

# Swimming Upstream: The Hard Politics of Health Reform in California

*by Walter Zelman, Ph.D.*

June 2009



# Contents

Part One: Introduction . . . . .	3
Part Two: Systemic Factors, Policy, Interests, and Leadership . . . . .	4
Part Three: Policy and Early Strategic Choices . . . . .	9
Part Four: The Search for Compromise. . . . .	12
Part Five: Compromise and Its Price . . . . .	17
Part Six: Defeat . . . . .	19
Part Seven: One and Many Words for Failure . . . . .	22
Part Eight: Core Lessons, Hard Realities, and Next Steps . . . . .	25

## Acknowledgments:

Support for the data collection was provided by grants from The California Endowment and the University of California (UC) Office of the President, California Program on Access to Care.

The author wishes to extend special thanks to Gilbert Ojeda of the UC Program on Access to Care for his invaluable and early support of the project, to Robert Phillips of The California Endowment for his ongoing insight and advice, and to Steven Wallace and E. Richard Brown of the UCLA Center for Health Policy Research for their generous assistance and counsel in all phases of the project. The author also wishes to thank Shelly Ten Napel of the State Coverage Initiatives program for her thoughtful comments on the final draft of this paper . The author also wishes to thank the many policymakers, lobbyists, stakeholder organization representatives, think tank representatives, political and policy analysts, consultants, researchers, foundation representatives, and others who gave their time—often when there was little time available—and their insights

to the project. Without their generosity of time and intellect, this project would not have been possible.

## About the Author:

Walter Zelman, Ph.D., was a Visiting Researcher at the UCLA Center for Health Policy Research and a Visiting Professor in the Department of Health Services at the UCLA School of Public Health during the data collection phase of this project. He is now Chair of the Department of Health Science at California State University, Los Angeles.

In addition to his present and past academic roles, the author has served as a public interest lobbyist, a candidate for public office, a special assistant to a California insurance commissioner, a Clinton White House health care advisor, and a president of a California state health care trade association. He has published numerous articles on health care and California politics and two books on health care market change and health policy.

This report is a companion piece to “Politics and Policy in State Health Reform.” To read more about lessons learned from state health reform efforts in New York, Massachusetts, Pennsylvania, Illinois and California, visit [www.statecoverage.org/node/1814](http://www.statecoverage.org/node/1814).

## Part One: Introduction

The history of efforts in the United States to achieve universal or near-universal coverage—state and federal—is largely one of failure. The Clinton administration’s failure, in which I played a role, is the most recent and probably the most dramatic; but it is just one of many.

California saw its share of failure as well. The most visible of these came in 2003–2004, when the legislature passed (2003) and former Governor Gray Davis signed legislation that would have required employers with 50 or more employees to provide insurance for their employees or pay an equivalent fee to the state. Opponents, however, led by the business community, collected signatures and forced the measure to a public referendum in November of 2004, where the reform was rejected by a very narrow margin.

But the goal never recedes very far. Partly inspired by the 2006 success in Massachusetts, California launched another major reform effort in early 2007. Perhaps this time the right set of circumstances and leaders would converge to subvert one of the fundamental rules of American politics; not the one that says “all politics is local” but rather the one that says “all policy is incremental.”

From both political and policy perspectives, the reform stars in California could not have been much more favorably aligned. A highly popular and Republican governor, fresh from a huge electoral victory, had taken the lead. He was offering the “new” construct of shared responsibility. (In fact, shared responsibility differed little from the existing system in which government, individuals, and employers all share in paying for insurance. As a new and positive framing of the issue, however, the construct offered considerable value.) Early polls showed high levels of both public concern about and support for various reform options.<sup>1</sup> Solid majorities of Democrats—and many of their support

groups, especially organized labor—had previously endorsed coverage expansions and could be counted on to do so again. Skyrocketing health insurance costs were renewing concern about access to insurance among the middle class, not just among low-income Californians. Some evidence even suggested a crack in the iceberg of traditional opposition—among insurers and large employers—to coverage expansions. If not pushed too far, these interests might support approaches they had long opposed.

Nevertheless, health reform in California was not to be. What happened? Why did reform fail again?

Our effort to answer these questions focuses on the intersection of four factors, all central to the world of legislative politics and policymaking. The first factor encompasses the impacts of long-term systemic forces or limitations—including economic forces, constitutional provisions, and federal statutes—over which state decision makers may have little control. These forces often set the parameters within which policymaking and political choices are made. The second factor is critical policy challenges and the efforts to overcome them. The third factor involves the perceptions, positions, and impact of major interest groups. Finally, the fourth factor is the role of political and legislative leadership in defining, promoting, and mobilizing support for reform goals.

We tell a story of political and policy opportunities that may never have existed and of some that went overlooked; of policy differences that were bridged with extreme difficulty and of some that could not be bridged; of coalitions that came together too slowly or not at all; of government rules that turned a difficult policy task into a herculean effort; of harsh economic realities that even a perfectly played political and policy game might not have overcome; and of leadership challenges that entailed more hurdles than opportunity.

It is a story of health reform in California, but it is also a story of politics and policy in America.

### A Methodological Note

In compiling the information used in this report, the author reviewed publicly available material, including press reports; polling data; analyses by academics, think tanks, foundations, and others; legislative committee reports and analyses; press releases; speeches; and other materials. He also enjoyed access to some documents that have not been publicly available. In addition, he attended many public events, including legislative hearings, floor sessions, press conferences, rallies, and speeches by leading participants.

The author also conducted more than 120 interviews with reform participants and knowledgeable observers between January 2007 and July 2008. He interviewed about 30 individuals, representing virtually all the major organizations or policymaker groupings, at least twice, at different stages in the process. He interviewed dozens of participants once or twice, usually at times when their or their organization’s role in the process appeared particularly significant. A few individuals provided ongoing insight on an almost monthly basis. Interviewees included legislators, legislative staff, gubernatorial staff, representatives of virtually every interest group involved in the reform process, and several observers from the foundation, think tank, and university communities, some of whom were engaged in some way in the reform process.

Many interviewees asked to remain anonymous; others did not. However, in writing the report, the author found that identifying sources who did not care to preserve their anonymity had the potential of suggesting the identity of other sources who did not wish to be identified. As a result, except where a source is a matter of public record, all sources are identified only by general descriptions of their role or position in the reform effort.

# Part Two: Systemic Rules, Policy, Interests, and Leadership

## The Systemic Environment

The challenge of crafting policies and mustering winning coalitions plays out in a systemic environment over which policymakers have limited and sometimes no control. The more confining the rules posed by systemic forces, the narrower is the room for maneuver and the smaller the margin of error accorded players. The struggle for health reform in California included plenty of maneuver room, but systemic rules and other factors imposed severe restraints that translated into painfully small margins of error.

In early 2007, a wide range of systemic forces framed the health reform effort, several of which proved particularly significant.

## Two-Thirds Vote Requirements

At the top of the list of systemic forces was California’s constitutional rule mandating a two-thirds vote in both chambers of the legislature for the

passage of a state budget and the approval of revenue increases. Only two states (Arkansas and Rhode Island)<sup>2</sup> share the first requirement while only 16 other states, to some degree, operate with the second requirement.<sup>3</sup>

Of the many infamous means—many of which Madison and others outlined over 200 years ago—of making sure that American majorities do not move too far too fast, the two-thirds vote requirement in both legislative chambers ranks as the most influential and most undemocratic. It provides the minority with powers far beyond its numbers or the votes it received. It may even encourage an aggrieved political minority—such as California legislative Republicans—to place excessive reliance on the few tools of leverage at its disposal. In 2007, all 15 Senate Republicans and 31 of 32 Assembly Republicans (one said that he did not want new taxes but that he also did not like pledges) signed a no-new-taxes pledge.<sup>4</sup> “The no tax rule,” explained a Republican staffer, “is the thing that holds the party together.” He emphasized that little leverage would remain “if we give on that.”

The two-thirds requirement for revenue increases has not been as visibly

contentious as the two-thirds vote requirement for the state budget. It does not routinely bring government to a standstill or leave providers of government services without paychecks, but it is nonetheless a dominating factor in California policymaking, including policymaking in the health sector. Without new revenues, insuring the uninsured was an unreachable goal. As one ex-legislator labeled it, the two-thirds vote requirement was the “Magainot line” of health reform.

Looking ahead in early 2007, reform advocates would either have to divide the Republican coalition or discover a way around the constitution. It was hard to say which task would be more daunting.

## Rising Health Care Costs

If the two-thirds vote requirement imposed the greatest procedural constraint, rising health care costs imposed the greatest economic constraint. In 2006, California premiums had risen by 8.7 percent, more than twice the rate of inflation (4.2 percent), to almost \$12,000 for family coverage. After years of remaining well below national averages, California HMO (health maintenance organization) premiums finally caught up.<sup>5</sup>

**Table 1: National Premiums and Poverty Levels**

	2000	2007	Percent Change
250% of Poverty, Family of Four	\$44,007	\$51,625	17
Health Maintenance Organization Family Premium	\$5,844	\$11,879	103
Premium as Percent of 250% of Poverty	13.2	22.9	

Source: Author’s calculations based on Kaiser Family Foundation, Employer Health Benefits Survey, 2007; U.S. Census data.

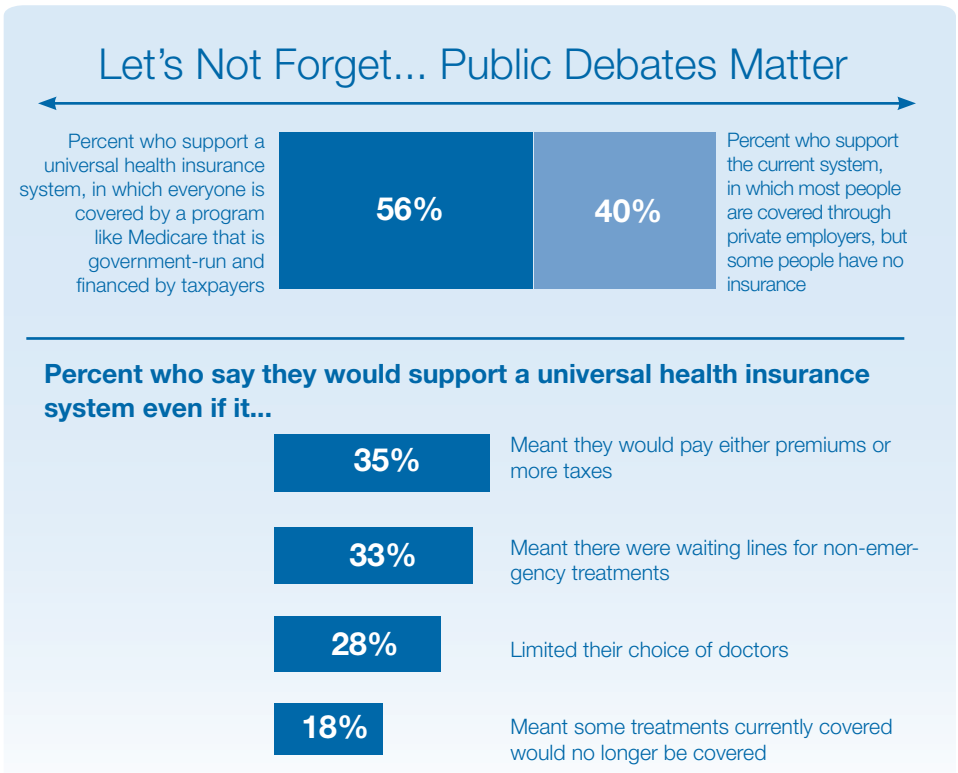
Worse still, while income for a family at 250 percent of the federal poverty level (FPL) had risen by just 17 percent since 2000, HMO premiums had escalated by 103 percent (see Table 1). The results of this trend, for health reform, were dramatic. In 2000, subsidies might have been required for those living under 250 percent FPL; by 2007, the equivalent subsidy level was 350 or 400 percent FPL. The subsidy costs of reform, then, would be much greater. Many have concluded that the United States has lacked the “political will” to achieve universal coverage. Perhaps that assessment is accurate; but, given rising costs, the political will needed to institute reform today is much greater.

Conceivably, effective cost containment strategies might ease the reform challenge. Unfortunately, however, such efforts have produced only marginal impacts at best. The 1990s successes of managed care were an exception to the rule, but proved short-lived. The tools employed to achieve cost reductions met with the disapproval of providers or consumers and, ultimately, of employers and legislators as well.

### Employee Retirement Income Security Act

With California’s legislative and economic constraints a challenge unto themselves, the Employee Retirement Income Security Act of 1974 (ERISA), which is the federal law that restricts states’ ability to make rules governing employer-sponsored health benefits, prevented reform advocates from calling for the imposition of certain requirements on employers,<sup>6</sup> including many requirements favored by Democratic advocates of coverage expansions. Under ERISA and several court rulings on the statute, it might be possible to define employer requirements as a percentage of payroll spent on health benefits, but the specifics of such a requirement remained unclear. The higher the employer requirement, the more likely it would appear as a mandate and face judicial rejection (not to mention increased employer resistance). ERISA also limited reformers’ capacity to specify a defined benefits package guaranteed to individuals and families. As a result, while the costs of reform might be clear, the promise, in terms of specific benefits, would remain elusive.

## Figure 1: National Public Opinion



Source: News/Kaiser Family Foundation/USA Today Health in America Survey (conducted September 7-12, 2006).

