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Politics and Policy in State Health Reform

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State Coverage Initiatives

Robert Wood Johnson Foundation



Part One: Introduction3

Part Two: Systemic Factors3

Part Three: Financing Reform5

Part Four: The Policy Development Process.....8

Part Five: Stakeholder Groups: Stability and Change12

Part Six: Political Leadership16

Part Seven: Conclusion: Limits, Prospects, and Opportunities17

Appendix20

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Readers interested in further analysis of the politics of state health reform may wish to review “Swimming Upstream: The Hard Politics of California Health Reform,” also by Walter Zelman. This in-depth look at California’s recent reform effort is also being published by the State Coverage Initiatives program and the UCLA Center for Health Policy Research and is available at the websites of those organizations.

Introduction

The purpose of this issue brief is to enhance understanding of the politics of health insurance coverage expansion efforts, thereby increasing the probabilities that such expansions may be achieved. The politics of expanded health insurance coverage encompasses several elements: policy options; stakeholder analysis; electoral and partisan considerations; leadership; policymaking processes; and public opinion and involvement. Highly relevant, too, are environmental, systemic, or governance rules that define the boundaries within which a policy initiative occurs and over which policymakers may have little or no control.

This study looks at recent coverage expansion efforts in five large, demographically diverse states—California, New York, Pennsylvania, Massachusetts, and Illinois. These states were selected for several reasons. First, in 2007, the political leaders of all five states were advocating universal or near-universal coverage. Second, the leaders' consideration of universal coverage allowed us to study the full range and interaction of stakeholder groups in coverage expansion efforts; reform efforts focused on incremental goals usually do not induce participation from a broad array of stakeholders. Third, a focus on large, socioeconomically diverse states permitted a comparative analysis of state efforts and informed a discussion of national options. Fourth, the success or failure of these state reform efforts, as in the case of Massachusetts, can potentially influence the national debate on coverage expansion policy.

As of September 2008, three of the efforts we reviewed—in California, Illinois, and Pennsylvania—had failed to achieve their reform goals. While New York has achieved some incremental coverage expansions, the comprehensive coverage expansion proposals remain in the modeling phase. Massachusetts is implementing its

breakthrough statute (enacted in 2006) and is clearly experiencing both successes (many more people covered) and challenges (higher-than-projected costs).

We conducted the study in two phases. First, we monitored public reports about coverage expansion efforts in the five states.¹ Second, we interviewed key reform participants or observers in each state on a broad range of policy, political, and strategic considerations.²

This brief reports on findings in five areas of inquiry that emerged as most crucial and that cut across the five states. The first area pertains to economic, governance, and other factors that define the systemic environment in which states sought coverage expansions. The second area describes the challenges of financing coverage expansions. The third area is the process of policy development. The fourth area of inquiry relates to the role of interest groups, particularly the views of interest groups regarding economic impacts of reform options. The fifth area is the role of political leadership. In reporting our findings, we occasionally comment on how they compare with the findings of previous research on state coverage expansion efforts.

We reached few definitive conclusions. Our review indicates that each effort was buffeted by many state-specific questions of policy, constitutional provisions, current funding and statutory arrangements, partisanship, leadership issues, and unique economic circumstances. Given the multiplicity of options and circumstances that characterize the policymaking environment, it is always possible to conclude that slightly different circumstances or decision-making behavior might have produced different outcomes.

Following our analysis of the five selected factors, we review the implications for state and federal policy options.

Systemic Factors

The five states initiated their reform efforts in an environment of “givens,” almost all of which proved more obstacle than opportunity. Some were unique to one or two states; others affected all five states.

Super-Majority Vote Requirements

By far, the two-thirds vote that California requires for proposed revenue increases proved the greatest obstacle to expanded coverage. Given solid Republican opposition to any tax increase, the super-majority vote rule transformed the always major challenge of funding reform into a herculean vote-getting effort marked by a tortuous debate over what was a fee (majority vote) and what was a tax (two-thirds vote). Ultimately, the rule required reform supporters to propose a ballot initiative that would have asked voters to approve reform funding—an approval viewed by almost all involved in the reform effort as highly unlikely. To understand the full impact of the rule, it is useful to imagine a majority-vote scenario in which Democratic legislative majorities had the votes and the governor a willing signature pen. Opponents would then have to contemplate not “how do we defeat the bill” but rather “how do we protect our vital interests.”

