Advancing National Health Reform

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Prescription for Success:
Lessons from California for National Health Reform

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INTRODUCTION

For the first time since 1994, the President and Congress have made health care reform a top priority. They do so on the heels of an abortive struggle over reform in California in which many of the key elements of current national proposals were intensely debated. Because the political and policy issues in California so closely resemble those on the national agenda—especially when compared with the more favorable environment that health reformers faced in Massachusetts—California's failed attempt at reform provides a useful roadmap for navigating some of the most difficult political issues that national lawmakers will confront as they move toward comprehensive action.

Many have written about the California reform debate.[1] Existing analyses provide general lessons about the importance of securing at least some bipartisan support, the need to reassure those who have insurance, the value of broad-based support and coalitions, and the imperative of showing the public that health care costs can be tamed. Yet these briefs were produced before Congress began crafting a health care reform bill and developing a strategy for its passage. As Washington policymakers enter the most challenging phase of passing health care reform legislation, this brief adds specific political recommendations tailored to what is happening in D.C. today.

Political Lessons: A Summary

1. Policymakers must address cost controls upfront because unfavorable financial projections are likely to destroy health care reform efforts.
2. A successful reform effort will rest on an explicit statement about the scope of the coverage and cost problems to be solved. These goals may not be achieved immediately, but they are vital to preventing a lowest-common denominator approach that defines "success" downward as the debate unfolds.
3. President Obama and lawmakers must find ways to offer certainty, security and affordability to the American public, with particular focus on middle-income voters.
4. Policymakers should resist the temptation to focus on shifting interest-group concerns and should instead rally support for big-picture reform.
5. Health care reform requires both high-level and broad-based legislative involvement; big concessions should not precede the legislative process.
6. Delay yields defeat. Lawmakers should focus on passing a good framework quickly and agree on issues to leave for the regulatory phase or future legislation.
7. Accountability is a two-way street. While the public and Congress will hold the President accountable for delivering, President Obama must hold lawmakers and the public accountable as well. This requires active presidential involvement.
8. Policymakers should recognize the interests behind organized groups' positions and use incentives to unite supporters, win new allies, and divide the opposition.
9. While policymakers must be responsive to difficult questions, they should distinguish concerns about affordability and viability from concerns about profit.
10. Central policy issues cannot be tackled in isolation. In some areas, policymakers may use pilot projects to test ideas and win support but health care reform requires an ambitious framework in which any incremental steps create the conditions and infrastructure for the next step.

CALIFORNIA'S YEAR OF HEALTH REFORM

In January 2007, Republican Governor Arnold Schwarzenegger proposed a health care plan that attempted to provide insurance to almost all Californians. By this time, two leading Democrats, Assembly Speaker Fabian Nuñez and Senate President pro Tempore Don Perata, had already introduced reform legislation.[2] For the next year, the Governor and legislative leaders, including Speaker Nuñez, worked to develop a compromise bill that could survive California's byzantine legislative process. In December 2007, the California Assembly passed this compromise proposal, numbered ABx1 1. A month later, however, the bill was defeated in the Senate's Health Committee, effectively bringing to close the "Year of Health Reform." These intense twelve months of policy debate and design provide key lessons for national policymakers attempting their own Year of Health Reform in 2009.

Those involved in national health care reform clearly recognize the relevance of the California experience.[3] Although the state of Massachusetts successfully enacted a plan for universal coverage in 2006, Massachusetts has many characteristics that set it apart from other states, including a high percentage of employers offering insurance, a relatively small uninsured population, an existing uncompensated care pool, a preexisting set of insurance market regulations that minimized the dislocations of new rules, and a Medicaid waiver that provided a ready federal funding stream. By contrast, California—with its diverse population, strained finances, lack of robust insurance regulations, and large numbers of uninsured—provides a better measure of the challenges that national policymakers will face.

