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Perspective

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California Dreamin' — State Health Care Reform and the Prospect for National Change

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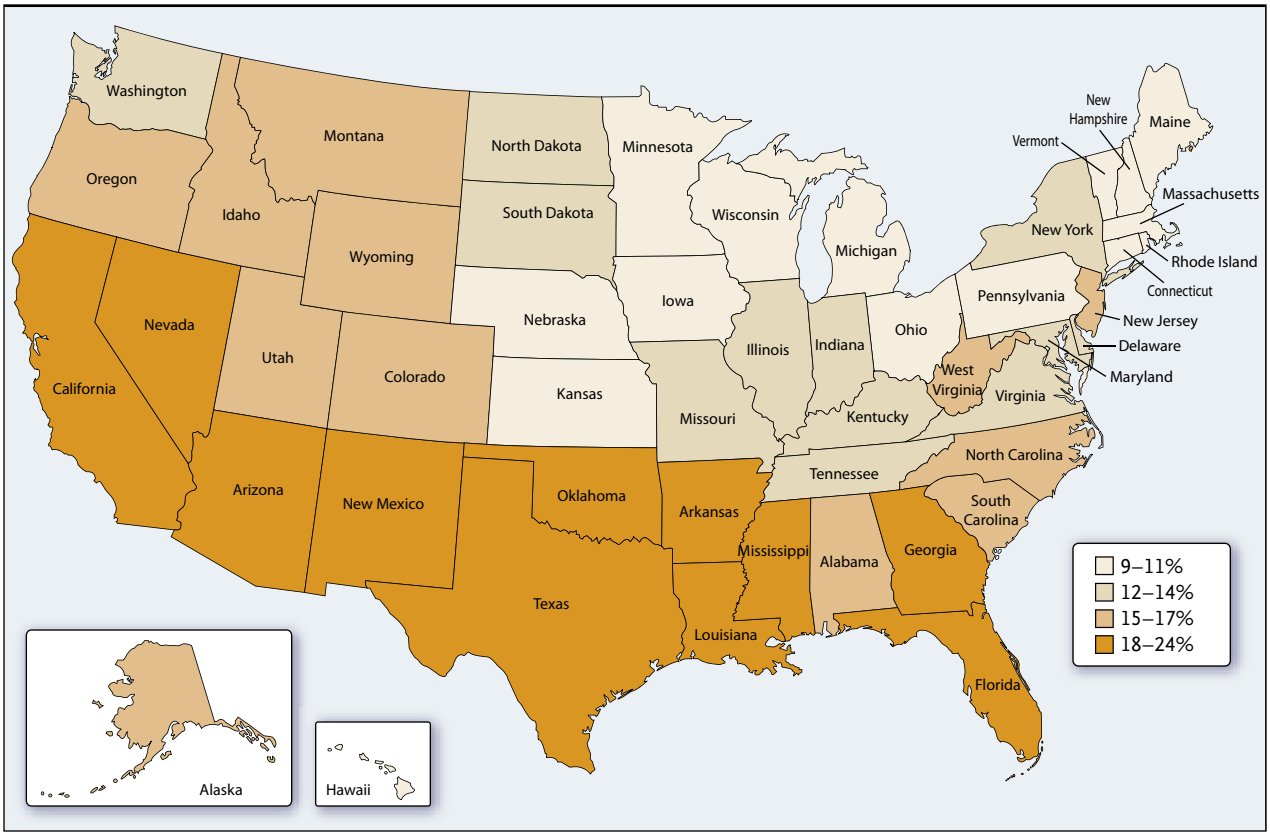
On January 8, 2007, California Governor Arnold Schwarzenegger announced a plan to ensure health care coverage for virtually all the state's residents, in part by requiring businesses to insure their employees and residents to have health insurance. Nearly a year later, the governor and California Assembly Speaker Fabian Núñez agreed on a compromise bill that kept most of the original proposal but revised the funding mechanism considerably. The Assembly passed the bill in mid-December along strict party lines (Democrats, yea; Republicans, nay) and sent it to the Senate, whose Health Committee rejected it overwhelmingly on January 28, 2008. Although Schwarzenegger and Núñez vowed to soldier on, the current prospects for health care reform in California appear to be nonexistent.

