savings Account plus a high deductible insurance plan). Although these numbers are confounded by the fact that those identifying as Republicans often have a higher income and therefore would be more likely to support a HSA proposal, it is still apparent that health care reform has as much to do with politics as policy. The major appeal of “shared responsibility” plans is that they are viewed as non-partisan – a system in which everyone gains and loses a little bit for the common good of increased coverage. A broad

base of political appeal is necessary for health care reform to be successful in California (or in any state), and “shared responsibility” allows health care reform to finally become a non-partisan issue.

The final aspect of public opinion in California is interesting and seems to be unique to the state. While in most states health care reform would be legislated through traditional channels, California has already tried to employ that route several times without success. Therefore, health care reform this time around is taking on an unusually public face. The hearings being held before the legislature are open to the public and broadcast on local public channels. Local affiliate stations of national public radio have been holding forums on the reform proposals in which callers can ask questions to legislators and interest group leaders directly. The public nature of health care reform legislation in California is refreshing, and is a by-product of legislators attempting to ready the public for whatever referenda which may take place as the result of legislation passed.

### **Conclusion**

Governor Schwarzenegger’s proposal is comprehensive. It deals with issues not only of increasing health insurance coverage but also including proposals for stemming rising health care costs and increasing the quality of care for patients throughout California. The institution of a Healthy Actions program would create an economic incentive to promoting healthy lifestyle choices. California will continue to pilot community based diabetes prevention and education programs. Electronic prescribing and the institution of an electronic medical records system will cut down on the cost of duplicative paperwork and prevent costly medical errors. Although these reforms offer

innovative solutions to persistent problems in the health care delivery system, most of the attention has been focused on Schwarzenegger's proposal for health insurance reform.

Central to the proposal for health insurance reform is the concept of an individual mandate, requiring all individuals to purchase a minimum level of health insurance, or to obtain such coverage through their employer. Because mandating individuals purchase health insurance is not enough to ensure universal coverage, the individual mandate is reinforced with "shared responsibility" provisions. "Shared responsibility" provisions include government expansion of pre-existing public health insurance programs; the creation of new state subsidized health insurance; requirements for health plans to "guarantee issue" to all Californians and health plans are prohibited from discriminating between individuals based on health status, age or occupation. Health plans and hospitals are required to spend 85% of their revenue on patient care, in order to improve patient care services and stem the amount of money hemorrhaged into administrative costs. Hospitals and providers are expected to pay a tax on their revenue, based on the principle that increased coverage and increased Medi-Cal rates will give them a larger revenue stream. Employers with more than 10 employees are required to provide a minimum level of insurance to their workforce or pay a 4% "in lieu" fee to the new state purchasing pool in order to cover the cost of coverage.

It is unlikely that all of the provisions will survive the legislative process in their current form. Those most likely to be modified are the provider tax and the employer contribution, since these provisions affect the most well organized and powerful interests in California's health care debate. Both the CMA and the California Restaurant Association have been instrumental in preventing reform proposals from taking place in

the past, and they will certainly exert similar influence as health care reform makes its way through the legislative process.

The provisions extending Medi-Cal coverage to all children (regardless of immigration status) up to 300% FPL is a provision supported by almost all legislators and is likely to pass. Medi-Cal rate increases are also popular enough to pass through the legislative process unscathed as are requiring employers to set up Section 125 plans for employees so that health plans can be purchased with pre-tax dollars. Whereas earlier reforms were unable to pass at the state level in California because those with more progressive views of health care reform were unwilling to compromise in the face of potentially better national reform efforts, the federal government's unwillingness to step up and address health care reform has discouraged anyone from thinking that health care reform is an issue the states can afford to avoid any longer.

Although Governor Schwarzenegger's individual mandate proposal is far from ideal for providing universal health care coverage, it is representative of a new political ideology sweeping health insurance reform. Balancing the growing need for expansion of health care with American's unwavering faith in the market over government intervention, the individual mandate is a compromise which allows health care reform to be considered seriously on both sides of the aisle. The discussion of health care and health insurance reform in an economic framework has allowed health care and health insurance reform to be discussed. Thus, one of the most impressive aspects of California's current health care reform discussions is that they are being seriously discussed in public forums.