Of course, California faced (and still faces) distinctive hurdles in passing health care reform legislation. Mandated term-limits mean that elected officials come to the complex issue of health care reform with limited historical understanding and must rely on interest groups and long-term staff for guidance. California is also one of only three states that require a two-thirds vote of the legislature to raise taxes or pass a budget. And unlike Massachusetts, which already had a dedicated source of funding, California faced a short-term fiscal challenge much more severe than that now faced by the federal government. The California Constitution requires the legislature to pass a balanced budget each year but by January 2008 the state was facing a $14 billion deficit (which has since ballooned to more than $24 billion). All this in a context in which health care spending represents 22 percent of the state's annual fund, the average annual growth in health care spending outpaces inflation by a factor of more than 2 to 1,[4] health insurance premiums have more than doubled since 2002,[5] and 20 percent of the state's population is uninsured.[6]

This brief is part of a policy series on *Advancing National Health Reform: Lessons Learned from California*, available at: http://www.law.berkeley.edu/chefs.htm. The first release in the series, *Healthy Competition: How to Structure Public Health Insurance Plan Choice to Ensure Risk-Sharing, Cost Control, and Quality Improvement*, by Jacob S. Hacker, explores how the nation can structure and implement a public health insurance option as part of overall health care reform. New and forthcoming Berkeley CHEFS policy briefs explore lessons learned from the California proposal in greater depth and set forth policy recommendations for national health reform:

- *How to Structure a "Play-or-Pay" Requirement on Employers*
- *Affordable Access for Individuals and Families*
- *State-Level Variation in the Private Insurance Market: A California Case Study*
- *Covering the Gaps; Preserving the Safety Net*

POLITICAL LESSONS FROM CALIFORNIA

Despite its specific political and policy environment, however, California presents a number of important lessons for national policymakers. The scope of the challenge in California meant that lawmakers and the Governor had to engage with the thorniest policy questions in a highly partisan environment in which budgetary considerations were front and center. And California's special parliamentary procedures find parallels in the U.S. Senate, where minority holdout remains an option due to the need to gain sixty votes to overcome a filibuster. (If health care reform is approached through the budget "reconciliation" process, as the congressional leadership currently envisions occurring in October 2009 absent earlier action, only a majority vote in the Senate would be needed.) As in U.S. House elections, moreover, California's increasingly non-competitive political districts have created secure Republican and Democratic seats, with the effect that lawmakers have little need to compromise and ideological positions, such as the Republican "no new taxes" pledge, trump pragmatism. Thus, while California's experience is only one source of political guidance, it offers a number of salient lessons that could increase national policymakers' chance of success:

1. **Policymakers must address cost controls upfront because unfavorable financial projections are likely to destroy health care reform efforts**. In California, the unfavorable analysis from the Legislative Analyst's Office, which came on top of bad financial news for the state, hastened the bill's failure. National policymakers should likewise be mindful of the Congressional Budget Office's (CBO) projections and design a regulatory structure with the power to control costs. The CBO score governs whether the bill meets the pay-as-you-go (PAYGO) rule that requires spending increases to be offset by tax increases or spending reductions. Moreover, the CBO will determine whether mandated individual or employer payments are treated as "on budget" or not—an explosive political issue. Regardless of whether mandated payments are included in the budget, however, national policymakers cannot rely on revenue options alone to finance reform. This means that serious cost-control measures, including a public plan competing with private insurance plans on a level playing field, cannot be put off as they were in Massachusetts.[7] President Obama deserves praise for focusing on both upfront cost savings and long-term cost controls. This approach is critical to the Administration's ability to convince Congress and the public that investing in health care now will pay off for the nation and the federal budget.

2. **A successful reform effort will rest on an explicit statement about the scope of the coverage and cost problems to be solved. These goals may not be achieved immediately, but they are vital to preventing a lowest-common denominator approach that defines "success" downward as the debate unfolds.** Discussions of cost and value are meaningless in the absence of an agreed-upon baseline (how many are uninsured or underinsured; what is the expected future trajectory of costs absent reform?) as well as clear goals with regard to the control of costs and expansion of coverage. California's ABx1 1 would have covered, according to one analysis, 70 percent of the state's uninsured population or 3.6 million people.[8] Legislative Republicans steadfastly disagreed with Democrats and the Governor not only about solutions[9] but also about the severity of the coverage problem, insisting that for half of the state's 5.1 million uninsured, new legislation was unnecessary or undesirable.[10] *(continued)*

California's Bill: ABx1 1

Federal approaches incorporate salient characteristics of the main California reform proposal, ABx1 1. The key policy points that state lawmakers wrestled with in crafting ABx1 1 can help inform the federal bill.