### Federal Medicaid Rules

Federal rules and regulations under Medicaid and other federal government programs as well as earlier state actions to maximize access to federal dollars also presented policymakers with a framework of options and limits. The first rule of state coverage expansion proposals is to maximize state access to Medicaid, the State Children’s Health Insurance Program (SCHIP), and other federal funds.<sup>7</sup> State health reform, in a word, is almost always tied to federal dollars. Consequently, federal laws and ongoing interpretation of those laws are central to state reform efforts, as are past state actions. Some states (New York and Massachusetts, for example) have been particularly aggressive or creative in accessing various federal revenue sources. (California has been reasonably aggressive in this regard, although to a lesser extent than New York and Massachusetts). Such states may be able to expedite coverage expansions because the expansions may involve, as one expert put it, “moving money from column A to column B” as opposed to finding new state or federal funding.<sup>8</sup>

### Public Opinion

Finally, a list of systemic forces often includes the nature of public opinion. Unlike the factors noted above, public opinion may be amenable to leadership influence. Policymakers might be unable to counteract constitutional, statutory, or economic forces, but they at least have a chance to shape public opinion. Moreover, only rarely does public opinion demand legislative action, and even less rarely a specific policy option. Still, public opinion sets parameters, suggesting what may be feasible or infeasible and warning, in extreme cases, where legislative decisions might have significant electoral consequences.

In early 2007, polls suggested that public support for health care reform was substantial and might range across a variety of options.<sup>9</sup> Most polls did not reveal, however, how the public might react to effective critiques or, most importantly, to information on reform costs.<sup>10</sup> Indeed, many polls before and after California’s reform effort argued for caution in gauging the depth of public support for reform. Interviewees



might support insurance coverage expansions, but not necessarily if it meant higher taxes or higher premiums (see Figure 1).<sup>11</sup> Overall, public opinion seemed permissive, and generally supportive of reform. Still, it was not demanding reform. And the polls had not even really challenged voters with the hard choices.

## Policy Challenges

The toughest of policy challenges involve clashes of values; they reflect clear lines of demarcation among voters, parties, and policymakers that tend to move only slowly and mostly at the edges.

## Matters of Value

The fundamental value at stake in health reform is universal coverage. Most elected Democratic officials favor the concept. Elected Republican officials do not necessarily oppose universal coverage but generally reject the necessary means—the redistribution of resources and government intervention—of achieving it.

Given the fundamental divide over the centerpiece of health care reform, reform efforts tend to focus on two questions that frame the debate: First, who will pay? Second, what will be the bottom-line impact of coverage expansions on various stakeholder groups and the public? The success of reform largely rests on the capacity to answer these questions in ways that meet the political, economic, and policy goals of a wide range of stakeholders. As many California informants suggested, “Follow the money.”

As to the first question, all parties to the debate had a good understanding of reform requirements and options. Universal or near-universal coverage would require some expansion of government funding (state or federal) to provide subsidy support and some form of mandate that employers and/or individuals purchase insurance. The most recent proposals had focused on the “play-or-pay” construct under which employers would either purchase insurance for their employees (play) or pay an equivalent

amount into a pool through which their employees and possibly others would receive insurance. To be sure, some legislative Democrats and many support groups favored the tax-based, single-payer approach adopted by Medicare or Canada’s health care system, but, in the California of 2007, that approach was off the table. The governor had vetoed (as all knew he would) such a proposal in 2006, and few but the staunchest single-payer advocates thought seriously about undermining a reform opportunity with another run at their holy grail. As *New Prospect* health writer Ezra Klein later quipped, “Socialized medicine is past its sell-by date.”<sup>12</sup>

Democrats, and especially their labor allies, had long favored either a direct employer mandate to purchase a defined amount of coverage or a play-or-pay version of that mandate. Few, if any, Democrats wanted to follow the individual mandate construct, the hallmark of the successful 2006 Massachusetts reform. The labor community in particular viewed it as a slippery slope and a shift in responsibility from employer to individual.

Republicans, by contrast, dismissed the single-payer approach out of hand and turned an almost equally negative eye on employer mandates. Many supported the notion that individuals should bear more responsibility for their own coverage, but in response to market forces rather than as a consequence of a government mandate.

## Beyond the Values

Policymaking, and health care policymaking in particular, must address more than just the big picture, value questions. Especially in its more comprehensive forms, policymaking involves a host of policies and options that cannot be easily separated or addressed individually. There are no isolated fixes. The result is complexity in both policy and politics. Policy-wise, one change will create the need for other changes. Politically, it becomes increasingly difficult, as a Massachusetts reform advocate put it, to “take on one opponent at time.”<sup>13</sup> The health policymaking process faces

further complexity due to the 50-50 split of health care financing into the private and public sectors.<sup>14</sup> Reforms of the private market have impacts on public programs and vice versa. Unintended consequences and uncertainty seem inevitable. To reform advocates—health or otherwise—risk and uncertainty are major liabilities. Reform proponents can assert that the status quo poses even greater risks, but this is, at best, a second-best argument. To opponents, by contrast, risk and uncertainty are major assets. They need not propose an alternative; the creation of significant doubt is usually adequate for their cause. But in policymaking, uncertainty, especially about finances, is likely to trump hopes of potentially positive outcomes.

Moreover, the non-value related questions—the “how to” questions or the “how-much-will-it-cost-to-do-this” questions—are often absolutely critical to one or more interests whose business model may depend on how the questions are resolved. Policymakers may not be interested in some of these questions or may wish to avoid them, but stakeholders will insist they be considered and resolved. As one Washington insider once stated, “Health reform *is* rocket science.”<sup>15</sup>

## The Interests

Interest groups often appear to be the moving parts of health reform efforts. Many policymaker choices will hinge on the question of whether a particular option can produce more interest group support or at least less interest group opposition.

The politics of most interest groups, however, may be more static than fluid. Their views are based primarily on longstanding perceptions of self-interest, most likely economic self-interest. They do not shift easily and thus seem more like givens than movable parts.

This is particularly true of the biggest interest group players—trade associations whose members span a variety of organizational types, missions, market circumstances, clientele, and policy and political attitudes. In these associations the

search for cohesion between and among member groups usually produces and sustains lowest-common-denominator policies. For these organizations, comprehensive change is, at a minimum, a risky proposition, from both policy and organizational points of view.

To defend their views and positions, the interest groups rely on an array of tools and leverage points in the policymaking process—campaign contributions, public status, lobbying expertise, longstanding connections to influential policymakers, media access, capacity to appeal directly to the public, and so forth. No one interest group commands all the tools, but all (even consumer groups articulating the needs of the poor) control some, and all have

learned how to focus on their primary needs (see Table 2).

Common Cause founder John Gardner once likened the politics of special interests to a game of checkers. Every interest magnanimously informs policymakers that the policymakers may move the checkers on the board—except, of course, the one under the interest group’s thumb. The problem, Gardner noted, is that at least one special interest thumb is on every checker.<sup>16</sup>

Health care politics is Gardner’s checkerboard writ large. With several varieties of physician groups, hospital organizations, pharmaceutical companies, technology companies, nurses, dentists,

health plans, and other allied health professionals—not to mention employer groups and unions and consumer organizations—the players in the game are vast in number and power. There are, in effect, about four thumbs on every checker. Therefore, it is hardly surprising that most comprehensive reform efforts usually bump up against the skepticism and at least some of the power of entrenched interests. This has certainly been the case in state and national health reform efforts.

### The Support

Still, in early 2007, the California interest group landscape offered some reason for hope. The reform cause would almost certainly be led by organized labor, which, given Democratic dominance of both

**Table 2: Tools of the Interests**

Interest	Greatest Lobbying Strengths	Lobbying Weaknesses
Physicians	Campaign dollars, lobbying capacity, public credibility	Limited grass roots potential; broad agenda means resources are spread thin
Hospitals	Lobbying capacity, strength in communities, expertise, perception as critical community institution	Diverse membership makes decision-making difficult; broad agenda
Organized labor	Campaign contributions, capacity to produce election volunteers and votes, close ties to Democratic leaders	Modest public credibility, limited capacity to work with Republicans, all issues seen as “hot button”
Nurses	Public credibility (as nurses rather than as a union), grass roots capacity	Viewed by some as extremist on reform
Big business, Chamber of Commerce	Campaign dollars, legislative lobbying, good ties to moderate Democrats, capacity to sound the alarm on economic matters	Broad agenda; tied too tightly to Republicans
Small business	Viewed as critical to the economy; case often made by larger business interests	Campaign funding and lobbying capacity; often viewed as knee-jerk conservative
Consumer groups	Access to media, public credibility, close ties to labor, capacity to mobilize grass roots	No campaign dollars, limited ties to Republicans, limited lobbying budgets
Health plans	Lobbying capacity, expertise, campaign contributions	Poor public image, internal differences on reform, ongoing differences with physicians

legislative chambers, was clearly the state's most powerful interest. Allied consumer groups, with their capacity to mobilize grass roots support and their easy access to the media, would lend support. Given its recent past support, the California Medical Association (CMA), perhaps the state's most publicly respected voice on all matters medical and one of the state's most generous campaign contributors, would likely enlist for the cause. The hospitals, too, might support reform, especially if they envisioned higher payments for the currently uninsured.

Moreover, breaking with tradition, the CEOs of two leading insurers—Kaiser and Blue Shield—had emerged as supporters of universal coverage. Bruce Bodaken of Blue Shield had been advocating for coverage expansions for several years. In December 2006, Kaiser's George Halverson offered a detailed blueprint for a similar universal coverage model.<sup>17</sup> In addition, a host of public health plans serving the state's Medi-Cal population could be counted on for vigorous support. Aside from providing potential support for reform efforts, the positioning of the insurers as reform advocates suggested that the state association of health plans might be divided and neutralized. In the effort to minimize the opposition's strength, the reform side could count such neutrality as a major victory.

Moreover, there was some evidence, represented most visibly by Safeway CEO Steve Burd, that elements of the business community—if not pushed too far—could support an employer mandate. In addition, a small business organization, Small Business California created by Bay Area insurance broker Scott Hauge, was prepared to support a modest mandate. Hauge's organization of several hundred, non-dues-paying small businesses could hardly claim to represent the entire small business community, but at least some small business organization had come forward to support some form of employer mandate. The state Chamber of Commerce might still be the business community's strongest and

clearest voice and would almost certainly continue to reject any significant mandate, but some business support could blunt the bad-for-business argument and give moderate Democrats some political cover in supporting a requirement on business.

In early 2007, the potential coalition in support of universal coverage appeared uniquely strong. That coalition, along with large Democratic legislative majorities and potential support from a popular Republican governor, provided cause for optimism. The opposition, of course, would be formidable and include most large and small business organizations, the restaurant association, some insurers, and even the California Nurses Association, which was firmly committed to a single-payer solution and unwilling to consider anything less.

But all things considered, if health reformers could marshal a traditional California coalition and bolster it with new insurance and business allies and support from a Republican governor, they might move some of the pieces on the proverbial checkerboard and more than rival the power of the traditional opposition. All of which produced a contrarian twist on the history of health reform. Were reform to lose again, the loss might result more from the failure of the proponents than from the success of the opponents.

### Leadership

Given a particular systemic environment, a limited range of policy options, and the positioning and strengths of affected interests, leaders must seek out opportunity. Their success in doing so depends primarily on their ability to select strategies, define issues, and apply the leadership tools at their disposal to weaken the opposition and/or strengthen support. They must attempt to expand their maneuvering room and set out to become masters rather than victims of the rules and other elements of the strategic environment. They need to use policy options not just as goals but also as means to attract and satisfy actual and potential supporters. Their success will depend in part on experience and knowledge of the

system, but every major leadership test will have its unique challenges. Almost inevitably, leaders will be required to make some decisions sooner than they would like, with too little information and too much uncertainty. Knowledge of the system may not inform them about when to compromise and when to hold out. In many cases, success may rest largely on the intangibles of political judgment.

In early 2007, the leaders of California's health reform effort started from a position of strength. The governor had just won a sweeping electoral victory. He enjoyed productive and cordial relationships with legislative leaders—Assembly Speaker Fabian Nuñez and Senate leader Don Perata—forged during a series of legislative successes in the previous year on global warming, minimum wage, and other matters. The Democratic leaders of their respective chambers were politically secure, almost certainly capable of delivering the Democratic vote, and seemingly committed to the challenge of health reform.

Moreover, for both the governor and the two Democratic leaders, especially the younger and more ambitious speaker, the political opportunities were unparalleled. For the governor, recasting the health care system—public policy's most intractable conundrum—would only underscore the national dawn of a new “post-partisan” era. To the extent they sought it, the Democratic leaders involved in shepherding health reform through the legislative process would move to the forefront of an impending 2009 attempt at national reform. A legislative success might also provide a critical boost in the effort to modify the state's stiff term limits law. If voters did not modify the law by early 2008, both legislative leaders would be termed out that year.

Perhaps even more important, though not as widely acknowledged at the time, both the governor and the speaker (who eventually emerged as the Democratic leader on health reform) cared more about achieving policy success than attending to policy details.



Advocates on both sides of the reform issue expected both leaders to prove flexible on many critical points. The combination of political strength, commitment, and flexibility pointed to a unique opportunity to invoke the tools of pressure and compromise. Still, the history of failure provided a haunting backdrop to all the systemic rules, policy challenges, and competing interests that shaped the reform environment. Taken together, these challenges proved daunting. Leaders had to find common ground and then push that common ground through the eye of a needle.

## Part Three: Policy and Early Strategic Choices

By late 2006, policymakers and close observers knew that, once the election was behind him, the governor would propose reforms to California's health care system. To mixed reviews, he had conducted what he termed a "health care summit" with major stakeholder groups in summer 2006. Some had been impressed by the governor's apparent commitment and full participation; others saw more politics than policy.

During the following months, the governor's representatives met with virtually anyone with policy insights or political capital. The rumors of a major gubernatorial initiative even compelled both Democratic legislative leaders to rush out coverage expansion proposals. Few had expected that 2007 would be the year of comprehensive health reform, but the Democratic leaders were not going to permit a Republican governor to usurp a Democratic issue.