The federal government, of course, has its own version of the extraordinary vote requirement. On a wide variety of policy efforts, success in the U.S. Senate requires 60, not 51, votes.

Employee Retirement Income Security Act

The federal Employee Retirement Income Security Act (ERISA) and its constraints on requiring an employer contribution toward insurance coverage also imposed obstacles to health reform in the states. Unquestionably, ERISA limited what some reform proponents, especially in California and Illinois, could propose as the employers' role in expanding coverage. Just as important, ERISA left all parties to reform uncertain as to what might or might

not be acceptable, and left many urging federal clarification or safe harbors on ERISA.³

Some recent analysis suggests that the “pay-or-play”-type proposals (in which employers are required to pay into a public fund or purchase insurance for their employees) offered in Illinois, California, and Pennsylvania, in which employer requirements were limited to no more than 3 to 4 percent of payroll, might be acceptable under ERISA.⁴ Still, interviewees in many states indicated that the uncertainty about potential ERISA challenges complicated policy analysis and created an additional concern that, even if reform could win approval, it would face a lengthy ERISA challenge with an uncertain outcome.

Federal Rules and Financing

The rules that define how states obtain and have historically obtained federal financing are also critical systemic factors. In the five states of interest (as in virtually all other reform efforts in other states), reformers pursued the apparent first rule of coverage expansion policy: maximize access to federal dollars.⁵ Accordingly, many reform supporters viewed recent Congressional and Bush Administration actions reducing state access to Medicaid or State Children’s Health Insurance Program (SCHIP) funds as major setbacks but see likely reversal of these policies in the Obama Administration as a major opportunity.

States’ dependence on federal money—whether already in hand or promised—highlights the connection between state and federal reform. Here, past is often prologue. States that have tapped disproportionate shares of federal funding, most notably New York and Massachusetts, may be able to expedite expanded coverage by merely shifting federal funds from column A (access) to column B (coverage).⁶ Indeed, policy analysts and policymakers reviewing the Massachusetts experience reported that a threatened loss of federal funds was a critical motivating factor in

Table 1: Conditions for Seeking Reform

	High Concern about Health	Modest Concern about Health
Strong Economy	A	C
Weak Economy	B	D

the state’s search for common ground.⁷ Specifically, the federal government threatened Massachusetts with a loss of uncompensated care pool dollars unless they shifted those dollars to a coverage model.

Budgets and Economic Cycles

Some environmental factors, particularly budget pressures and economic downturns, may be beyond the reach of state policymakers. Sources in all states but Massachusetts, which, significantly, completed its reform effort before the current economic downturn, confirmed the importance of cyclical economic forces.

Many observers and reform participants viewed budget pressures and economic downturns as diminishing states’ capacity to sustain enacted reforms in hard times and undermining their capacity to build on rising public concern to enact reform in good times. As one New York insider commented, “You cannot responsibly make reform commitments unless you can see your way through the next recession.” California legislators voiced similar concerns upon rejection of the final reform compromise. The irony of the governor’s efforts to seek Medicaid expansions in a reform proposal while advocating for Medicaid cuts to meet a budget shortfall was lost on few.

State constitutions requiring balanced budgets only aggravate matters. As Lisa Dubay, Christina Moylan, and Thomas Oliver have argued, “State political leaders take this requirement seriously.”⁸ Many are reluctant to approve reforms that may be economically feasible upon passage but could be infeasible in the near future.

A paradox emerges. Reformers may be able to build support for coverage expansions in challenging economic times (especially when premiums are rising) as public concern emerges over increasing insurance costs and the growing number of uninsured. But the same hard times limit states’ capacity to fund new or sustain already enacted reforms. By contrast, in better economic times when some funding might be available, pressures for reform may decrease. Table 1 describes various conditions for seeking reform.

Most of the current and recent state reform efforts are taking place under conditions of Box B or D. Public and other pressures for reform may be considerable, but state funds are not easily available. Perhaps the ideal scenario for reform is a period in which the economy is recovering, but concern about the system and its costs is still high (Box A). Interestingly, the last such period might have been 1993–1994, the years of the Clinton failure to pass reform at the national level. The new Obama Administration may find itself in the high-concern/low-capacity Box B.