Like California's approach, federal proposals envisage a **purchasing pool** or **exchange** through which the uninsured access health insurance. The California Cooperative Health Insurance Purchasing Program (Cal-CHIPP) would have covered uninsured workers as well as some parents and childless adults through a combination of public programs (Medicaid and CHIP expansions) and contracts with private plans. Cal-CHIPP included a modest version of a **public plan**, built upon county health plans. At the national level, a public plan modeled after Medicare is possible and would have greater capacity to control costs and improve quality. The pool's **administration and rulemaking authority** would have rested primarily with a board jointly appointed by the executive and legislative branches. To achieve **solvency**, California tapped into **diverse financing streams**, each of which spawned significant debate: individual premium payments, percent of payroll contributions from non-offering employers (those opting to "pay" rather than "play"), federal Medicaid and SCHIP[11] matching funds, a 4 percent tax on non-Medicare hospital revenues, contributions from counties, and a tobacco tax.

The **employer play-or-pay mandate**, also key to federal proposals, required employers to contribute a sliding scale of 1 to 6.5 percent of their payroll to employee health benefits. Employers were split on the measure: many employers accepted this provision in the context of broad reform; others opposed it.[12] California's proposal would have allowed employers to meet their financial obligation by covering only part of their workforce and lacked benefit standards for "play" employees.[13] Some interest groups worried that the mandate was too small to level the playing field[14] or too weak to prevent crowd out—that is, a replacement of employment-based coverage with new public and private coverage options through the pool [15]—or to achieve coverage goals.[16]

Congress is considering **individual market reforms** designed to increase access to coverage, portability, and risk-spreading, many of which California successfully incorporated into ABx1 1. The California bill required insurers to provide guarantee-issue coverage to all individuals covered by the mandate using a modified community rating that included age, family size, and geographic factors but eliminated medical underwriting. The bill also prohibited policy rescission and removed waiting periods and pre-existing condition exclusions. It required that all individual market insurance offerings meet one of five tiers of health care coverage to allow for plan comparisons on value and cost. Plans would have been required to direct 85 percent of premium revenues to pay for medical services.

Like leading Congressional proposals, ABx1 1 would have imposed an **individual mandate** with subsidies and sliding scale tax credits to offset the cost of premiums, and exemptions for some low-income individuals. But ABx1 1 did not cap the premiums insurers could charge and left the details of maximum out-of-pocket expenditure standards to regulation, generating concern among consumer advocates about a mandate without greater **affordability** protections.[17] Moreover, despite coverage expansions and individual market reforms, estimates projected that approximately 1.5 million Californians under age 65 would have remained uninsured.[18] These remaining uninsured included those potentially exempt from the individual mandate on the basis of affordability or hardship: children over 300 percent of the federal poverty level, undocumented adults, middle-income individuals (especially ages 50-64) unable to afford coverage on the individual market, and workers offered unaffordable employer coverage or whose employers met their obligation through non-insurance health-care expenditures. Lastly, ABx1 1 would not have eliminated underinsurance. Federal proposals similarly fail to address the issue of employer-based coverage with low benefits and high out-of-pocket costs. In California and nationwide, "**gap populations**" will continue to face extreme barriers to health care access.[19]

Finally, ABx1 1 included **delivery system reforms** aimed primarily at **cost containment**—among them, preventive health care and public health initiatives, health information technology expansions, public disclosure of cost and quality data, payment reforms, and bulk purchasing of prescription drugs. The bill addressed **capacity** concerns through highly controversial "scope of practice" reforms and increased safety net funding. Despite these measures, many people questioned whether the proposal offered the serious structural reform needed to adequately address cost containment and capacity issues.[20] Similar questions remain at the federal level.