For the most part, the proposals offered by both legislative leaders took expectedly Democratic orientations. The proposals featured "play-or-pay" approaches but did not specify the percentage of payroll that employers would be required to contribute. (Later, payroll contributions were pegged at 7.5 percent, which was less than labor allies preferred, but as much as leadership thought feasible given ERISA provisions and the governor's views.) The proposals

also laid out individual market reforms such as guarantee issue, creation of purchasing pools, ways to increase the state's Medicaid match, and limits on what insurers could retain as administrative expenses and profit. Surprisingly, given labor's strong opposition, Senate leader Perata's proposal included a modest individual mandate imposed on those with incomes over 400 percent FPL.

Given their assumption of no Republican votes for such plans, the two Democratic leaders structured the employer contribution as a "fee" in order to skirt the two-thirds vote requirement. In fact, they called for no revenue sources that would require a two-thirds vote. With these limits on revenues, the Democratic proposals would not achieve universal coverage and instead would reach about 3.4 million of the state's 4.9 million uninsured.<sup>18</sup>

### Policy Challenges: The Middle Ground and Other Places

The two Democratic leaders believed that they were staking out bold terrain beyond which the governor would not venture. They were wrong. The governor's proposal, unveiled in January in a national media roll-out, was a stunner. Most observers, even many insiders, were anywhere from "surprised" to "blown away." Given the proposal's scope, many were equally surprised that, in the political world of leaks, the policy ship had been incredibly tight.

The governor's proposal was influenced by the 2006 Massachusetts success and its individual mandate. Indeed, the governor had been intrigued as early as 2004 by the New America Foundation's treatment of the mandate and, by 2006, New America's and other organizations' concept of shared responsibility. Under the governor's version of shared responsibility, individuals with incomes over 250 percent FPL and without employer-based insurance would be required to purchase at least a catastrophic insurance policy (\$5,000 deductible); access to Medicaid and SCHIP would be expanded; employers would face a play-or-pay requirement set at 4 percent; and state government, largely by accessing federal

Medicaid matching funds, would provide subsidies for low-income citizens. The proposal also included market and insurance reforms that paralleled the Democratic proposals, a somewhat more limited purchasing pool, a variety of incentive-based programs aimed at reducing the growth in health care costs, and several other features. The proposal's total cost was calculated at \$12.1 billion, almost \$5.5 billion of which (45 percent) would come from the federal government.<sup>19</sup>

Perhaps the boldest element of the governor's proposal was a 2 percent fee on physician revenues and a 4 percent fee on hospital revenues. The fees, totaling about \$3.5 billion in revenues, would be matched by federal Medicaid dollars and largely returned to physicians and hospitals in significantly higher Medi-Cal payments. The provider fees (ultimately deemed taxes) were central to the governor's larger aims of fixing the "broken system" and eliminating the "hidden tax" that the current system shifts to employers and individuals by underpaying providers. That hidden tax, the governor argued, calculated (generously, many believed) at the proverbial last minute by New America researchers, approached 10 percent of premiums, or \$1,186 per family.<sup>20</sup>

Less striking but ultimately no less controversial to those affected by it was a reduction of \$2 billion in state spending on state and county safety nets, justified by the sizable reduction in the number of uninsured and by higher Medicaid provider payments. (This provision caused widespread concern, discussed later, over the capacity of the safety net to survive sudden and deep reductions in support.)

The combination of an individual mandate, more limited subsidies, the catastrophic benefit design, and other features meant that the governor's plan would cover more of the uninsured (4.1 million) than would the Democratic proposals.<sup>21</sup> Many observers admitted that, in addition to being surprised by the scope and reach of the Governor's proposal, they were struck by the depth of detail offered, especially in the proposal's

financing. Others, especially those representing key interests, offered responses that were generally respectful and open-minded but more guarded. Representatives of the business community praised the governor's leadership on the issue, but State Chamber President Allan Zarembeg asked, "How will the inevitable shortfall in funding be addressed? Will the tax (Zarembeg left no doubt here—it was a tax, not a fee) have to be doubled in 10 years?"<sup>22</sup> On the reform side, spokespersons agreed that many of the governor's proposals were constructive and at least negotiable.

Lurking under the surface, however, was the major fault line of how much shared responsibility should be borne by each of the partners. An individual mandate at 400 percent FPL raised objections among many reform advocates; a mandate pegged at 250 percent FPL was out of the question, as was a \$5,000 deductible. Even more unacceptable was the modest 4 percent payroll contribution required of employers, widely perceived by labor and consumer groups as easing the responsibility of employers while dramatically increasing that of

individuals. "His 4 percent is like a \$4 minimum wage," said one labor lobbyist, "We appreciate the thought, but it is not nearly enough."

Nevertheless, as many noted, the governor's proposal was still a case of "Nixon going to China." Perhaps the governor could deliver what Democrats could not: some Republican votes, some business support, and some political cover.

**Table 3: Timeline-Phases of Reform**

<b>Phase 1: Proposals Developed, Early Negotiations, December 2006–July 2007</b>	<b>Phase 2: Budget Crisis, July–August 2007</b>	<b>Phase 3: Regular Session, After the Budget is Passed, August–September 2007 (from budget resolution through end of regular legislative session)</b>	<b>Phase 4: Special Session, September–December 2007</b>	<b>Phase 5: Final Agreement Fails to Pass the Senate, January 2008</b>
<p>December 2006–Senate and Assembly Democrats' health reform plans released.</p> <p>January 2007–Governor's health reform plan released.</p> <p>Governor aggressively promotes plan, engages in extensive public and private meetings. Governor's staff holds several stakeholder meetings.</p> <p>January 30, 2007–Senate Republican legislators offer reform proposal.</p> <p>March 13, 2007–Assembly Republicans offer reform proposal.</p> <p>April 24 and 25, 2007 –Leadership bills pass first committee tests in Assembly and Senate.</p> <p>June 7, 2007–Assembly and Senate pass leadership bills.</p> <p>June 21, 2007–Legislative leaders merge proposals. Speaker begins to assume lead on reform issue.</p> <p>July 2007–Beginning of state budget stalemate.</p>	<p>Budget crisis consumes the Capitol. No visible movement on reform. It becomes clear that the governor lacks sufficient influence over the Republican legislators to achieve a successful two-thirds vote approving health reform. The "bi-partisan" deal would be between the Democrats and the governor.</p> <p>Democratic leadership relations worsen during budget crisis.</p>	<p>August 21, 2007 –Budget deadlock ends.</p> <p>September 6, 2007 –Governor and hospitals agree on plan to tax hospitals to support reform financing; November 2008 ballot measure becomes a necessity.</p> <p>September 10, 2007 –Legislature approves Nuñez health reform proposal; governor vows veto and calls for special session.</p>	<p>October 12, 2007 –Governor vetoes Nuñez proposal, negotiations continue.</p> <p>Early-mid-November 2007–Governor and Nuñez offer adjusted proposals that narrow differences.</p> <p>Late November 2007 –SEIU President Andy Stern intervenes to alter the union's position on reform.</p> <p>December 14, 2007 –Governor and Nuñez agree on reform plan that will require legislative passage and then voter approval on November 2008 ballot.</p> <p>December 17, 2007 –Assembly approves Nuñez bill on party line vote.</p>	<p>January 23, 2007–Senate Health Committee hears reform proposal.</p> <p>January 28, 2007–Senate Health Committee votes and rejects reform legislation.</p>

## Strategy and Strategic Considerations

In the legislative environment, the two most obvious strategy options for achieving major reform call for building consensus in the middle (of policymakers and stakeholders) or mobilizing one side and overpowering the other. Most efforts end up as some hybrid of the two.

The Democratic hybrid was closer to the second of the two options. While the governor might trumpet the legislative successes of 2006 as “bipartisanship” at work, such bipartisanship was limited to himself and Democrats. No Republican legislators had supported the “bipartisan” successes. In 2007, Democrats saw no reason to expect anything different. They believed the challenge would lie in finding common ground (especially on financing) with the governor and achieving what they could with majority votes. Interest group positioning on both sides would count, but the ultimate deal, they assumed, would be struck between themselves and one Republican.

The governor, by contrast, emphasized a consensus-building, middle-ground strategy. He pressed for enhanced individual responsibility—a theme commonly associated with conservative and Republican thinking—while seeking the Democratic holy grail of universal or near-universal coverage. He insisted publicly and privately on a bipartisan approach, although he never specified how many Republican votes defined bipartisan. In effect, the key strategic difference between the governor and the Democratic camp hinged on whether the governor’s proposal would garner any Republican support.

Democrats proved more prescient. Republican staffers participated in discussions with their Democratic counterparts. Assembly Republicans offered an alternative proposal that focused on high-deductible Health Savings Accounts and tax breaks to businesses offering insurance.<sup>23</sup> Senate Republicans advocated a less traditional proposal based on expanded access to enhanced safety net services.<sup>24</sup> But neither Republican proposal came close to

the proposals offered by the Democrats or the governor. Republican views soon became irrelevant.

Thus, what may have started as a gubernatorial focus on finding consensus between two political parties reverted to something closer to the Democrats’ hybrid. Two challenges defined that hybrid: First, could Democrats and the governor find common ground somewhere along the policy continuum? Second, would that common ground hold enough attraction for most of the Democratic stakeholder coalition—primarily labor—and at least some of the governor’s stakeholder supporters—primarily some portion of the business community? In short, could Democrats and

the governor find what one administration negotiator defined as the “sweet spot”?

## Processes of Negotiation: A Staff-Driven Process

Beneath the larger battlegrounds of employer requirements, individual mandates, and other value-driven issues lay a maze of policy conundrums. A small group of gubernatorial and legislative staffers wrestled with these policy matters on a daily basis. Their efforts were underwritten by California foundations that paid top national experts to consult on financial modeling and other matters. According to those involved, the assistance proved invaluable, especially the independent analysis that generated the numbers that

## Republicans: And Then There Were None

Longstanding philosophic differences are enough to explain the reluctance of Republicans to participate in serious negotiations over the health reform proposal. Their disciplined opposition to increased taxes of any type, their reluctance to support expansive government programs, their opposition to employer mandates—even for most of the individual mandates—were well documented. “Anything that creates a big government oversight program is doomed to failure,” said Assembly Republican Leader Mike Villines (R-Clovis).<sup>25</sup>

In addition, the Republicans did not share the view that the health care system was in crisis. As one staffer noted, the system was not doing so badly. A large majority of California citizens had insurance, and most were satisfied with it. Moreover, the number of uninsured was not 6.5 million but instead ranged from 2 to 2.5 million after subtracting California’s high number of illegal immigrants, individuals earning over 300 percent of FPL who could presumably afford but had chosen not to purchase insurance, and those eligible for Medi-Cal or Healthy Families who simply had not enrolled. Lack of access to insurance might be an issue, but it did not justify the type of government intervention under consideration.

The Republicans’ opposition to health reform, however, might have stemmed from more than just philosophic differences with the Democrats and a belief that a functioning health care system did not need repair. For many Republicans, the governor was more deserter than leader. While trumpeting his “bipartisan” agreements and good relations with Democratic legislative leaders, he offered little legislative and political support to his Republican compatriots. He did little to assist them in the election campaign of 2006. By spring 2007 if not earlier, he had alienated many of them. By summer 2007, many thought nothing of punishing him by refusing to deliver needed votes during an embarrassing stalemate on the state budget. On health reform, they also saw no reason to offer support.

informed policy formulation and on which all relied. Still, the expertise was not sufficient to guarantee certainty in the analyses. On some issues, California was in uncharted waters. Staff wanted the consultants to offer answers and to do so with confidence. All too often the experts responded that, “There is no clear answer here. . . you are the first ones to get to this level of detail.”

Some of the issues were unique to California, some were not. At the top of the issue list was which of the potential revenue sources might be defined and constructed as a “fee” and thus require a majority vote and which might be construed as a “tax” and thus require a two-thirds vote. Ultimately, it was the legislative counsel’s job to provide the answer, but the specific language used might affect the counsel’s decision. As one insider noted, “You keep asking questions until you get the right answer.”

ERISA was another thorny issue, and led to critical questions of what and how much could be required of employers and what form requirements could take. Technical and legal in nature, the answer (unclear as it was) would define acceptable financing options. All parties knew that the imposition of almost any employer requirement would likely lead to a lawsuit. “The paperwork is already being processed,” one said jokingly. The awareness did not stop progress but it weighed heavily on those trying to move forward.

Still other critical questions needed answers: How should individual market reforms be structured? How might an individual mandate be enforced? How would subsidy mechanisms work in the proposed pool and what were the likely impacts of allowing different sets of individuals into it?

The details are beyond our scope and purpose, but the point is that the issues, as is inevitable in health care policymaking, were interconnected and expansive. What might begin as a non-political, technical question could become a critical matter of politics or finance. What for some might be

an analytic exercise could mean the support or opposition of a critical stakeholder. In some cases, resolution of an issue required decisions by leaders who were not available or not yet ready to make them. In other cases, difficulties in resolving an issue simply delayed the process of negotiation and absorbed precious time, more time than was available.

In addition to their analytic work, the small group of legislative and gubernatorial staff members functioned as critical political players and conveners of various stakeholder outreach efforts. Early in the process, gubernatorial staff conducted a series of discussions that brought together large numbers of stakeholders around a variety of issues. Most participants, other than some on the governor’s staff, saw little value in the discussions.

Later in the year, as negotiations grew more intense, the same staff members—especially the speaker’s point person and the governor’s legislative staff—met with key constituencies in a traditional one-on-one format, with all sides voicing concerns or demands or probing for information or evidence of flexibility. Almost all the discussions took place behind the scenes either in Capitol rooms or during staff or board meetings of various constituency groups or coalitions. Public hearings (until the final hearing in early 2008) were almost devoid of any meaningful analysis or debate as is often typical of California’s and many other legislative environments. We will consider this point in depth later.

## Part Four: The Search for Compromise

By late spring 2007 and certainly by the end of summer 2007, the path to successful health reform was evident to all. The governor and speaker (Senator Perata had ceded leadership to the speaker) would have to fashion a policy outcome that would afford them and a significant share of their stakeholder supporters an opportunity to find common ground. Most participants assumed that the two leaders, given their political goals and

policy flexibility, could find that common ground. The critical question, then, was could they bring their support groups with them? A second question was what would happen if, as appeared increasingly apparent, the governor could not deliver any Republican votes and no two-thirds support for anything?