Rising Health Care Costs

A few years ago, most health policymakers could routinely cite the increasing numbers of uninsured individuals. Today, most can cite evidence that health care costs are rising two to three times the rate of inflation or wages. Reform presentations consistently highlight this factor, and it is certainly the dominating challenge in state coverage expansion efforts. Under such conditions the number of individuals and families requiring financial support in purchasing insurance expands, as does the amount of support they need. All of which heightens the revenue challenge for reform advocates.

Less than a decade ago, reform proposals might have credibly limited subsidies to individuals or families with earnings under 250 percent of the federal poverty level (FPL). With average family premiums up more than 100 percent in seven years to almost \$12,000, families at 250 percent FPL must spend almost 23 percent of their income on premiums, a level of expenditure that almost certainly is not sustainable from either an economic or political perspective. Given recent cost growth, credible subsidy levels today must go up to the 350 to 400 percent FPL range. At such levels, the number of qualifying households soars, as do the costs of reform. (see Table 2).

Complexity and Interconnectedness of the Issues

Finally, our review suggests that reform supporters—even many who might prefer to start with modest steps—are often forced to confront the interconnectedness of the health policy puzzle. Reports from all states indicate that during in-house education processes, governors expressed growing awareness of the interconnectedness of policy issues. Attempts to reposition just one piece of the puzzle (e.g., individual market reform) quickly affected other issue areas, much like the redistricting process in which a modest change in one legislative district will ripple out and force changes in many other districts. One result of such interconnectedness can be the movement from modest to comprehensive reform. In turn, the prospect of comprehensive reform complicates the politics of reform by attracting large numbers

of concerned stakeholders. It becomes more difficult to find outcomes acceptable to all or even most of the impacted interests. From an advocacy point of view, it becomes increasingly difficult, as one Massachusetts advocate commented, to “take on one opponent at a time.”

The interconnectedness of the health policy puzzle is magnified, as Skocpol and Keenan have suggested, by the complex web of public and private sector and federal and state funding relationships.⁹ Proposed policy changes in the private or public sector or at one government level or another inevitably impact programs, funding streams or policies in the other sector and other government levels, again generating expanded interest group concern and involvement. Most important here is the connection between state reform and federal financing. In all the states reviewed reform financing relied heavily on federal dollars.

Financing Reform

Our review highlights two seemingly obvious reform challenges. The first is to find politically acceptable means of financing coverage expansions. The second is to address concerns about financing and other economic impacts of reform on key stakeholder groups. Each potential source of reform financing—employers, individuals, providers, special taxes, and the general public—has its supporters. But the opposition to each funding source, usually led by those most concerned about adverse economic impacts on their respective

constituencies, is almost always the most intense and committed of involved stakeholders. The exception to this general rule, at least at the state level, may be limited to coverage expansions that depend on increased federal government contributions as opposed to targeted interest group resources. Even these expansions, however, generally require a match in state dollars that, especially in times of tight budgets, are difficult to secure.

In all the states that actually produced reform proposals, (New York being the exception) policymakers sought to maximize federal funding via SCHIP and/or Medicaid expansions. Beyond seeking federal funds, California, Massachusetts, Illinois, and Pennsylvania adopted the pay-or-play construct. Republican Governor Mitt Romney advocated an individual mandate without an employer requirement. Democratic Governors Edward Rendell and Rod Blagojevich proposed modest employer requirements (3 percent of payroll) but no individual mandate. Only California’s Governor Schwarzenegger proposed both. Beyond those requirements, funding choices varied considerably, sometimes changing over the course of the reform effort. Alternative sources included existing funds already directed to the uninsured (Massachusetts especially), cigarette taxes (California and Pennsylvania), excess funds in a state account established to subsidize malpractice insurance (Pennsylvania), a gross receipts tax (Illinois), and a tax on physician and hospital revenues (California) (see Table 3 on financing sources).