Lesson 2 (continued)

Supporters of ABx1 1 can be applauded for standing by their goals even in the face of cost-based challenges. Without these "lines in the sand," advocates run the risk that what counts as success will be defined down to meet cost projections. In D.C., GOP pollster Frank Luntz has encouraged Republicans to acknowledge the health care crisis but redefine it in their terms.[21] The most recent Republican proposal—the Patients' Choice Act of 2009—admits that more than 45 million Americans lack health insurance but presents a market-based solution in which tax subsidies for premium purchases, high deductible health plans and Health Savings Accounts are inaccurately characterized as coverage for the uninsured. The bill's sponsors also emphasize their "revenue neutral and budget neutral" solution. The Administration and Democratic lawmakers must respond. National policymakers should secure agreement on what true "coverage" means and measure all proposals and their costs against a single, explicit baseline.[22]

3. **President Obama and lawmakers must find ways to offer certainty, security and affordability to the American public, with particular focus on middle-income voters**. Even though health care reform is an inherently uncertain process, the public wants certainty about the outcomes. Policymakers should be prepared to answer one key question: "What will happen to me?" Concerns about the current situation should not be equated with willingness to accept change and its potential costs. The paradox of health care reform is that middle-income voters will be broadly but thinly supportive at best before legislation is passed—mainly because most of these voters have some coverage and are skeptical about the capacity of government to improve their lives.[23] In ABx1 1, California lawmakers recognized the importance of preserving existing coverage for middle-income voters. The bill would have made changes that affected the largely low-income uninsured. The fact that the bill protected the *status quo* for middle- or high-income insured individuals was touted as a strength. Practically speaking, however, this meant that the voters with the most clout—and who will be subsidizing coverage for the uninsured—remained disengaged from the process. California lawmakers also failed to connect with voters on their experience with the health care system. In D.C., critics of reform are already on the offensive, raising the spectrum of "health care rationing" and "sacrificing" quality to save costs.[24] A successful national effort must not only reassure voters of the security of their existing coverage, but also include provisions that *improve* the situation for them in order to garner their active support. Of the 84 percent of Americans who have insurance, almost half feel worried or very worried about their health care needs not being paid for.[25] National policymakers should engage middle-income voters through the issues they care about: affordability and increasing cost-sharing, job lock and job loss, portability, supply problems, delivery problems, hospitals closing, waits in the emergency room, and doctors not accepting new patients. Advocates must make a credible claim that they will not only lower the cost of coverage for those without it, but also make coverage more affordable and secure for those with insurance. They must also recapture the themes that critics are attempting to appropriate: denials, delays, quality, choice, and the doctor-patient relationship.

4. **Policymakers should resist the temptation to focus on shifting interest-group concerns and should instead rally support for big-picture reform**. The national debate is just getting underway. But, as happened in California, interest groups will automatically coalesce around particular points in health care reform that affect them most. One great frustration for reform supporters in California was that while opponents were intent on defeating ABx1 1, supporters lobbied for changes to the bill rather than for the bill itself. "It's important to realize that there will be no 'perfect' package that everyone will love. But we can work together on consensus and on the right compromise," reflected California Health and Human Services Agency Secretary Kimberly Belshé in a recent radio address.[26] The potential for widespread support exists. Polls confirm that business leaders support making health care more affordable, especially if smaller employers receive financial benefits as well.[27] To garner support for reform—even with compromise— national policymakers have the responsibility to keep the public's focus on the need for change.

"It's important to realize that there will be no 'perfect' package that everyone will love. But we can work together on consensus and on the right compromise."
—Kimberly Belshé, Secretary, California Health and Human Services Agency

5. **Health care reform requires both high-level and broad-based legislative involvement; big concessions should not precede the legislative process**. National lawmakers and policymakers should avoid California's mistakes. Political leaders expended too much time and political capital campaigning to get interest groups to sit at the table and making concessions without securing their support for a bill. Notably, the bi-partisan support that the Governor built with interest group leaders did not translate into a single Republican vote for the legislation he championed. Also, not only must the Legislature's leadership and powerful committee chairs be involved and committed to reform, but they must also give Members outside the key committees a stake in the effort and the opportunity to be educated about the proposals so they feel the urgency to act. Ultimately, moderate rank-and-file members of Congress will decide the fate of key reform measures, and they must not be treated as backbenchers. Although ABx1 1 failed in the Senate Health Committee, a Senate Democratic Caucus discussion of the bill indicated an ultimate lack of votes on the floor to pass the bill. In D.C., members of the Senate Finance and Health, Education, Labor, and Pensions Committees are holding closed-door sessions with interest groups that could undermine opportunities for broad Congressional buy-in. As happened in California, a small group of lawmakers runs the risk of making too many decisions and tradeoffs behind closed doors and emerging with a proposal that will not survive the legislative process. Instead, lawmakers who are crafting the bill should save concessions for the legislative phase and keep other Members of Congress informed and engaged through briefings, open hearings, and other opportunities.