With no evidence of public demand for reform, public opinion did not seem central to achieving reform. Furthermore, legislative support did not appear to be at stake. The general assumption held that, if the governor and the Democratic leaders could craft an agreement reflecting strong, broad support from interest groups, then legislative Democrats would endorse the reform package. The needed coalition of interest groups, however, remained elusive. Major differences hinged on the economics, the “follow-the-money” questions of who would pay how much, and the economic impacts of reform on various stakeholders. Once again, health care reform would be about the interests.

### Employers: The Business Community Remains Opposed

From the beginning, the governor’s primary goal and challenge lay in winning the business community’s support or limiting its opposition. He focused on the “hidden taxes” that businesses were paying and on the benefits to business of the lower costs that would emerge as California fixed its “broken health care system.” The business community, large and small, had long and persistently opposed any form of employer mandate. Even so, business was facing premiums rising at near double-digit rates and many business leaders recognized that they were paying for benefits not provided by their competitors. Moreover, employers providing insurance coverage—virtually all large businesses were doing so—were paying more than two or three times the 4 percent of payroll proposed by the governor and expected to continue paying at that level.<sup>26</sup> Consequently, some business leaders were receptive to the governor’s appeal and listened to the merits of his proposal; others listened because, given a legislature dominated by liberal Democrats and their



labor allies, a gubernatorial veto was their best ally, and good relations with the governor were a likely prerequisite.

The governor worked hard to win business's backing and managed to achieve some tangible progress. Early in the process, he gained, in principle, the support of the state retailers association, one of the most significant business associations in the state. Its president advised his members that the governor's reform proposal was "about as good as it is going to get." The governor also secured varying levels of support from the Los Angeles and San Diego Chambers of Commerce and the Silicon Valley Leadership Group, which represented more than 200 Silicon Valley employers. In a statement, the group declared, "We support the governor's vision for comprehensive health care reform this year. When your leg is broken you get to a doctor right away. When your health system is broken it should get the same immediate attention."<sup>27</sup> Safeway CEO Steve Burd continued to support the governor's proposal and rallied an impressive list of corporations in a statement of principled support for coverage expansions and several other principles embodied in the governor's proposal.<sup>28</sup>

The Small Business California coalition also endorsed the governor's proposal creating an ally far more important for what it symbolized (the fact that not all small businesses opposed reform) than for the legislative clout the group could deliver.

In view of the additional business support that emerged in the health plan and hospital communities, the support lent by the business community was a significant breakthrough. At a minimum, it suggested that business, especially firms already insuring their employees and paying well over the 4 percent demanded by the governor, was not in lock-step opposition to reform. Indeed, some businesses made the case for reform privately, and some in the governor's camp believed that sizable portions of the business community were willing to accept the governor's proposal even if they would not openly advocate it.

Whatever the potential support list might have looked like on paper, it did not translate into much active public or legislative pressure. Burd's coalition was broad and impressive but did not involve itself in the debate, did not counterbalance the state Chamber, which remained opposed, and certainly did not break with it or outrightly attempt to alter its position. Aside from Burd, most business leaders supporting shared responsibility usually did so without noting the employer requirement. As one observer noted, the "class consciousness of business was just as strong as that of labor."

In addition, it was far from clear that the business community was accepting the hidden tax argument and that reform would reduce the costs passed on to business. To some in the reform community this seemed surprising, if not outrightly duplicitous, as the business community had, for years, been making that argument itself. To the governor's team, the business community's resistance to the cost shift argument was a disappointment. "I tried," reported one aide to the governor, "to convince business on the cost-shift argument; but I couldn't do it. They did not see enough benefit there." In the end, the business support won by the governor was for *his* proposal—and sometimes for just the "principles" of his proposal, leaving even potential business supporters far from positions taken by Democratic leaders and even further from those of their labor allies.

All during the governor's efforts to enlist business support for his proposal, the state Chamber, the primary voice of the business community, maintained its opposition to the reform package. During the late summer, the Chamber's California Restaurant Association allies floated an alternative proposal—an increased sales tax—to cover the uninsured. It drew some support in the business community as a broader source of funding coverage expansions, but it also spurred a privately harsh response from Republicans not used to the business community's support of tax increases. In any case, the proposal apparently polled poorly and was short-lived. Like others in the business community, the California Restaurant

Association only stiffened its opposition as negotiations between the governor and Democrats began to lean to more substantial employer requirements. Thus, while the dam of business opposition might have cracked, it hardly broke.

### **Insurers: Movement and Division**

For its part, the insurance industry remained divided over the reform package. Most significantly, Anthem Blue Cross, the state's largest insurer and the industry's largest contributor to state legislative campaigns, opposed the reform proposal. It based its opposition on restrictions—part of all the reform proposals—on insurer activities in the individual market, which it dominated.

Anthem Blue Cross argued that the proposed reforms would likely drive up costs in the individual market, especially for younger individuals. It would be wiser, Anthem Blue Cross asserted, to allow insurers, via underwriting, to keep premiums affordable in the individual market; costs of higher-risk individuals could be spread over larger populations in ways that would not drive up premiums in the sensitive individual market.

In some respects, Anthem Blue Cross put forth a credible argument, perhaps dismissed too quickly by reform proponents. As one insurance industry lobbyist commented, however, Blue Cross, with its clear stake in current rules, was probably not "the best messenger." More important, the argument simply did not fit the ethical, policy, or political frameworks of universal coverage.

Of all the opponents, Anthem Blue Cross proved the most aggressive. Others, perhaps in deference to relationships with the governor, tended to downplay their public opposition. In contrast, Anthem Blue Cross representatives pulled no punches in condemning core elements of the reform proposals and warning of grave adverse impacts should reform be enacted. It even funded a series of advertisements attacking the proposed reforms.



Kaiser and Blue Shield, on the other hand, continued to work cautiously for reform. Health Net, a for-profit insurer, joined them. Health Net CEO Jay Gellert had cultivated particularly close ties with the governor's administration. All may have seen more gain in increasing the number of insured than in risking an inevitably enhanced government regulatory role that would accompany coverage expansions and government commitments to finance subsidies. Most significant, all were less reliant than rival Anthem Blue Cross on underwriting practices and the offering of multiple benefit options that marked Anthem Blue Cross's market strategy, both of which might be threatened by reform.

The lynchpin for the supportive insurers remained the individual mandate. Without it, the guarantee-issue promise of reform would leave individuals free to move in and out of insurance, with painful impacts on insurers and premiums. The insurers' concerns complicated matters for the reform coalition, some of whose actual or potential members remained adamantly opposed to the individual mandate.

### **Physicians: From Support to Neutrality to Opposition**

Unfortunately for the reform cause, the success in gaining some insurer support was more than outweighed by the failure to maintain the support of the California Medical Association (CMA). It was hardly surprisingly that CMA quickly rejected the governor's proposed fee on physician revenues. To be sure, the governor's proposal would have returned to the physician community all the funds raised from that fee in the form of higher Medi-Cal payments. That description, however, masked the sizable matter of distribution. The fee, to be imposed on all physicians, would be returned only to the 20 percent of physicians accepting Medi-Cal. CMA was never likely to accept that proposition. According to one observer, the reception received by a gubernatorial representative when appealing to CMA leaders was anything but pleasant.

The composition of the CMA membership also was relevant. Primary care physicians had often supported reform, expecting that reform provisions and the need for cost containment would place increased emphasis on primary care. The state medical association, however, is dominated by specialists who would be more negatively affected by demands for lower costs. As interest group politics go, the state legislature was never likely to approve a physician fee over CMA opposition. Consequently, the physician fee was an early casualty in the governor's proposal.

Once the fee proposal disappeared and especially after it became clear that physicians would still receive the proposed increases in Medi-Cal payments, many expected the physicians to join the reform cause. They had supported reform before, and some physicians would benefit from enhanced Medi-Cal funding. In addition, perhaps 4 million more individuals would have insurance and thus greater capacity to pay.

For a while, CMA appeared likely to join the reform camp. In May, it participated in a broad coalition called Together for Healthcare Coalition with prominent senior citizen, labor, insurer, and business groups, including AARP, Blue Shield of California, the California Labor Federation, the California Teachers Association, Catholic Healthcare West, Health Net, Kaiser Permanente, Service Employees International Union (SEIU), and the Silicon Valley Leadership Group. The coalition launched a pro-reform advertising campaign that initially focused on the state's emergency room crisis.<sup>29</sup> As with other "strange bedfellow" coalitions, however, the group never got beyond agreement on very general principles. Hopes for policy or political breakthroughs never materialized and the coalition quietly disappeared.

As the reform effort progressed, CMA withdrew into neutrality and ultimately assumed an increasingly negative posture. It expressed growing concerns about reforms—transparency in costs, scope-of-

practice issues, and so forth—that many viewed as minor issues. According to at least one insider, CMA may have been concerned (with good reason) that proposals calling for increased government responsibility for cost control would inevitably mean reduced payments to physicians. Alternatively, CMA, in the words of one ex-legislator, may just have "retreated to [the] baseline of professional association politics; when in doubt, say no because too many members get hot."

In late summer and early fall, as the probability that reform would require public approval of a ballot measure grew, CMA concerns increased. Like most in the Capitol, CMA strategists doubted that a ballot measure would pass and feared that they would be pressed by the governor and Democratic leaders to lead the effort and allocate major resources to a certain and lopsided defeat. As CMA shifted from likely support to neutrality to opposition, the reform side lost one of its most powerful and publicly respected advocates. All of which prompted some in the reform camp to lament, "Where was Steve Thompson when we needed him?" As CMA's former chief lobbyist, Thompson was as well-known, liked, and respected as any Sacramento lobbyist. Over the past 10 years, he had cajoled, pushed, and guilt-tripped the organization into leadership on the universal coverage issue. But he had died in 2004 and, two years later, CMA Executive Director Jack Lewin left for a position in Washington, D.C. Lewin also had been a strong supporter of coverage expansions that dated back to his leadership role in Hawaii's approval of an employer mandate and near-universal coverage.

### **Hospitals: A Breakthrough and Less**

Like physicians, hospitals were skeptical about the governor's proposed revenue fee and about reform in general. Some hospitals would be losers. Those who received little in Medi-Cal payments would pay much more in fees than they would be paid for services. As for the larger picture, the reform proposals entailed high levels of uncertainty

and risk that suggest caution to major trade associations. The hospitals would stay on the sidelines for most of the year. The distributional effects of the governor's proposal, however, were different for the hospitals than for the physicians.

Under the governor's proposal, considerably more hospitals would be "winners" than "losers." Given the real chance for gain, in Medi-Cal payments and in payments for the uninsured, the risks of reform seemed less severe. Several of the state's leading systems, including Catholic Healthcare West and Kaiser (which, to be clear, would actually be a "loser") favored reform on its merits. Others saw gains, in good will and other policy questions, that might be achieved by reaching an agreement with the governor. The reform cause sorely needed a deal with the hospitals if were to have any chance of generating the revenues needed for reform. As hopes for reform faded in late summer, one knowledgeable staffer concluded, "Watch the hospitals. Success or failure may lie there."

In early September, after an intensive series of discussions, the hospitals and the governor reached an agreement. According to one hospital representative involved in the process, "It was as intense as any negotiation I have experienced in many years in this business." The hospitals agreed to accept a fee permanently capped at 4 percent, which would generate \$3.3 billion from a combination of hospital money and federal matching funds. The governor would guarantee that the collected funds would return to the hospitals through increased Medi-Cal payments and other arrangements.

The agreement injected a badly needed breath of optimism into the reform cause but also cemented a harsh reality that many had seen coming for some time; reform funding would hinge on a tax. Given solid Republican opposition to any tax, the only path to the \$3.3 billion was to seek voter approval via California's initiative process in November 2008.

## The Division of Labor

The most crucial problems for the reform coalition emerged from a quarter most likely to lend its whole-hearted support to coverage expansions—organized labor. To most in the labor camp, even the Democratic proposals fell far short of long-held goals. The governor's proposal, while offering some positive elements, was clearly unacceptable.

In his effort to move labor toward a new position, the speaker, normally a staunch labor ally, started from a weakened position. Important elements of labor remained extremely upset by the speaker's support of Indian gaming compacts, negotiated by the governor, that significantly limited labor's organizing rights. From most reports, the disappointment sometimes turned personal, resulting in persistent doubts as to whether labor could trust the speaker.

Labor's resistance to the proposals offered by Democratic leaders surprised many. For decades, the main energy behind the universal health care movement had been organized labor, which viewed universal coverage as a flagship cause. Those earlier proposals, however, were a different breed. The Clinton plan or California's 2003 reform package, for example, required employers to pay the lion's share of employee benefits. Thus, there was no conflict between labor's support for universal coverage and labor's need to deliver benefits and security to its own, usually well-insured, members.

Now California was looking at something different. The primary beneficiaries of the governor's proposal and, to a somewhat lesser extent, of the Democratic leadership's proposal were the low-income uninsured. The benefits to organized labor, to those who already enjoyed good benefits, were more intangible, creating a painful wedge between labor's longstanding support of the uninsured and its need to protect employer-paid benefits into the future. The hard reality was that the governor's proposal

provided little for those already well-insured and no guarantee that employers would be required to continue paying the large share of insurance costs into the future. In labor's worst-case scenario, the governor's 4 percent employer requirement would easily become more ceiling than floor or at least a tangible target to which employers' reduction in benefits could be pegged.

In addition, many in labor believed that, rather than generate shared responsibility, the governor's proposal would produce an unfair and unlevel playing field, benefiting those who do not bear their share of responsibility. Why, many wondered, should subsidies be delivered to employers (and their employees) who were not now paying to insure their employees while other employers (and their employees), often competing against the non-insuring employer, were paying their full share?