Had the reform succeeded, California would have been the fifth state to insure nearly all its residents (see map for a state-by-state breakdown of the U.S. population without health insurance). The first was Hawaii, which passed its State Health Insurance Program in 1989. Maine, Vermont, and Massachusetts, from whose approach California borrowed liberally, have enacted health care reforms during the past 5 years. The setback in California and the experience in these other states illustrate the importance of addressing six obstacles to health care reform — five substantive and one political.

The first obstacle is employer mandates. Requiring companies to cover employees or pay into a state fund generates opposition from business, especially small business. Setting the assessment level is tricky — too low and employers will simply opt to pay it, too high and it can ruin small companies. In California, labor argued that Schwarzenegger's proposed levy of 4% of payroll was too low; the business community considered it too high. The compromise was a levy ranging from 1 to 6.5%, depending on company size. Massachusetts set an assessment of $295 per uninsured worker, Vermont a $365 assessment. Whether these levels — which seem very modest — are appropriate remains to be seen. Employer mandates may also face legal challenges for violating the Employee Retirement Income Security Act, which prohibits states from regulating health insurance plans.



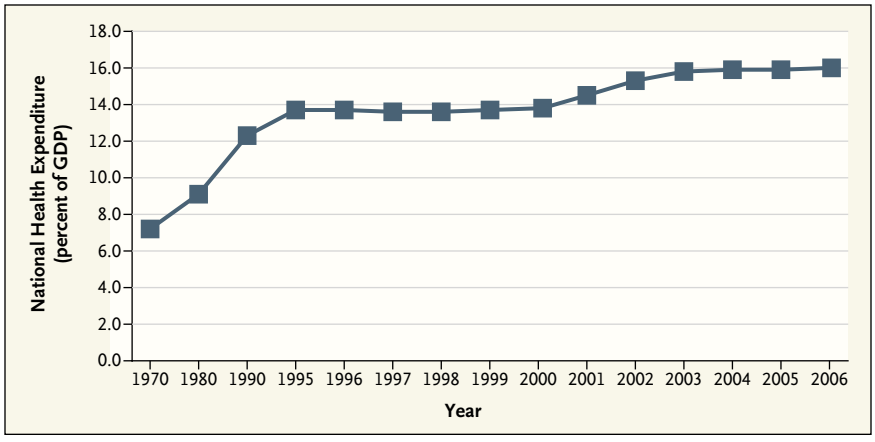
Percentage of U.S. Population without Health Insurance Coverage, 2005–2006.
Data are from the Kaiser Family Foundation.

A second obstacle is the individual mandate, a requirement that people not covered by an employer or a public insurance program purchase their own insurance. Individual mandates draw fire from both the right and the left: libertarians consider forcing people to buy insurance an infringement of liberty, and liberals argue that business or government should pay for insurance. To be workable, an individual mandate requires both that government subsidize the cost for those too poor to buy policies and that policies affordable to most consumers be made available.

Governments have been willing to subsidize insurance for the needy. The challenge is determining the amount of subsidies and the income level at which they should end. In California, the governor originally proposed subsidies for families earning up to 250% of the federal poverty level; the Assembly bill included tax credits bringing the cutoff up to 400% of the poverty level.

Affordability is a serious concern. California generally followed the lead of Massachusetts in allowing individuals to buy private insurance through a state-organized marketplace (called the CommonwealthConnector in Massachusetts). The Massachusetts experience, however, raises questions about whether people can actually afford to purchase policies. The state has exempted 18% of its uninsured citizens from the mandate because they can't afford the premiums. The Connector's executive director, Jon Kingsdale, observed: "This is not sustainable if we don't deal with affordability."[1] The prospect of requiring people to buy unaffordable insurance policies led California Senator Leland Yee, a Health Committee member, to oppose his state's bill, claiming it "would cause too much hardship on California's working families."[2]

The third obstacle is cost (see graph) — the Achilles' heel of health care reform and what doomed it in California, which faces a $14 billion budget deficit. The California Legislative Analyst's Office projected annual cost overruns of $300 million to $1.5 billion after 5 years —



National Health Care Expenditures per Capita and Their Share of Gross Domestic Product, 1960–2005.