6. **Delay yields defeat. Lawmakers should focus their efforts on passing a good framework quickly and agree on issues to leave for the regulatory phase or future legislation**. In California—where 2007 began as the "Year of Health Reform"—mid-year concerns over water supply and the state's growing fiscal deficit took energy and time away from health care. The same risk exists at the national level. History tells us that President Obama has a narrow window in which to advance his health care agenda.[28] As consumer advocate Anthony Wright said at the start of the California effort in 2007, "Do it. Do it right. Do it right now."[29] For national health care reform, the time to act is now. The mammoth task of reforming the health care system requires a multi-phase approach in which broad proposals move forward in the legislative phase, regulators fill in the details, and non-essential reforms are left for a later date. Threshold decisions—Should there be an individual mandate? Should there be a public plan? How do we guarantee affordability? What are the financing streams?—cannot be delegated or postponed but implementation questions can and should be. Differences of opinion on delegation boil down which branch of government interested parties trust most to respond to their specific concerns. For example in California some thought benefit design was an issue for regulators while for others the lack of legislative details on minimum benefit standards was unacceptable. Politically, to the extent that lawmakers and interest group leaders trust the Obama Administration to enact acceptable regulations through an inclusive process, Congress should pass a bill now rather than spend months tinkering with the details, during which time the political and financial environment may yield new problems, new priorities, anxiety about the increasing debt burden, and voter fatigue.

> "Do it. Do it right. Do it right now."
> —*Anthony Wright, Executive Director Health Access*

7. **Accountability is a two-way street. While the public and Congress will hold the President accountable for delivering, President Obama must be actively involved and hold lawmakers and the public accountable as well**—and not allow them to rely on him and his charisma to make health care reform happen. In California, newly-elected Governor Arnold Schwarzenegger projected so much confidence with respect to his health care reform agenda that many assumed he would succeed and relied on him to move the agenda forward. President Obama, who faces a similar risk, must require lawmakers and the public to own the health care reform process and take responsibility for its success or failure. This has tactical implications: In California, much negotiation happened in closed-door meetings. The lack of transparency limited opportunities for the public and even lawmakers to engage. President Obama should help mobilize the public through a transparent process while reminding voters to hold Congress accountable for swift progress. He must also demand that naysayers put forward concrete proposals that strive for common ground—something Governor Schwarzenegger never demanded of California Republicans.

8. **Policymakers should recognize the interests behind organized groups' positions and use incentives to unite supporters, win new allies, and divide the opposition**. National policymakers must first unite supporters. In California, supporters of comprehensive health care reform failed to unite in support of ABx1 1.[30] At the national level, having more specifics on affordability would help unite supporters. But although some blame the defeat of California reform efforts on the divisions within labor, consumer groups, and proponents of a single-payer system, the strongest opposition came—not surprisingly—from the business community, insurers, providers, and big tobacco.[31] This resourceful opposition has the potential to block national health care reform efforts. And one of the greatest pitfalls for health care reform is the perception among members of the public that their employers, doctors, and insurers are a monolithic constituency opposing reform. Policymakers should therefore determine how to win allies from among the opposition and highlight the rifts within opposition groups. They should also recognize that opposition is inevitable, and that the best that can be expected with some groups is acquiescence or muted criticism rather than support. "I cannot think of another topic that requires so many people to be heard to build consensus," remarked California Senate President pro Tempore Don Perata at the start of California's 2007 effort.[32] The inevitability of opposition makes the creation of a strong support coalition with true grassroots support all the more crucial. In this area, President Obama has greater scope than did either President Clinton or Governor Schwarzenegger, because of the formidable national movement he helped create during the 2008 campaign. This movement will have to be mobilized for reform to succeed.