The governor's insistence on an individual mandate only exacerbated these fundamental divisions. Labor representatives understood the argument—soon to be played out in the health debate between presidential candidates Barack Obama and Hillary Clinton—that only if all have insurance coverage can insurers accept all individuals without rating them on their health status and experience. Labor could also accept a requirement for either individual participation in the form of a progressive tax imposed on all individuals or employees' partial payment of the premium for which their employer pays the predominant share. But as the centerpiece of reform, and when combined with only a modest employer requirement and no guarantee that the mandate would be affordable, the individual mandate appeared as a slippery slope moving from employer to individual responsibility.

The fight over the individual mandate was fierce. The governor appeared ideologically committed to the mandate and more reluctant to yield his position on this matter than on any other. On the other side, some in the labor and consumer communities

raised the bar of opposition just as high, rejecting entreaties of some reform supporters that some level of individual mandate was “a condition of getting a bill signed.” As one legislative insider reported, “Labor would not let Nuñez accept an individual mandate, and the governor would not drop it.”

Differences within labor and between labor and those supporting the reform proposals pitted friends against friends in the legislative staff and lobbying communities. Many supporting the governor or speaker expressed regret, frustration, and even anger that much of labor could not move beyond ideological opposition to an individual mandate, however modestly imposed. They feared that labor’s resistance would undermine the achievement of a long-sought goal.

### **Consumer Support and Lack Thereof**

Labor’s divisions had an additional side-effect. In the view of some reform supporters, labor’s doubts undercut the reform effort’s capacity to win support from a host of Democratic support groups that represented consumers and low-income and community-based constituencies. Some of these organizations preferred the single-payer approach and might have resisted the proposals before them under any circumstances. Other consumer and community organizations typically look to labor for policy guidance and legislative support, and might, therefore, have adopted labor’s concerns as their own. Many other organizations, however, given long standing ties to Democratic legislators and low-income constituencies, might normally have been expected to support the reform cause, but did not. Many observers believed that some of these organizations might have been reluctant to break with labor on an issue as crucial as health reform.

The community-based constituency’s primary concern was affordability. Despite the obvious potential benefits to low-income, uninsured individuals, most community groups saw the reform

proposals as highly flawed, particularly the combination of the individual mandate, modest subsidy levels, and no limits on individuals’ out-of-pocket costs. In their view, it would be exceedingly difficult politically to raise the employer requirement; as a result, the individual would bear the risk of rising costs and would potentially be required to purchase an unaffordable insurance policy. As the conflict on the affordability issue wore on, consumer leaders became increasingly frustrated with the governor’s ongoing reluctance to ease off on the mandate and offer consumers additional protections—in the form of greater subsidies or opt-out provisions—from potentially rising costs.

Consumer advocates had legitimate concerns on affordability, but so did the governor. Additional subsidies (to 350 or 400 percent FPL) would drive up the costs of the reform package and require additional funding that would, in turn, generate increased opposition. Just as importantly, the highly valued support of some insurers and their willingness to forgo charges to individuals based on health experience or status depended on full imposition of the individual mandate. If individuals could opt out of the mandate, insurers would again demand the right to base charges on health experience and status. Reform would then lose either one of its most appealing features or the support of insurers.

Many of those close to the consumer community and in support of the governor’s plan or the speaker’s proposal attempted to move consumer groups from the expression of concerns to support. They outlined the benefits as they saw them. They brought a leading Massachusetts consumer advocate to California to explain how he and others came to tolerate an individual mandate. They asserted that no legislature would force individuals to purchase a product that was not affordable and stressed that consumer advocates had to take some risks to achieve the larger goal. Many grew frustrated with consumer group resistance, as they had with labor’s resistance. In one individual’s words,

“This,” referring to the general thrust of the Nuñez and gubernatorial proposals, “is a truly progressive proposal with no progressive support.”

Whether it was loyalty of some to single payer, a need to stand together as a small community of advocates, or genuine opposition on the specific merits, the liberal-left consumer community, with the exception of the Latino Coalition for a Healthy California, remained in the “support if amended” camp for almost the entire year. Some stayed in that camp even longer.

### **Premature Demise of Reform**

A flurry of proposals—for sales tax options, alternative payroll tax schemes, and leasing of the state lottery—to help fund the reform proposal marked the end of the regular legislative session in September and the early part of a special session called by the governor in fall 2007. Almost all such proposals needed voter approval. None gained much traction nor did the governor make any headway in mid-October when he finally released a full 200-page reform proposal. It offered some concessions to Democratic support groups, largely in the form of a tax credit for families earning up to about \$60,000 on the portion of premiums that exceeded 5 percent of income, but it failed to satisfy labor and consumer groups’ demands for affordability or employer responsibility. “The year of healthcare reform has been a failure, and it has largely been a failure because of the governor,” asserted Art Pulaski, head of the powerful California Labor Federation.<sup>30</sup> In one widely reported event, labor leaders walked out “in anger” on a meeting in the governor’s conference room.

Once again, reform appeared to die, stifled by interest group differences too wide to resolve. On November 1, *Los Angeles Times* columnist George Skelton summed up the situation. “If this were football, it would be fourth down and long yardage with time running out, the fans pretty much resigned to losing,” but the “key players not giving up.”<sup>31</sup> Whether it was the governor’s unbounded

optimism, the speaker's memories of growing up uninsured, the political legacies perceived to be at stake, the hope that success in health care might salvage a victory on the upcoming vote on term limits, or the willingness to put off a realistic assessment of the likely outcome of a health reform ballot measure, neither Nuñez or the governor would accept defeat.

## Part Five: Compromise and Its Price

In early November, Speaker Nuñez announced an adjustment to his proposal that decreased the maximum employer contribution from 7.5 to 6.5 percent and reduced the requirements on small business to 4 percent (payrolls under \$250,000) and 2 percent (payrolls under \$100,000). He also accepted the individual mandate, but with subsidies for individuals and families that bested the governor's and with guarantees, similar to those offered in Massachusetts, that allow exemptions from the mandate for families paying more than 6.5 percent of family income for premiums. To assist in funding expanded subsidies, the speaker proposed a substantial \$2 increase in the state cigarette tax.<sup>32</sup> (See Table 4)

A few days after Nuñez adjusted his proposal, the governor's deputy legislative secretary sent out a memorandum outlining compromises that further reduced the differences. The governor expanded the employer mandate to cover all businesses but created a sliding scale that would allow smaller firms to pay less. The governor also increased the top employer requirement to 5.5 percent from its original 4 percent. The memorandum concluded with a significant adjustment to the tax credit proposed by the governor a few weeks earlier. "In the interest of achieving a compromise to fix our broken health care system, the Governor has modified his proposal to extend his proposed tax credit up to 400 percent of poverty."<sup>34</sup>

Finally, the end of November saw the largest single breakthrough in the reform debate. National Service Employees International Union (SEIU) President Andy Stern, upset with California union leaders on a variety of matters and wanting his union to be flexible in seeking national and state reforms, intervened to force a leadership change that reversed the union's reform stance. The most powerful union on health care matters had been the most potent force resisting the proposals on the table. Now, it became reform's most articulate and powerful supporter.

The change in SEIU's position did not move the state's other major labor player, the California Labor Federation, which continued to express concerns about mandates, affordability, cost control, and other matters. Still, SEIU broke the dam of opposition.

In mid-December, with SEIU in support, the governor and speaker reached an agreement that combined aspects of their proposals and extended insurance to 3.7 million individuals. The proposal set forth a maximum requirement on employers of 6.5 percent and

would require employers with payrolls up to \$250,000 to pay just 1 percent. The cigarette tax would increase between \$1.50 and \$2 (later set at \$1.75). Those with income under 250 percent FPL would receive subsidies; others with income up to 400 percent FPL would be eligible for tax credits if their premiums exceeded 5.5 percent of income. All financing, including the 4 percent tax on hospitals, the employer fee, and the cigarette tax increase, would go before voters on the November 2008 ballot.<sup>35</sup>

A few days later, on December 17, 2007, the full Assembly, on a party line vote of 46-31, approved the compromise proposal.

After the Assembly vote, the speaker and governor assembled their supporters in the Capitol rotunda for an emotional celebration. Steve Burd from Safeway was there. Andy Stern was there. Representatives from several other unions were there as well, along with leaders from AARP, the Children's Defense Fund, the San Diego Chamber of Commerce, and others. All lauded the success. If approved by a simple majority in the Senate and by the voters

### Intervention by SEIU President Andy Stern

Comments made and articles written by Andy Stern shed little light on what specific health reform policies the SEIU president favors.<sup>33</sup> Many suggested that Stern's views were less traditional than those expressed by AFL-CIO leaders who represented higher-paid workers and seemed more tied to employer-based insurance. Others emphasized that Stern's perspective is significantly influenced by SEIU's heavy involvement in the health care sector and the reality that an increased flow of funds into health care might benefit union members. Interestingly, SEIU representatives had strongly argued the case for affordability, which did not necessarily translate into lower costs but rather increased support for those who must purchase insurance. In contrast, California Labor Federation representatives remained far more concerned (many as purchasers of health care) with cost containment and lower costs.

Stern's flexible views on reform also led him to engage in and promote several efforts with employer, insurer, and consumer groups and others seeking common ground on health reform. It was that potential common ground and the need for progress rather than a specific proposal that seemed to motivate Stern's intervention. Whatever the reasons, Stern did not see the SEIU's California leadership as promoting the larger effort. Clearly, he preferred progress in California rather than stalemate or defeat laid at the doorstep of unions.



in November, the reform package would represent the largest step ever in the history of state coverage expansions for the non-poor and non-elderly population. Speaking last and most eloquently, Fresno’s Major Alan Autry (Republican) told the story of how lack of insurance kept his immigrant father from receiving care that might have saved his life. “It is not a political issue,” Autry concluded. “It’s not an economic issue. It’s a moral issue.”

It was the high point of the reform effort. Even many of the cynics in the crowd forgot about tobacco, the restaurant association, the Chamber, Anthem Blue Cross, the pending initiative fight, the looming budget deficit, and even the Senate. For a moment, at least, it was a time to believe.

The victory received widespread recognition. National commentator Ron Brownstein lauded California’s leaders for bringing together a coalition of diverse interests—such as business, labor, and insurance—in a way that national leaders had thus far failed to do. “This week,” Brownstein wrote in the *Los Angeles Times*, “all of those interests and many others finalized a breakthrough agreement that could not only ensure universal health coverage in the nation’s most populous state, but stamp the template for federal action that finally guarantees health insurance for all Americans.”<sup>36</sup> Brownstein’s comments, of course, would prove highly optimistic.

### The Price of Compromise

In many respects, the deal represented an extraordinary success for the governor and the speaker. Both had brought elements of key constituencies to a middle ground. Both had compromised, but both had also protected core values critical to them or their constituencies. Most important, the compromise—from both a political and policy perspective—came about as close to the “sweet spot” as could have been asked. Not only had the governor and speaker reached agreement on the major points of financing, but their staffs had, for the most part, successfully navigated the maze of policy complexity. Compromise, however, came at a great price, literally and figuratively. The increased financial protection for consumers raised

**Table 4: Movement to Compromise**

	Governor’s Original Position	Compromise	Nuñez Original Position
Individual mandate	Included, no opt-out provisions	Individual mandate with enhanced protection for low-middle-income families up to 400% of poverty. Hardship provisions if premiums exceed a specified percentage of income	No individual mandate; employees required to accept coverage if it does not exceed “reasonable” percentage of income
Employer requirements	4% on employers of 10 or more employees	Sliding scale (1 to 6.5%) for all employers, based on size of payroll	7.5% on employers except for very small firms
Medi-Cal and Healthy Families Expansions	Proposals varied here, but all sought to maximize federal dollars coming to California by extending Medi-Cal or Healthy Families eligibility to more children, parents, and childless adults and by seeking waivers where possible or necessary. Taxes or fees raised from physicians or hospitals would draw down additional federal matching funds.		
Subsidies, credits for consumers	Government subsidies up to 250% of poverty through purchasing pool	Those uninsured with income between 250 and 400% of poverty eligible for refundable tax credits through the purchasing pool	Subsidies for non-Medi-Cal eligible adults to 300% of FPL. No tax credits
Provider fees	4% fee on hospital revenues; 2% fee on physician revenues. Their Medi-Cal rates are increased to Medicare levels	4% tax on hospital revenues; Medi-Cal rates for hospitals and doctors increased to Medicare levels	No provider fees/taxes, no Medi-Cal increases
Vote requirements	Likely to require two-thirds vote in legislature	Majority vote in legislature, public approval on ballot	Majority vote in legislature



reform's price tag by about \$2 billion to over \$14 billion and required a new cigarette tax, triggering the opposition of tobacco industry. Moreover, the increased requirement on business would erode some large and small business support.

The delay in reaching a compromise also exacted a toll. The reform drive failed to beat the inevitable onset of a new state budget crisis. Just days before the Assembly vote, legislators learned that the impending 2008 budget gap had reached \$14 billion, a number that coincidentally equaled the projected cost of the health reform compromise.<sup>37</sup> Such numbers were fuel in the hands of opponents and provoked legitimate concern among moderate Senate Democrats, who still had to approve the measure. At a minimum, the numbers might offer some cover to those Democrats who might wish to oppose the reform package.

The delay in reaching agreement and the continuing absence of some labor and consumer support also limited the potential grassroots support for reform, which had always been, at best, diluted. Exhortations to support a vague definition of health reform simply do not pack the punch of calls to support a specific proposal with a specific number. Now, with little time before a critical Senate vote and the approach of the holiday season, any pressure would be modest in scope and impact.