Table 2: 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	

2007 Kaiser Family Foundation Employer Survey, census data.

Table 3: Financing Sources for State Coverage Expansion Proposals

State	Additional Federal Funds	Employer Mandate	New Taxes	Idiosyncratic Funding Sources	General Revenue
California	Additional federal funds through Medicaid and SCHIP expansion	Sliding scale (1 to 6.5%) payroll tax, scaled to total payroll, on businesses spending less on health care benefits	Additional \$1.75 per pack tax on cigarettes New 4% tax on hospitals	Proposal to lease state lottery	No
Illinois	Additional federal funds through Medicaid expansion	3% payroll tax on businesses spending less than 4% of payroll on employee health care	Original plan relied on a gross receipts tax; rejected by state legislature	No	Yes
Massachusetts	Additional federal funds through Medicaid and SCHIP expansion	Contribution of \$295 per employee by employers who do not provide “fair and reasonable” contribution to employee coverage	No	Shift in funds from uncompensated care pool to coverage	Yes
New York	Proposals Still in Development				
Pennsylvania	New waiver for additional Medicaid matching funds to cover previously ineligible individuals	Original proposal included 3% payroll tax on non-insuring employer; later abandoned	Increased tobacco tax and new tax on cigars and smokeless tobacco	Excess funds in an account established to subsidize malpractice insurance for doctors in the state	No

Advocates of government-funded, single-payer-type systems remained active in all states, especially New York and California. With some exceptions, however, legislators, and to a lesser extent, stakeholder groups still claiming to favor the single-payer approach, viewed it as impractical and off the political table. Interestingly, several Massachusetts sources commented favorably on the critical role played by key consumer leaders who accepted and led the effort for an alternative to their preferred single payer approach. Similar comments were offered regarding the leading Illinois consumer coalition. In California, however, single payer advocates were more divided. Some were willing to work within the non-

single-payer frameworks offered by elected officials. Others remained wary and still others took the position that only single-payer proposals should be acceptable.¹⁰

Employer Requirements

Reform outcomes in the reviewed states suggest a reluctance on the part of policymakers to require employers to pay anywhere near the 80 percent of the defined benefit required in the Clinton plan or the 10 to 12 percent of payroll paid by most employers providing comprehensive coverage.¹¹ Massachusetts, the only state with a successful initiative, imposed the smallest employer burden at \$295 per year. Other governors proposed employer requirements in the range

of 3 to 4 percent, although some legislative Democrats in each state advocated higher employer requirements. The ultimate California compromise would have imposed a sliding-scale employer requirement of up to 6.5 percent of payroll on the largest employers.

It is impossible to draw any firm conclusion regarding the cause of this trend in employer requirements. Our review suggests, however, increased concern about the impacts of unabated cost increases on the economy. Of greatest concern was the assumption that, even if state reform programs could sustain current cost levels, the ongoing rate of increase would render reform unsustainable.

California

Note: This summary is based on “Swimming Upstream: The Hard Politics of California Health Reform,” written by Walter Zelman and published by the State Coverage Initiatives program and the UCLA Center for Health Policy Research.

California’s most recent effort to achieve major coverage expansions began in late December 2006, with the introductions of reform proposals by Democratic legislative leaders Speaker Fabian Nuñez and Senate President Don Perata. Both leaders proposed reforms based on required employer contribution in the pay-or-play construct (eventually set at 6.5 percent of payroll for all but small employers), expansions of federal government programs and establishment of a connector-type pool. The Perata proposal included an individual mandate for individuals over 400 percent FPL. The Democratic plans would not achieve universal coverage in large part because Democrats believed no Republican legislators would support broad coverage expansions, making it impossible to achieve the two-thirds vote necessary to raise the new revenues that would be required.

In January 2007, after an extensive, private effort to obtain input from multiple stakeholders the governor surprised many by introducing a bold plan for universal coverage. Drawing on the Massachusetts success of 2006, Governor Arnold Schwarzenegger (R) proposed a “shared responsibility” approach that included an individual mandate (based on a \$5,000 deductible policy) for those over 250 percent FPL, a pay or play proposal at 4 percent of payroll, and expansions of government programs. The governor also proposed a fee (later to be determined a tax) of 4 percent on hospital revenues and 2 percent on physician revenues to be returned to the providers largely in the form of increases in Medi-Cal (California’s Medicaid program) payments to providers. The fee was projected to raise about \$3.5 billion.