Increasing health care costs represent a major impediment to both state and national health care reform. Data are from the Kaiser Family Foundation.

estimates that proved so damaging that only 1 of 11 members of the Senate Health Committee voted for the bill.

Expanded coverage may be paid for either by increasing revenues or by reallocating available money. Because raising taxes is unpopular, states generally avoid imposing new ones to pay for health insurance. And when they do, they target tobacco: Vermont pays for part of its expanded coverage through increased tobacco taxes, California proposed to do the same, and Massachusetts is considering this option. Another approach has been to assess the parties that benefit from expanded coverage. Maine imposed a charge on insurers to offset savings from the reduction in uncompensated care. In response, the insurance industry and the Maine State Chamber of Commerce mounted a legal challenge, which they lost. The California governor's plan proposed levies on physicians and hospitals, though only the hospital levy made it into the Assembly bill.

Given the difficulty of imposing new taxes, the option of shifting federal Medicaid funds from safety-net institutions to premium subsidies is attractive. Massachusetts obtained a federal waiver to redirect nearly $400 million in federal Medicaid funds that was earmarked for uncompensated care. Nevertheless, the state's new health insurance program faces a $147 million deficit this fiscal year, and larger deficits are expected in the future.[3]

The fourth obstacle is containing costs. Following the lead of Vermont, which built its Catamount Health plan around prevention, the reduction of unhealthy behavior, and better care for chronic illnesses, California planned to offer financial incentives to encourage people to join health promotion programs that all insurers and health plans would have to offer. Although an approach emphasizing prevention and management of chronic conditions appears to have saved money in some managed-care systems, whether it can do so when applied on a wide scale is unknown.[4]

The fifth obstacle lies in the design of the benefits package. Since more ample benefits mean more costly policies, designing a benefits package pits proponents of reducing costs against those favoring broader benefits. Policymakers must therefore consider how to develop policies with reduced benefits to attract young, healthy people and whether to retain state-mandated benefits, such as coverage of chiropractic or mental health care. These discussions, in turn, open the door to lobbying by interest groups whose services may not be covered.

Although the most serious substantive obstacles have been financial, partisan politics may represent a more imposing barrier, especially in the national arena. In 1993, Republican party analyst William Kristol wrote a series of influential memos advising Republicans to kill the Clinton health care reform plan because its passage would strengthen Democrats. Republican legislators took his advice and blocked the reform (and won control of Congress). Republicans may again find it politically advantageous to attack Democratic initiatives that would expand coverage and give political capital to the Democrats.

Perhaps a Democratic landslide in 2008 will propel national health care reform, or a spirit of bipartisanship will unexpectedly grip Washington. Short of these remote possibilities, the best means of catalyzing reform may still be the states — despite their financial problems and California's failure.

The states that have enacted or nearly enacted health care reforms have rejected both single-payer and strict market-based approaches in favor of a middle-ground strategy that expands

eligibility for public insurance programs and subsidizes care for the needy, imposes an employer mandate (and sometimes an individual mandate), emphasizes preventive care and management of chronic diseases, and spreads costs among business, government, and consumers. Yet putting all the pieces together demands compromises that can alienate key constituencies, which is why enacting reform has been so difficult.

In Massachusetts and Vermont, business leaders and health care activists — and Republican governors and Democratic legislatures — were able to reach compromises. In California, reform proponents could not withstand opposition from antitax groups and free-market advocates on the right and single-payer proponents and labor on the left. Moreover, Senate Democrats weren't kept involved in the proposed reform; having invested no political capital, they turned against it.[5]

Twelve states are currently considering health care reform, and Rhode Island's lieutenant governor recently introduced a reform package emphasizing universal coverage and cost cutting. The results of a few state experiments are unlikely to lead to major change. If, however, a dozen or more states enacted affordable reforms, the momentum could trigger national reform, as well as offer models on which it could be based.

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