Finally, there was the matter of the ballot initiative and needed voter approval of the reform package's revenue elements—an uphill fight. As in almost any initiative campaign, the opposition had the natural advantage. Proponents would have to persuade voters, whereas opponents—including major business interests, Anthem Blue Cross, and now tobacco—would only need to sow doubt. Noting the cost and complexity of the proposed package, one proponent jested that the options for attack would be so extensive that “for the Blue Cross PR guys, it will be like going to Disneyland.” Moreover, in an initiative fight, the opposition had a painfully large financial advantage. Overpowering the business

community in the legislative arena might be achievable, but overpowering business interests on a ballot measure, where finances are critical, was another matter.

### A Final Hurdle

The final hurdle was the Senate. Historically, relationships between Assembly and Senate leaders have often been cool. The traditional differences between the upper and lower houses frequently produce conflict, along with differences in leadership style, competition for the political spotlight, and competing policy preferences. From all accounts, however, the relationship between the two Democratic leaders during 2007 had grown especially sour, the result of matters large and small. Maneuvering around the past summer's budget crisis had stoked tensions, as had comments made by the speaker that he and the governor (not the three leaders) were close to a reform deal. Differences between the governor and Senate leader Perata over a water storage and conservation bond that Perata spearheaded as his primary legislative project may have further alienated the Senate leader. According to some, even political differences over whose political consultants would be responsible for what elements of the February term limits ballot measure had aggravated tensions.

Whatever the explanations, Senator Perata and his Democratic caucus had become increasingly disengaged from the health reform drive. In April 2007, Perata had seemed fully committed. “Shame on us,” he claimed, “if we cannot get something done this year.” He warned that the effort would be a “full contact sport” and urged senators to participate.<sup>38</sup> By fall, circumstances had changed. The Senate had not involved itself in the reform effort, Perata's support was questionable, and no one had confidence that the Senate would routinely ratify a compromise forged by the speaker and the governor.

Many knew all along that the real fight would take place in the Senate. The Democratic caucus included both single-payer supporters in favor of more reform and pro-business moderates in favor of less reform. The caucus knew that business

support was tenuous and that large elements of labor still opposed reform. Few could point to any senator, including Perata, who would assume leadership of the effort.

Those working the Senate counted the votes on the 11-member Health Committee, which consisted of 7 Democrats and 4 Republicans. Six votes from the committee's 7 Democrats would be needed for approval, and no one could count that many with any level of certainty. Chair Sheila Kuehl, the state's leading single-payer advocate and its strongest voice on health care matters, was certain to oppose the reform package. The reform cause could not lose any other Democratic vote.

As a sign of the coming challenge, and of the frayed relationships that had evolved, Senator Perata was absent from the Rotunda victory celebration. As the speaker and governor celebrated, Perata commented to a local television statement in Oakland that the Nuñez-authored bill was dead on arrival in the Senate. Most significantly, he requested Elizabeth Hill, the state's widely respected legislative analyst, to prepare a report on the proposal's financing. Circumstances did not bode well for success in the Senate.

## Part Six: Defeat

The curtain came down on health reform in two days of hearings before the Senate Health Committee in late January 2008, a year after the governor had first placed the issue at the top of the policymaking agenda and less than a month after the speaker and the governor had supporters thinking the unthinkable under the Capitol dome.

To this observer at least, all the pitfalls of past health reform failures and many of the broader explanations for why, in the United States, sweeping change ends up as incrementalism or nothing at all seemed to be laser-beamed into the hearing room: the economics of health care costs; the complexity of the issues; the uncertainty about reform's impacts on the state budget; the continued division among support groups; the advantages of those interests outlining the risks of potential pain over

those trying to promote the likelihood of gain; the absence of committed leaders; and even the reminder that personalities and personal relationships matter.

The tone was set early when Senator Perata opened the hearings with what was, at best, encouragement to explore the issues. He did not invoke anything close to a leadership demand for passage—something that most insiders believed was required. Budget analyst Elizabeth Hill then delivered a stark warning of higher-than-projected costs and budget shortfalls. If premiums in the purchasing pool turned out to be \$300 per month rather than \$250, the gap between program revenues and expenditures would reach \$1.5 billion by the fifth year of reform. Hill added that, while her \$300 figure might be off, she was confident that it erred on the low rather than the high side.<sup>39</sup> Given the challenges of estimating future premiums, the margin of error was not alarming. For legislators fearing chronic budget shortfalls or seeking a rationale for opposition, the numbers were enough.<sup>40</sup>

Supporters at the hearings were many: SEIU, Safeway, AARP, the Congress of California Seniors, the California Association of Physician Groups, Kaiser, Blue Shield, and others. Opponents included many traditional reform opponents—associations of large and small businesses, the restaurant association, insurance brokers, Anthem Blue Cross—and at least one prominent non-traditional opponent, the California Nurses Association, adamant to the end that anything short of a single-payer approach would be a step backward. The nurses' opposition, in particular, drew scorn from some supporters. Many believed that the nurses had “swallowed the single-payer pill” as much for organizing purposes as out of a genuine belief in the policy.

Even more telling was the list of groups not lending support at the hearings. The California Medical Association was still on the sidelines and bordering on opposition. The hospital association supported the reform package

only in name and, by all reports, was not aggressively lobbying for its passage. Much of the critically needed business support was absent (including the California Retailers Association and Small Business California, a casualty of changes in the level of employer requirement). Several community-based consumer and advocacy groups remained “concerned,” which at this point in the process, meant opposed. Again, the liberal groups from which Democratic-driven reforms derive energy were split.

Most important was the continuing division within the labor community. On issue after issue, SEIU representatives rose to express support while, with equal frequency and intensity, representatives of the California Labor Federation and its many member unions rose to express “concerns” about mandates, affordability, cost control, and other matters. One labor representative, among those most upset with the speaker's support of the California Indian gaming compacts, was particularly vigorous, almost disdainful, in opposing the reform package. The substance mattered, but less than the visible division. As one former legislator noted, the “anchor tenant in the Democratic mall is labor.” And the anchor tenant, in this case, was divided. In the intensive lobbying efforts leading up to the two days of hearings, Senate Democrats were under intense pressure from two sides that are usually one. One Senate staffer explained that his boss spent hours meeting with groups on the issue, but “everybody was split. One day we had a coalition of labor unions come in urging him to vote for it; a couple of hours later a bunch of unions came in and said vote no. If they had been unified, it would have been much easier for some to vote for it, and much harder for others to vote against it.”

Only one member, Darrell Steinberg of Sacramento, seemed to be seeking compromise. Proponents hoped that Steinberg might provide the needed leadership, as he had engaged in recent discussions with reform supporters. He was, however, also the most likely successor to Perata if the upcoming initiative to extend term limits failed. According to some, he

did not want to get too far in front of the caucus at this time, especially not for an apparently losing cause.

In terms of policy matters, many of the concerns expressed by opponents were legitimate. Those concerns focused on the “follow the money” issues of who would pay and what would be the long-term economic impacts on stakeholders. Fears that gaps in financing would fall on the state were legitimate. So, too, was the fear that requirements imposed today might be expanded in the future, especially as costs continued to increase. The guarantees and assurances wanted by some were—given economics and the rights of future legislatures—out of the question.

Process seemed to matter, too. As noted, the reform effort had been a leadership-driven exercise in which few legislators participated. According to many reports, legislators who may have wished to play visible and supporting roles found themselves with only limited opportunities to do so. Democratic-dominated committees rubber-stamped reform bills, knowing that they were forerunners of compromises that leadership would eventually negotiate with the governor. In the Assembly, the speaker kept a group of members informed and somewhat involved at least in the early going, although even then the “inform” element was probably the larger part of any communication. In the Senate, members were even less involved in the process, especially after Senator Perata ceded leadership on the issue to Speaker Nuñez.

In addition, as described earlier, a small group of key staff dominated the policy-vetting and policymaking process, and at least some believed that they sometimes did so in a manner that was too controlling and, at times, disrespectful. According to one long-time advocate, “Never before in all my experience have I seen a process more staff-driven. Members know nothing. They are in no meetings. I once asked a participant in many of those innumerable meetings if there was ever a Member in the room. ‘Never’ was the answer.”

To some, the staff-driven process was par for the course, at least on major issues, and perhaps indicated how California's rigid term limits prevent legislators from developing the expertise, power, confidence, or freedom from next-step political calculations to emerge as policy leaders. But, to others, the absence of member involvement in general is a major liability. Members—not staffers—must close deals, broaden coalitions, and increase the overall leverage necessary to achieve difficult majorities. The risk of greater transparency and of interest groups pulling big ideas apart piece by piece has to be accepted. In the end, this view asserts coalitions of committed

lieutenants are more capable of achieving major successes than one powerful general.

In the Senate Health Committee hearings, the legislative process and absence of public vetting became the subject of opposition. Legislative opponents, leaning in part on the legislative analyst's doubts, questioned whether the proposal had been thoroughly vetted. Perhaps some were just seeking another justification for opposition, but the Senate was clearly unprepared to wrestle with the magnitude of the policy change before it. Members had little familiarity with the proposal, and there were no leaders or committed members to champion it.

## The Final Vote

At the request of Senator Perata, the Senate Health Committee postponed its vote for a few days. Lobbying was intense and focused on the full Senate. But there was no more support there than in the committee. In the end, Perata asked his members to vote no or abstain. When the committee met to vote the following week, Speaker Nuñez quickly recognized the inevitable and conceded defeat. As expected, the four Republicans voted no. Three Democrats, including Kuehl, voted no. Three others, including Steinberg, abstained. Only Mark Ridley-Thomas of Los Angeles voted aye.

**Table 5: The Final Stakeholder Line-up (Partial List)**

(As Listed by Senate Health Committee, January 23, 2008)

(Comments are from the author.)

Support	Comments	Opposition	Comments
AARP (if amended)	Many key support groups continued to lobby for specific changes, reducing the strength of the reform cause	Assn of CA Life and Health Insurance Companies	Does not include state's major managed care plans
American Federation of State, County and Municipal Employees		Blue Cross of CA	
Blue Shield		CA Chamber of Commerce	
CA Assn of Physician Groups	Represents 1000's of MDs, but without the clout of medical assn	CA Assn of Health Plans	Major insurer trade association: major members on both sides
CA Assn of Public Hospitals and Health Systems		CA Business Roundtable	
CA Conference of Carpenters		CA Conference of Machinists	
CA Hospital Assn	Not actively in support	CA Manufacturing and Technology Assn	
CA Labor Federation (if amended)	In fact, actively opposing final compromise	CA Nurses Assn	
Consumers Union (with amendments)		CA Retailer Assn	Had supported earlier version
Health Access (with amendments)		CA Restaurant Assn	
Kaiser Permanente (if amended)		CA Teamsters Public Affairs Council	Their lobbyist was most aggressive labor opponent
Latino Coalition for a Healthy California		Foundation for Taxpayer and Consumer Rights	Wanted much more regulation of insurers
SEIU (with amendments)	Actively lobbying for passage	National Federation of Independent Business	
Western Center on Law and Poverty (if amended)		United Food and Commercial Workers Union	

Running for supervisor in Los Angeles County, Ridley-Thomas felt that, despite the risks, the legislature should capitalize on the opportunity at hand. No doubt, he also felt strongly that his new constituency—and probably his current one as well—would not take kindly to a no vote.

In the immediate aftermath of the hearings and in attempts to understand the absence of Senate support, many in the reform camp blamed Senator Perata. They believed that if he had made health reform a test of leadership, as Speaker Nuñez had in the Assembly, the outcome might have been different. But he did not.

The explanations varied for Perata's failure to lead on the reform proposal. Some pointed to Perata's testy relationships with the speaker and the governor. Many viewed him as "disengaged" or not invested in the issue. If he was not going to lead on a defining issue, why had he not ceded the matter to a committed lieutenant? Those sympathetic to Perata's circumstances argued that the votes were just not there or that Perata was wise to pull the plug on a flawed policy and a rush to judgment driven by the political needs of the speaker and the governor. The *Los Angeles Times's* George Skelton summed up that point of view. While strongly supporting the goals of reform, Skelton praised the Senate for pulling "the plug on [a] seriously ill universal coverage proposal." The "veteran Senator," Skelton wrote, "paused, took a deep breath and buried the bill."<sup>41</sup>

## Part Seven: One and Many Words for Failure

In the aftermath of defeat, reform supporters and observers had a multitude of explanations for the outcome. All knew that there was no one cause of defeat, but most were quick to pin blame on various participants in the reform debate. Most summed up their response in a word or two.

"Labor," said one, emphasizing that the lack of unanimity among various labor groups and the absence of full-court pressure from labor were the central weaknesses on the reform side.

"Tobacco," said another, noting tobacco's opposition to the proposed increase in the tobacco tax and the realities of tobacco money in an initiative campaign.

"Republicans," said another, stating an obvious starting point. "Before we blame everyone else, we need to remember that they were the number one problem."

"Kuehl," suggested another, highlighting the division between those who wanted the most they could get and those seeing compromise as too little.

"Fourteen billion," said another, emphasizing that the ultimate cost of reform proved to be too much.

"(Nuñez) should not have accepted those Indian gaming compacts," concluded another, focusing on a sore point that seemed to symbolize a larger breakdown.

"Perata," said several, offering a variety of reasons.

"Organizational ego," said another, emphasizing the breakdown among the Democratic leaders and between the Assembly and Senate.

Interestingly, no one pointed to the actual or potential role of the public, perhaps because the public had little to do with the reform effort. Except for a few interest group-inspired, packed hearing rooms and a few rallies at the Capitol and elsewhere, public pressure was barely visible. In all likelihood, not one member—Republican or Democrat—would be punished or even electorally impacted by his or her vote on the issue. Commenting on this circumstance in the national rather than state context, one

### Why Not Some Incremental Change?

#### How Could California Have Come Away with No Reform at All?

##### A Reflection from the Author

Early in the California health reform process, one staff insider asked me, "Given your Clinton experience, what advice would you give us?" I recounted a story. In an early strategy meeting, President Clinton gave the reform team two directives. "First," he said, "tell me what you think is the best thing we can do in health reform. Second, tell me what is the smallest thing we could do that would have real value?" The president, in effect, wanted a Plan B. He never received it. Many options were proposed, but, for one reason or another, they were rejected, and reform came away empty handed.