## **MASSACHUSETTS AND CALIFORNIA: A POLICY PATH FOR THE FUTURE OF HEALTH CARE REFORM IN THE STATES**

The federal government has made it imminently clear that there will be no national comprehensive health care reform in the near future and as such 2007 will become the year of health care reform in the states. Several Governors have stepped up and begun to address health care reform issues both because of the increasingly obvious policy failures in the health care system and because of the increased public interest in health care reform legislation. These two factors have made health care reform an issue that will be of importance to state politicians who wish to be taken seriously on the national political scene. The case studies of Massachusetts and California represent valuable examples of state's attempting health care reform in the absence of comprehensive national reform. Massachusetts and California are at different stages of health care reform policy development. Massachusetts provides a model for the implementation of a policy of "shared responsibility" health care reform, while California provides a model offers a look at how as to how health care reform can be developed into legislation.

In Massachusetts the "shared responsibility" approach to health care reform centering on an individual mandate has become the bi-partisan solution for health care reform, and Massachusetts is well on the way to successful implementation of this reform. The Commonwealth Health Insurance Connector Authority is in many ways the key to success of implementation of Massachusetts' health care reform legislation. The Connector Authority board members are committed to reform, and this commitment shows in their timely implementation of legislated policy goals. If the Connector were

poorly run, or run by political appointees who did not value health care reform, the health care reform effort in Massachusetts would fail. In order for a “shared responsibility” approach to work, all stakeholders must be committed to the reform proposal. Other states looking at a the “shared responsibility” model of health care reform as must be sure they develop cooperation among the various stakeholders (e.g., health insurance, providers, hospitals, individuals and employers). As shown in Massachusetts, such cooperation, while difficult to obtain, can be achieved. If California can successfully implement their version of a “shared responsibility” plan, such an approach to health care reform may be able to be replicated on the national level.

Other states looking to “shared responsibility” health care reform can also learn from California’s innovative legislative approach. By educating the public and keeping them informed about the health care reform through public hearings and forums, the public may be less susceptible to advertising prepared by groups opposed to health care reform, such as business associations. This education enables the public to make a more informed decision and not be swayed by negative advertisements or by other appeals to the public’s fears of change in the status quo. This public approach may also help to sustain support for health care reform measures, which typically start off strong and then weaken as reform moves along in the legislative process and is attacked by special interest groups. While health care reform is usually presented as an issue of the social justice, politicians serious about health care reform should be constantly reminding the public of what they stand to benefit economically from health care reform. Individuals respond with greater enthusiasm when their personal economic interests are at stake, and legislators have not, and should not, shy away from appealing to these interests.

This paper outlined the important policy aspects of the Massachusetts and California health care reform plans while looking at the legislative history of health care reform in both states and the current political climate surrounding reform. My analysis is intended to provide a snapshot of health care reform in these two states which are continuously evolving towards remedying all three points of the “iron triangle” of health care reform (expanding health insurance coverage, improving quality of care, and decreasing health care costs). Continuing to monitor the progress of both these state’s reform efforts is crucially important as health care reform resurfaces as an issue of national interest in 2008. Health care reform is the most important domestic political issue for many voters as the presidential primary season gears up, and candidates will need to look to the successes and pitfalls of health care reform legislation in Massachusetts and California. While state-by-state reform is not ideal because of the lack of uniformity resulting from disparate policies and levels of benefits, may be a necessary means of overcoming federal failure to address comprehensive health care reform. Successful state reforms will act as the baseline for eventual national reform efforts and as such deserve continual analysis at all stages of legislation and implementation.

The constant frustration in health care reform policy is that the politics of reform so predictably get in the way of the results. In discussing Governor Schwarzenegger’s proposal in the California Senate, Senate President Don Perata implored his colleagues to be prepared to compromise for the sake of health care reform; “It has to be done. We have to work diligently to a conclusion. And whatever the end product is, there must be an end product ... there is too much at stake” (CA Health Committee Hearing, 2/15/07). The sentiment of frustration with ideological gridlock and piece-meal incremental

reforms is obvious from the discussions of health care reform both in Massachusetts and California and indicates that legislators may finally be ready to find middle-ground solutions to the problems of the health care system.

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