> "I cannot think of another topic that requires so many people to be heard to build consensus."
> *—Don Perata, California Senate President pro Tempore*

9. **While policymakers must be responsive to difficult questions, they should distinguish concerns about affordability and viability from concerns about profit**. In California, efforts to win over the business community failed in part because reformers repeatedly resorted to arguments that did not convince employers (for example, that cost shifting due to the uninsured was a "hidden tax" on business that health care reform would eliminate or reduce) and failed to respond to employers' true concerns (that the employer contribution would be unaffordable or make them less competitive). Interest groups know what their concerns are and will attack proposals when policymakers are unresponsive. Moreover, the concerns that interest groups present may well be legitimate and deserve a thoughtful response (for example, fears that gaps in financing will fall too heavily on one part of the system or another—especially as costs increase). At the same time, in California concerns about affordability and profit were bundled. The concerns that consumer advocates or small businesses raised about being able to afford a new mandate were not sufficiently distinguished by policymakers from the concerns raised by some providers or insurers about having to accept a potential reduction to their profit margin. National policymakers must respond thoughtfully to true affordability concerns, which—if not properly addressed—would prevent the system from functioning, while sending a strong message that profit motives will not determine the outcome of the debate. Groups should be praised when they make positive contributions to the discussion, but national policymakers should express and demonstrate their independence when a commitment to shared sacrifice is lacking.

10. **Central policy issues cannot be tackled in isolation. In some areas, policymakers may use pilot projects to test ideas and win support but health care reform requires an ambitious framework in which any incremental steps create the conditions and infrastructure for the next step.** One way to attract supporters and defuse critics is by integrating pilot projects into the bill that could be expanded if they are effective and allowed to sunset if they are not. But many key elements of reform—individual market reform and the individual mandate; the individual mandate and affordability—are interconnected and do not lend themselves to pilots. Moreover, national policymakers must guard against increments that lead nowhere; and they must fight efforts to make vital elements of reform temporary, rather than permanent. This means replacing efforts to "trigger" important measures (which may never be activated) with true demonstrations in law. It also means fighting attempts to "sunset" (or legislate that certain provisions will automatically expire) crucial pieces of any reform package. And, finally, it means keeping the focus on broad, systemic reforms that are designed to help all working-age Americans and their families, rather than retreating to proposals for covering only the most sympathetic or disadvantaged groups. Unlike ABx1 1, some 2007 California bills[33] focused exclusively on children's coverage. While covering children is a worthy goal, children are relatively easy and inexpensive to cover, so solving the problem of uninsured children—while undeniably important—does not promise to yield solutions for uninsured adults. A health care reform plan that only covers the most vulnerable groups runs the risk of being a stopping point rather than a first step. Pilot projects must be integrated into a bold reform effort, not replace it. National policymakers must remain ambitious and craft a framework that includes the necessary elements for true long-term change.

CONCLUSION

History tells us that President Obama and his Congressional allies have a narrow window in which to advance health care reform. They must keep the public mobilized and maintain pressure on wavering Members of Congress to pass a bill this summer.

Although the economic situation in California derailed health care reform in 2007-2008, the worsening economy may auger well for the future of national reform. In today's economic context, the *status quo* is simply not a viable option. The increasing insecurity that Americans and their families face is mirrored in the dire financial situation of employers, state governments, private insurers, and providers. California's experience teaches us that successful legislation cannot just target the uninsured but must also guarantee security and meaningful reforms to middle-class voters who want to know they will be able to obtain high-quality medical care when they need it without facing unaffordable costs.

The national economic crisis provides the context and the motive for quick action. But if policymakers in Washington are not careful, they risk falling into the same pitfalls that brought down reform efforts in California. In addressing this crisis quickly and boldly, national leaders would do well to heed the lessons that California's health care debate offers for turning a window of opportunity into real policy change.