I responded to the staff insider as follows: "Think big, of course, but think small as well. Make sure you come away with something."

The most obvious Plan B in 2007 was coverage of all children. Surely, reformers could have achieved that. But, as with the Clinton effort, California's failure was total, perhaps suggesting that seeking dramatic, comprehensive change may mean giving up the option of achieving small change. In terms of political considerations, leaders who advocate for big change for months may have difficulty stepping back. In terms of policy considerations, if modest, less complex, less risky options are on the table, too many may prefer the modest alternative. Leaders, in short, may be able to push for big change only when incrementalism is off the table.



Washington, D.C.-based observer argued that reform will rarely generate enough votes on the merits. “Some votes,” he said, “will come only with a fear of electoral defeat.”

### **Systemic Factors, Policy, Interests, and Leadership**

The reasons for failure of the reform package largely parallel the four features discussed earlier.

#### **The Impact of Systemic Factors**

One systemic factor that clearly worked in California’s favor was the availability of more than \$5 billion in federal funding. Without that funding, no serious reform was possible. Other systemic factors, however, exacted damage. ERISA was a continual challenge for policymakers by limiting and compounding options and promising an almost inevitable lawsuit if reform became law.

Even more important, although less visible on the surface, were the impacts of 7 to 10 years of rising health care costs. The ultimate political and economic challenge to the reform effort lay in discovering a politically feasible path to funding coverage expansions. The increases of past years rendered that challenge far greater than it would have been just a few years earlier. Especially amid growing economic uncertainty, the funding challenge proved too great.

Finally, California’s two-thirds vote requirement on new revenues posed a major hurdle that sometimes went overlooked. With Republican votes written off early in the process, it was the absence of Democratic, not Republican votes, that appeared to spell defeat.

If, however, the reform package had faced merely a majority-vote hurdle, it is easy to envision an entirely different scenario, especially for interest groups. Victory, in the form of compromise between the governor and Democrats, would have appeared likely. Many interest groups would have found themselves reducing their expectations and thinking less about opposition and more

about accommodation. They would have used their leverage to secure tolerable outcomes on reform elements that were most critical to them, and accepted elements of reform that they might have otherwise opposed. At a minimum, even if the needed two-thirds vote did not affect the substance of reform’s outcome, it forced proponents into a highly problematic initiative strategy.

#### **Policy Matters**

As discussed, the central policy challenges surrounding the reform proposal involved the funding of reform and the crafting of acceptable bottom-line impacts on major stakeholders. In the end, these challenges went unmet. From a pure policy perspective, though, California policymakers achieved a laudable outcome. Both in its wealth of detail addressing several policy conundrums and its capacity to address the larger follow-the-money questions, the California compromise may provide a model for other states and the nation. In the end, leaders came as close to an acceptable shared-responsibility compromise as might have been imagined under the circumstances. They demonstrated policy creativity in both big-picture matters and detail—sliding-scale responsibility, subsidy mechanisms, and means of funding a pool. The ultimate policy agreement came too late, however, and could not garner the necessary support, but it is unlikely that any other set of policies could have fared much better.

The chance for success, to be sure, would have been enhanced if the ultimate policy outcome had been less complicated and embodied less risk for pivotal stakeholders. In the real world of policymaking, however, comprehensive reform does not come without complication and risk. Speaker Nuñez, wrapping several of these explanations together, suggested months after the defeat that reform died largely because of a “fear of change, and so many moving parts.” He seemed to point to two distinguishable factors, but, unquestionably, the latter was fuel for the former.<sup>42</sup> For this reason, it might have been easier and prudent for the leadership to lay

out a path to universal coverage and take the first steps—such as children’s coverage—down that path. But the drive for comprehensiveness is understandable and may seem necessary to solve the problem at hand. For those with a sense of history, the temptation to seize apparent opportunity to achieve something comprehensive is often difficult to resist.

#### **The Role and Impact of the Interests**

The likely strength of the opposition was never in doubt. What turned out to be striking in the California experience was the weakness of support. As difficult as it was for leaders to reach agreement, it was still harder to bring their constituencies with them. In the end, reform failed more because of the weakness of its support than because of the strength of the opposition.

Labor’s lack of unanimity, CMA’s lack of support, the late and ambivalent support from the hospital association, the continued opposition from those favoring single-payer approaches, the reluctance of consumer groups to accept less, and the reticence of safety net support groups all left the reform effort with limited political fuel. The lack of that fuel, in turn, limited the level of public or community-based demand that might have been generated.

Among opponents, the reform cause made real inroads with insurers and appeared to make modest gains with employers. But business support proved limited and legislatively quiet, much of it dissipating as the employer requirement became stiffer.

#### **Matters of Leadership**

Conceivably, effective leadership might have overcome the many obstacles to reform. Of the four features discussed throughout this paper, leadership is clearly the most intangible and most variable, but it is a short-term force up against, in this case, longer-term and more ingrained forces. Neither the governor nor the speaker can be faulted for effort. They both fueled the reform cause, which would have died countless times without their efforts to keep it alive. Both also scored some success in



bringing their constituencies to, or close to, a final and respectable compromise.

The same, of course, cannot be said of Senator Perata. Whatever the wisdom or lack of it in his final decision, there is little justification for his limited efforts to further a cause that had been critical to his party. Here, though, the speaker and governor shared some blame as well. It was probably never reasonable to assume that the Senate would simply ratify an Assembly proposal of the magnitude of the reform package, at least not without Senate leadership. That the Senate was allowed to disengage to the extent it did and that leadership differences over non-health care matters created such an apparent rift was the fault of all.

The absence of legislative lieutenants, especially in the Senate, may also have undercut the reform package's chances for success, along with the absence of serious legislative vetting. Other than the speaker and the governor, few saw much political gain—public standing, state or national recognition, improved support from stakeholder groups, media exposure, and so forth—from assuming leadership in the reform effort.

Finally, there was the governor's leadership, which in many respects was impressive. Throughout the effort, the governor appeared determined and committed. He brought a highly talented and politically respected team of policy specialists and administration leaders to the cause. Many, even those unimpressed with his proposal, were impressed with his skills in various forums—small group and large group, public and private. He even achieved some breakthroughs in the business community and with the hospitals. Most important, he produced a credible, middle-ground proposal that asked something of everyone.

In other respects, the governor's performance and decision-making were uneven. Above all, he could not deliver—and then seemed to be the last to realize that he could not deliver—the necessary

handful of Republican votes. ("I could have gotten more Republican votes," mocked one labor lobbyist.) The governor's failure, many suggested, lay in the largely burned bridges of his relationship with his party. He had achieved national recognition for his "post-partisan" successes. In the process, however, he largely abandoned his party's policy vision and political needs. He did little to parlay his sizable popularity and impending 2006 landslide reelection victory into support for Republican candidates.

Some lamented that a modest helping hand from the governor in 2006 might have produced considerable value in 2007. Even if most Republicans, almost all of whom were in safe political seats, did not need the governor's help in 2006, those looking ahead to statewide races in 2010 would certainly need it. They were familiar with the long odds against hard-line conservative Republicans winning statewide office in California. Yet, the governor offered no support. In the view of many, that lack of support resulted in an absence of indebted Republican allies and increased Republican intransigence (some defined it as punishment) on health policy and, even more so, on the 2007 budget.

His failure to win any Republican support and then his failure to accept the reality of no such support caused considerable delay in the negotiation process. Apparently the governor was skittish about bargaining directly with Democrats. As he clung too long to the strategy of bringing all together to a point of compromise, he lost precious time as other strategic options evaporated. Earlier recognition that the parties to the final compromise would be the governor and the Democrats might have led to an earlier resolution of differences and a stronger support coalition. It might also have avoided the rush to judgment that accompanied the final product.

In the end, the governor seems to have operated with a combination of energy, vision, optimism, tenacity, and flexibility, some of which brought the seeds of inevitable liabilities. His optimism and tenacity kept the effort alive but may also have created an exaggerated confidence that he could persuade key players—Republicans, various stakeholders, and, ultimately, the public—when he could not. It may also, by some accounts, have rendered him more immune to the political pressures exerted by labor and consumer

## Perils of the Middle Ground

The absence of support suggests an unfortunate paradox. Middle-ground or compromise strategies may be required, but they are not the strategies that tend to generate political energy. The middle is moderate; it neither mobilizes nor energizes. It may generate broad support, but the support is not deep, and support that is not deep is not likely to stand up to significant differences in needs and goals.

Moreover, middle-ground strategies often fail to find a middle ground, a "sweet spot" on which all can safely land. Noted one Republican staffer, "It is true that the governor is in the middle. He thinks that all will suffer some pain, and he sees that as sound compromise. But it is shared gain that gets votes, not shared pain." The middle ground, in this case, had too much pain for too many.

From the outset, the governor was the only policymaker standing on middle ground. In a highly partisan-charged legislative environment, the governor's proposal earned the respect and praise of many but generated the support of no one. The governor was, in fact, as *Sacramento Bee* columnist Dan Weintraub described him, a "Party of One."<sup>43</sup>

groups on the question of affordability. “I could not believe,” said one consumer advocate, “that he did not recognize that, politically, at least, he had to compromise on the affordability question.”

At the same time, the governor’s unpredictable combination of flexibility and firmness left many wondering about what was and was not critical to him, perhaps leading some to think that they could move him further than he would likely move. As one pro-reform lobbyist remarked, “He’d sign a shoe if they sent that over.” In the end, flexibility enabled the governor to reach critical compromises, but it also reduced his, or his staff’s, capacity to lay down a bottom line and close a deal.

Despite all the leadership pitfalls in advancing the reform package, it is unwise and inaccurate to conclude that leadership was the problem. The fact remains that the state’s two most powerful political figures led the reform effort. Both had enormous political incentives to succeed, and both mounted enormous efforts to do so, expending considerable political capital along the way. Both achieved significant success and progress at various points but still came up short of the goal. Many may believe that more appropriate gubernatorial strategic choices might have increased the chances of reform’s passage, but it is more likely that, without the governor’s extraordinary effort, there would have been no chance for passage at all.

### No One Right Answer

In the end, there was no one reason the effort failed; there was no one event, strategy, or positioning that, had it been different, might have led to success. As one Senate staffer close to the process concluded, “All these things were part of the thread that made up the rope to hang the thing.”

Indeed, an effort to highlight one or two causes of defeat—even if accurate—might render a disservice to the larger point; briefly put, the obstacles were major

and many. It is equally true that no one factor that contributed to defeat had the capacity by itself to lead to defeat. Any of them—perhaps many of them—might have been overcome if other factors fell into place. In American politics, major change is rare and occurs only when the many relevant and critical forces are uniquely aligned and leaders play the political game with enormous skill. The margin of error is always small. For better or worse, incrementalism or something less than incrementalism is the most likely outcome.

## Part Eight: Core Lessons, Hard Realities, and Next Steps

In 2006, Massachusetts sent a clear message: States can indeed undertake health reform. California’s message may be just as clear but far more painful: Massachusetts and a few other states may be the exceptions. The numbers are stark. Only 9.8 percent of the Massachusetts population was uninsured in 2005–2006 compared to 18.8 percent in California and 15.9 percent in the nation.<sup>44</sup> Just 6.1 percent of the Massachusetts population was both uninsured and earned family income under 250 percent of poverty as opposed to 13.5 percent in California and 11.6 percent in the nation, indicating that a significantly larger percentage of California’s population would need financial assistance in the purchase of insurance.<sup>45</sup>

Most important, Massachusetts faced serious consequences if it did not reform health care financing; it might have lost upward of \$1.2 billion in federal funds. Many report that, without the threatened loss of federal funds, it is likely that the Massachusetts reform effort would have failed.<sup>46</sup> Compared to Massachusetts, then, most states, including California, face a far more difficult reform environment.

### The Hard Politics and Economics of Reform

The reform environment is characterized by steep revenue challenges and the resistance of all parties—employers, government, and perhaps providers, to name some—to shoulder too much shared responsibility or bear too much future risk. Even if funding is available, fears of what will happen in leaner times and uncertainty about the impacts of comprehensive reform dominate the political debate.

The limited evidence of success in reducing the rate of growth in health care costs compounds reform’s financial challenge and fosters a climate of uncertainty. The states and the nation may face a painful paradox: It may be impossible to achieve coverage expansions *without* cost containment, but, given political resistance to cost control, it may be equally impossible to achieve reform *with* cost containment. Similarly, while reform success would seem to require lower costs, the demands of key stakeholders—for adequate payment (providers), substantial subsidies and benefits (labor and consumers), and adequate profit margins (insurers)—suggest that the easiest path to reform is to expand rather than shrink the health care pie. Why, in the end, should health reform compromise differ from compromise in other policy arenas?

Public concern and demand might overcome these hard realities. Given the inherent advantages of the opposition, however, the breadth of concern would need to extend well beyond the currently uninsured to those now well-insured and satisfied with their insurance. Still, the mobilization of major public demand around state legislative targets remains difficult, and, as noted earlier, public concern may not indicate a public willingness to accept the costs of reform.

From a policy perspective, despite some calls for sweeping reform, most reform voices—in California and elsewhere—seem to have converged on some variant of the

play-or-pay model that involves a pool and some degree of insurance reform. The individual mandate remains a serious point of contention, but that contention might recede if the mandate is proposed with adequate subsidy protection (as in Massachusetts or the final California compromise) and less ideological fervor than in California. The policy lesson of California, then, may be relevant for others. It may be less difficult for leaders to craft a policy compromise than to bring their constituencies to that compromise.

### What to Do?

The California experience prompts several suggestions for future reform efforts—state and federal. We offer them here as options for consideration and under the assumption that both state and national reform advocates will probably not have the strategic option of simply overpowering the opposition. Reform, we presume, will have to win somewhere near the middle. Even when supportive Democratic majorities appear secure, they will not be willing or able to ignore too many interests to too great an extent.

First and most obvious, if reform is to be left to the states, the federal government must ease the restrictions imposed by ERISA. At a minimum, states need some safe harbors.<sup>47</sup> The middle-ground solutions that states will find most palatable will involve employer requirements of some type; confusion over what is acceptable will complicate the task of finding that middle ground.

Second, reform efforts need time. The technical work itself—modeling, sorting out details of exchanges or pools, enforcement practices, tax policy, market reforms, and so forth—consumes an enormous amount of time, as does interest group ground work—the process of seeking input from, meeting with, and analyzing the wants, needs, and tipping points of various interests. Reform, then, might be at least a two-year process, with the first year devoted to laying the ground work and preparing the policy

options and the second year dedicated to political efforts to forge a winning coalition of policy, votes, and interests.<sup>48</sup>

Third, reform advocates need to solidify their natural base of reform. Their efforts must start with organized labor and extend to consumer and community-based groups, many of which may still find near-middle-ground approaches unacceptable. There are a number of strategies that might be employed to address this challenge, but at least two stand out. First, supportive legislators with strong relationships with organized labor and consumer and community-based groups must be brought into the debate early and

must be committed to success and the accommodations it may require. Second, policy options that might appeal to these groups—large pools or some form of public competitor to private insurance—might be incorporated into reform packages and presented as options that could be expanded if they prove successful.

Building such options into reform packages may be critical for other reasons as well. Today, many policy analysts acknowledge the weaknesses of our employer-based system, but few see any other politically viable approach to major coverage expansions. Federal or state options, therefore, that allow alternatives without

## Seven Challenges for Reform

1. Most political advisors would say “keep it simple,” but comprehensive health reform and simplicity do not go together. Health reform “is rocket science.”
2. It may be impossible to achieve coverage expansions without cost containment, but, given major interests’ political resistance to cost control, it may be equally impossible to achieve reform with cost containment.
3. The reform cause needs to reduce the subsidy and other government costs of coverage expansions, but the easiest road to broader support among many stakeholders is to have government spend more, not less.
4. Policy analysts routinely note that significant reductions in cost growth require “delivery system change,” but most agree that achieving such change will be among the most difficult of cost containment challenges.
5. Comprehensive reform takes time, but legislative attention spans and calendars, election cycles, the demands of other issues, the capacity to keep the public involved, and other factors limit the window of opportunity.
6. Reform seems most likely to be achieved near the political middle, but the middle ground lacks energy and often loses the support of the most committed and energetic.
7. The public wants the system changed, but most individuals prefer the health care delivery system in which they currently participate. It is difficult to promise security while simultaneously demanding major systemic change.

directly threatening the premature erosion of employer-sponsored benefits may offer long-term benefit.

Fourth, the reform coalition needs to broaden its base by drawing more support from providers (hospitals and physicians) and at least some insurers. Unfortunately, the potential means of securing such support—higher Medicaid payments, avoidance of aggressive cost control, the promise of increased numbers of paying patients without expectations of reduced payments, a guarantee that safety net providers will not lose public funding as demand for services declines—will be costly. Still, without some support from the provider community, the coalition for reform will remain limited.

One solution for the short term is to accept, as Massachusetts did, higher costs as the price of reform, deferring hard decisions and setting in place processes to address cost reduction. Another option for securing provider support is to seek it from (and then enhance the visibility of) physician and hospital organizations that are prepared to disassociate themselves from the larger, lowest-common-denominator-oriented trade associations. Large medical groups, associations of primary care physicians, some hospital systems, and so forth may currently lack the clout of the larger associations, but they can still participate effectively in the reform process and earn recognition for and demonstrate evidence of broad stakeholder support. The same logic applies to the business community.

Fifth, major policy efforts should explore the means of easing the uncertainty of those facing significant and potentially negative economic impacts of coverage expansions. Reform can unfold in a series of incremental stages by instituting various sunset-type approaches; imposing caps on requirements for employers, individuals, and even government; and mandating serious

reviews of various reform elements. A number of such mechanisms were built into the California reform, but too late in the process and without adequate clarity as to what they meant or how they might be applied. While such guarantees may not produce widespread, new support, they may at least reduce the intensity of the opposition.

Sixth, success may require at least the hope of some modest cost containment. Attempts to impose guaranteed cost reductions might doom any effort, but pro-reform policymakers need to provide evidence that they recognize the need for eventual progress in stemming cost increases. Initiatives might include major commitments to study improvements in chronic care management; the appointment of credible, high-status commissions on keeping health care affordable; investments in technologies that may enable delivery systems to operate at lower cost; and, higher-visibility commitments to effective prevention strategies and improved public health. These and other initiatives may all provide value in terms of both real gain and longer-term, realistic public understanding of high costs and their causes.

Seventh, policy leadership should consider the value of building a legislative support team, early on, that sees policy and political value in success and is firmly committed to reform. Ideally, the team should be in place at the outset of the reform effort. It should participate in ongoing discussions with stakeholder groups and, it is hoped, bring those constituencies to final agreement. The political risk in this strategy, as many feared might be the case in California, is that too much transparency and too many legislative lieutenants will render final deal-making more difficult. The best strategy will likely vary with each state's political and legislative culture.

Eighth, reform advocates must continue to consider less-than-comprehensive solutions and sometimes incremental options. Comprehensive approaches, while seemingly logical and perhaps necessary for obtaining full buy-in from some stakeholders, can also generate more opposition than is manageable. Incremental success may be all that is achievable; it can even be structured as first steps in a longer process. Comprehensive reform efforts may be undermined by the visibility of more modest options, but proponents will still want them available.

Finally, given current state budget shortfalls and the results of the November 2008 election, it should be obvious that the potential for overall progress is infinitely greater at the federal level than at the state level. The California experience and the experience of other states suggest that |state-based strategies to achieve national universal or near-universal coverage probably will not succeed. Some states might get close; most will not.

National leadership and visibility may also be required in the quest to limit the rate of growth in health care costs and to make the investments needed to address technology and infrastructure opportunities and challenges. Whether the need is for coverage dollars or for these kinds of investments, the starting point for state reform will be federal dollars.<sup>49</sup>

A federally-focused reform strategy may cloud, but need not undermine state-based reforms. Federal reform will, almost inevitably, entail considerable state flexibility. Leading national reform proposals do not impose a new national insurance or delivery system model; all build on the current state-based, state-regulated insurance system. Federal reform will likely support and energize rather than replace state reform. Even for those long-attached to state reform, a near-term focus of reform energy on the federal arena is the obvious strategic choice.



## Endnotes

- 1 See, for example, *Californians and Their Government*, Public Policy Institute of California, March 2007, San Francisco, California. Over 70 percent favored a proposal similar to that put forward by the governor in which employers, individuals, and government would share costs.
- 2 National Conference of State Legislatures, Table 6-2, "Vote Required to Pass the Budget," [www.ncsl.org/programs/fiscal/lbptabls/lbpc6t2.htm](http://www.ncsl.org/programs/fiscal/lbptabls/lbpc6t2.htm).
- 3 National Conference of State Legislatures, "Which States Require a Supermajority Vote to Raise Taxes?" [www.ncsl.org/programs/fiscal/suprmajr.htm](http://www.ncsl.org/programs/fiscal/suprmajr.htm).
- 4 *Orange County Registrar*, editorial, "A Tax by Any Other Name," April 10, 2007.
- 5 *California Health Benefits Survey*, California Health Care Foundation, and Center for Studying Health System Change, November 2006.
- 6 For a detailed analysis of ERISA and its relationship to state reform efforts, see Butler, P. A., "ERISA Implications for State Health Care Access Initiatives," prepared for State Coverage Initiatives and the National Academy for State Health Policy, November 2006.
- 7 Zelman, W. A. Politics of Health Reform in Five States, presentation to AcademyHealth Annual Research Meeting, Washington, DC, June 2008.
- 8 Interview with Kenneth Thorpe, April 18, 2008.
- 9 See, for example, *The Field Poll*, Field Research Corporation, January 3, 2007.
- 10 "Health in America Survey," ABC News/Kaiser Family Foundation/*USA Today*, September 7–12, 2006.
- 11 Ibid.
- 12 Klein, E.. comments at public forum, California Endowment, June 19, 2008.
- 13 Individuals interviewed in the course of research were promised that names of sources would not be used without permission. In the end, the author determined that the wisest course was to use no names of sources. Listing some (even with permission) might make it easy to identify those who did not want to be identified. Names are used when comments were made in public or are part of a public record.
- 14 See discussion in Skocpol, T., and Keenan, P. S. "Cross Pressures: The Contemporary Politics of Health Reform," in Mechanic, D., Rogut, L. B., Colby, D. C., and Knickman, J. R., editors., *Policy Challenges in Modern Health Care*, Rutgers University Press, New Brunswick, 2006: 26-36.
- 15 Kahn, C., president of the Federation of American Hospitals, April 25, 2008.
- 16 The author worked for Common Cause from 1978 to 1990. This analogy was commonly used in Common Cause materials that are no longer available.
- 17 Halvorson, G., et al. "A Proposal to Cover the Uninsured in California," December 12, 2006, *Health Affairs* Web Exclusive, December 12, 2006.
- 18 Gruber, J. "Modeling Health Reform in California," presentation in State Capitol, May 16, 2007. The figure 6.5 million uninsured is more commonly used in California but refers to the number of uninsured at any time over the past year. For the purpose of projecting costs, 4.9 million, the number of uninsured at any point, is the appropriate figure to use and was used by project estimators.
- 19 Office of the Governor, "Governor's Health Care Proposal," January 2007.
- 20 Harbage, P., and Nichols, L. "A Premium Price: The Hidden Costs All Californians Pay in Our Fragmented Health Care System," New America Foundation, December 2006.
- 21 Gruber, J. "Modeling Health Reform in California," presentation in State Capitol, May 16, 2007.
- 22 Rau, J. "Gov Offers Bold Prescription," *Los Angeles Times*, January 9, 2007.
- 23 Ibid.
- 24 Rau, J. "Senate GOP Leaders Offer a Health Plan," *Los Angeles Times*, January 31, 2007.
- 25 Schultz, E.J. "GOP Unveils Health-care Proposals," *Fresno Bee*, March 15, 2007.
- 26 Percentage varies considerably with the nature of payroll and the benefits offered by an employer.
- 27 Carl Giordino, CEO of the Silicon Valley Leadership Group, from group statement, May 24, 2007.
- 28 Coalition to Advance Healthcare Reform, press release, July 11, 2007.
- 29 Together for Health Care, press release and press conference, May 31, 2007.
- 30 Rau, J. "Unions Give Up on Gov's Health Plan," *Los Angeles Times*, October 16, 2007.
- 31 Skelton, G. "Time Running Out for Deals on Health, Water," *Los Angeles Times*, November 1, 2007.
- 32 Rau, J. "Democrats Propose New Health Plan," *Los Angeles Times*, November 6, 2007.
- 33 See, for example, Stern, A., "An American Partnership for Universal Coverage," *Health Affairs*, Vol. 27, No.3, 2008, pp. 686-7.
- 34 November 9, 2007 email from Herb Schultz attaching memorandum signed by Ana Matosantos.
- 35 Rau, J. "Gov., Nunez, Forge a Health Plan," *Los Angeles Times*, December 15, 2007.
- 36 Brownstein, R. "The California Compromise," *Los Angeles Times*, December 21, 2007.
- 37 Rau, J. "Budget Gap May Scuttle Health Plan," *Los Angeles Times*, December 14, 2007.
- 38 Perata, D., testimony before Senate Health Committee, April 25, 2007.
- 39 Hill, E. "Report to Senator Perata," Office of the Legislative Analyst, January 28, 2008.
- 40 Technically, the reform package was "off-budget," meaning that unexpected increases in costs would not affect the state budget. However, many feared that, unwilling to cut back or eliminate the program in the face of a shortfall, legislators would turn to state spending to fill any gaps.
- 41 Skelton, G. "Health Plan's Death Shows System Works," *Los Angeles Times*, January 31, 2008.
- 42 Presentation at the California Endowment, Los Angeles, June 19, 2008.
- 43 Weintraub, D. *Party of One*, Sausalito, CA: PolipointPress, LLC, 2007.
- 44 "State of the States," State Coverage Initiatives, January 2007.
- 45 Curtis, R. and Neuschler, E. "California's Shelved Health Care Reform," *Health Affairs* blog, March 5, 2008.
- 46 Zelman, W., presentation to AcademyHealth Annual Research Meeting, Washington, DC, June 6, 2008.
- 47 For further discussion, see "State of the States," State Coverage Initiatives, January 2009.
- 48 Many states are already moving in this direction; see McDonough, J. E., et al. "A Progress Report on State Health Access Reform," *Health Affairs*, Web Exclusive, January 29, 2008.
- 49 For additional discussion of federal options and opportunities see "Politics and Policy in State Health Reform," Zelman, W. A., and Melamed, A. State Coverage Initiatives and UCLA Center for Health Policy Research, 2009.

### About SCI

The State Coverage Initiatives (SCI) program provides timely, experience-based information and assistance to state leaders in order to help them move health care reform forward at the state level. SCI offers an integrated array of policy and technical assistance services and products to help state leaders with coverage expansion efforts as well as with broader health care reform. Our team of policy experts tailors its approach to meeting state decision makers' needs within the context of each state's unique fiscal and political environment. SCI is a national program of the Robert Wood Johnson Foundation administered by AcademyHealth. For more information about SCI, please visit our Web site: [www.statecoverage.org](http://www.statecoverage.org).

### About the UCLA Center for Health Policy Research:

One of the nation's leading health policy research centers and the premier source of health-related information on Californians. Visit us at: [www.healthpolicy.ucla.edu](http://www.healthpolicy.ucla.edu).