NOTES

[1] Rick Curtis, "Summing Up the Special Session: Technical Observations and Design Issues for Health Care Reform in ABx1-1" (Washington: California Health Care Foundation, 2008); Rick Curtis and Ed Neuschler, "California's Shelved Health Care Reform," available at http://healthaffairs.org/blog/2008/03/05/californias-shelved-health-care-reform/ (last accessed June 2009); Rick Curtis and Ed Neuschler, "Shared Responsibility: The Better Course," available at http://healthaffairs.org/blog/2008/03/10/shared-responsibility-the-better-course/ (last accessed June 2009); Rick Curtis and Ed Neuschler, "Affording Shared Responsibility for Universal Coverage: Insights from California," *Health Affairs*, 28 (3) (2009): 417-430; Rick Curtis and Ed Neuschler, "Designing Health Insurance Market Constructs for Shared Responsibility: Insights from California," *Health Affairs*, 28 (3) (2009): 431-445; Peter Harbage, Len M. Nichols and Leif Wellington Haase, "Lessons from California's Health Reform Efforts for the National Debate" (Washington: New America Foundation, 2008); Health Access, "California Health Reform (ABx1-1):Who Gets What Help?" (2008); Katherine Howitt and Michael Miller, "California's Near Miss: Understanding the Policies and Politics of Proposed ABx1-1 Legislation" (Boston: Community Catalyst, 2008); Insure the Uninsured Project, "Health Reform: Lessons from California" (2009); Rick Kronick, "The Mandate Wars, In California and Beyond," available at http://healthaffairs.org/blog/2008/03/06/the-mandate-wars-in-california-and-beyond/ (last accessed June 2009); Patricia Lynch, "Opportunity Lost: The Failure of California's Health Reform," available at http://healthaffairs.org/blog/2008/03/05/opportunity-lost-the-failure-of-california%E2%80%99s-health-reform/ (last accessed June 2009); Marian R. Mulkey and Mark. D. Smith, "The Long and Winding Road: Reflections on California's 'Year of Health Reform'," *Health Affairs*, 28(3) (2009): 446-456; Elliot K. Wicks, "Framework Assessment of ABX1 1" (Oakland: California HealthCare Foundation, 2008); Lucien Wulsin, "California: Negotiating the Intersections of Reform," available at http://healthaffairs.org/blog/2008/03/06/california-negotiating-the-intersections-of-reform/ (last accessed June 2009).

[2] This policy brief focuses on California's hybrid health reform proposals that built on the current system of job-based coverage with additional public and individual responsibility. Other significant proposals under consideration in the California Legislature included Senate Health Committee Chair Sheila Kuehl's single-payer bill, SB 840.

[3] See Gerald F. Seib, "California Stages Trial Run for U.S. Health-Care Overhaul" *The Wall Street Journal*, May 20, 2009, p. A2.

[4] The average annual growth in health care spending in California was 5.9% from 1994 to 2004, during which the average rate of inflation was 2.6%. California HealthCare Foundation, "California Health Care Spending: Quick Reference Guide" (2009).

[5] California HealthCare Foundation, "The California Employer Health Benefits Survey" (2008).

[6] California HealthCare Foundation, "Snapshot: California's Uninsured" (2008).

[7] See Jacob S. Hacker, "Healthy Competition: How to Structure Public Health Insurance Plan Choice to Ensure Risk-Sharing, Cost Control, and Quality Improvement" (Berkeley: Center on Health, Economic & Family Security, 2009); Jacob S. Hacker, "The Case for Public Plan Choice in National Health Reform" (Berkeley: Center on Health, Economic & Family Security, 2008) available at http://www.law.berkeley.edu/chefs.htm.

[8] This estimate is taken from the analysis of the bill by Jonathan Gruber, "Population Movement Estimates for Health Care Reform under ABx1-1with the Voter Initiative." (Cambridge: MIT Department of Economics, 2008). This brief takes no position with respect to whether the legislation would indeed have covered 70% of the uninsured, but rather makes the point that discussions of cost and value must take place in the context of a coverage goal.

[9] To the extent that they engaged with the issue of health care reform, Republicans proposed primarily individually-focused, market-based approaches such as high deductible health plans or Health Savings Accounts.

[10] In their view, the higher-income uninsured could afford to buy coverage, those eligible for existing public programs could enroll, and undocumented immigrants should not be covered at all.

[11] The State Children's Health Insurance Program, now known as CHIP.

[12] Gilbert Chan, "Feeling Pinched: Some Small Business Owners Call Governor's Health Care Plan Unaffordable" *The Sacramento Bee*, January 12, 2007, p. D1.

[13] These provisions stemmed in part from concerns about ERISA preemption—a challenge that federal lawmakers will not face.
[14] Jordan Rau, "The State: Gov. Offers Bold Prescription" *Los Angeles Times*, January 9, 2007, p. 1.
[15] Editorial, "Arnold's Big Rx: He Calls for Major Surgery on Health Care" *The Sacramento Bee*, January 10, 2007, p. B6; E. Richard Brown, "The Governor's Plan Uncovers the Middle Class" *Los Angeles Times*, January 17, 2007, p. 17; Senator Don Perata, "Letter to Governor Arnold Schwarzenegger," January 28, 2008, available at http://majoritycaucus.casen.govoffice.com/index.asp?Type=B_PR&SEC=%7B9E153CE6-F41B-49EE-9F91-CDF977D572F4%7D&DE=%7BC4F522C7-14A7-4CE5-8173-0D9662BD2D82%7D (last accessed June 2009).
[16] Legislative Analyst's Office, "Health Care Reform" (2008), available at http://leginfo.ca.gov/pub/07-08/bill/asm/ab_0001-0050/abx1_1_bill_20080116_amended_sen_v95.pdf (last accessed June 2009).
[17] E. Richard Brown, "The Governor's Plan Uncovers the Middle Class."
[18] According to Jonathan Gruber, Ph.D., 1.5 million individuals under the age of 65 would have remained uninsured. Jonathan Gruber, "Population Movement Estimates for Health Care Reform under ABx1-1with the Voter Initiative."
[19] Although some low-income individuals in California and other states can access care through state or local programs and clinics, most of the uninsured have no access to non-emergency care. The federal Emergency Medical Treatment and Active Labor Act (EMTALA) guarantees emergency care access but does limit how much hospitals can charge for such care. California law, codified at California Health &. Safety Code § 127400 et seq., includes limitations on hospital charges but does not eliminate the need for the greater protection that comes with insurance or a coverage program.
[20] See, e.g., Senator Leland Y. Yee, "ABX1 1 favored insurers over health for all Californians" *San Francisco Chronicle*, February 5, 2008, p. B7.
[21] Frank I. Luntz, "The Language of Healthcare 2009," available at http://www.politico.com/static/PPM116_luntz.html (last accessed June 2009).
[22] Mitt Romney, "The Answer is Unleashing Markets—Not Government" *Newsweek*, May 18, 2009, p. 39.
[23] Lydia Saad, "Americans Rate National and Personal Healthcare Differently," Gallup, December 4, 2008, available at http://www.gallup.com/poll/112813/Americans-Rate-National-Personal-Healthcare-Differently.aspx (Last accessed June 2009).
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[26] California Office of the Governor, "Guest Host California Health and Human Services Agency Secretary Kim Belshé Discusses Health Care Reform in Governor's Weekly Radio Address," April 11, 2009.
[27] The Robert Wood Johnson Foundation, "Attitudes of Business Leaders Regarding Health Care Coverage" (2005).
[28] Whereas on average 72 percent of the legislative items introduced by Presidents Kennedy, Johnson, Nixon and Carter between January and April of the first year of their presidencies were enacted, the success rate dropped to 39 percent for introduced between April and July, and 25 percent for items introduced in the second half of the first year. Jacob S. Hacker, *The Road to Nowhere: The Genesis of President Clinton's Plan for Healthy Security* (Princeton: Princeton University Press, 1999).
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[30] Mike Zapler, "Democrats Assail Health Care Plan: Governor's Proposal Called Too Costly For Middle Class" *San Jose Mercury News*, November 1, 2007, p. B5.
[31] Daniel Weintraub, "The Death of Health Care Reform: How Arnold Schwazenegger's Overhaul Plan Was Doomed By the Legislature's Liberal-Conservative Partisan Crossfire" *The Sacramento Bee,* February 10, 2008, p. E1.
[32] Jesse McKinley, "Schwarzenegger's Plan for Universal Care Draws No Universal Agreement" *The New York Times*, January 10, 2007, p. A20.
[33] AB 1 (Laird & Dymally) and SB 32 (Steinberg).

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