Over much of the year, stakeholders and policymakers struggled with both multiple complex policy issues and the economic and political challenge of finding a compromise between the various stakeholders and options. The governor and Speaker Nuñez, along with key staff members, were the central players in the effort. The governor made some progress in winning modest levels of support for his approach in both the small and large business communities, and several large insurers indicated support for key reform elements. But Republican legislative opposition remained solid, the business community remained largely opposed, key hospital and physician groups remained on the fence, and organized labor and allied consumer groups continued to express serious reservations based around affordability, the modest size of the employer requirement in the governor’s plan, and the individual mandate.

In September, the governor reached an agreement with the hospital association on the revenue tax. (The proposed physician fee/tax had been dropped early in the process). Then, in December 2007, during a legislative special session, the governor and speaker reached an agreement. It included a sliding scale pay-or-play requirement (1 percent to 6.5 percent) on employers. The compromise also included an individual mandate with subsidies and opt-out provisions, establishment of a connector, a variety of insurance reforms, Medicaid and SCHIP expansions, an increase in the state’s cigarette tax, and a variety of other measures. The proposal was expected to extend coverage to 3.7 million individuals.

However, given the inability to secure any Republican votes, the compromise required voter approval of all its revenue provisions on the November 2010 ballot. Even the most ardent of reform advocates believed that winning voter approval would be a very uphill effort.

The state Assembly quickly passed the measure on a straight party-line vote, but, in January 2008, it was rejected by the state Senate, including Senator Perata. Explanations for the rejection were many, including: the emergence of a \$14 billion state budget deficit; projections by the state’s legislative analyst that projected program revenues would be inadequate; concerns that voters would reject the required ballot measure; continuing opposition from some key elements of organized labor; a lack of champions in the Senate; strong opposition from business; and an overall weakness in stakeholder and legislative support.

Such concerns, of course, apply with far greater force to the circumstances of small employers. While the organizations representing small employers are often not particularly effective in voicing their political demands, policymakers remain highly sensitive to their concerns. As more than one interviewee suggested, many policymakers emerged from the world of small business. Moreover, lobbying interests that represent larger businesses regularly point to reform's impact on small businesses and effectively attack the employer requirement at its weakest link—the small employer. Consequently, even in the absence of small employer organizations to make the case against reform, big business protects the interests of small business.

Individual Requirements

Fueled by its centrality in proposals offered by Governors Romney and Schwarzenegger and its embrace by presidential candidates Clinton and Edwards, the individual mandate has gained prominence and earned the support of some key policymakers and many policy analysts. An Illinois task force charged with developing reform proposals approved the individual mandate, and some key reform supporters in Pennsylvania viewed it as “not out of the question.” Moreover, some business coalitions view the mandate as critical to the shared responsibility construct, and potentially supportive insurers insisted on its inclusion in reform legislation if underwriting is to be limited or eliminated in the individual market. Even consumer groups recognized the difficulty of imposing underwriting reforms without some form of individual mandate.

Nonetheless, the individual mandate lacks a champion and has drawn little or no support from Democratic policymakers or labor or consumer groups, except—as was the case in California and Massachusetts—as something to be reluctantly accepted as part of a larger compromise. Moreover, the individual mandate's value is limited as a component of a low-cost strategy for expanding coverage if, as was the case in Massachusetts and California, the mandate

is ultimately imposed only on those with substantial incomes or its price in terms of policy compromise is subsidies or tax credits for individuals at 350 or 400 percent FPL. It might reduce the number of the uninsured, but it does not reduce the government's subsidy burden, which remains the greatest impediment to coverage expansion. If anything, with more insured individuals requiring government support, government's subsidy burden will increase.

Financing through Cost Containment

Governors and legislators in the five states (Illinois is a possible exception) pursued reform under the assumption that it could not be achieved—and certainly not sustained—without progress on the cost front. Indeed, recent polls have indicated that the public is as concerned about cost (36 percent view it as the single most important health care issue) as about coverage (33 percent).¹²

However, with the exception of efforts to control Medicaid costs through the application of available regulatory tools, cost control efforts remain largely in the proposal or unproven stage. Several states have enacted or considered connectors or pools (Massachusetts, California, and Illinois). Whatever other value connectors/pools may offer, their potential to control costs has yet to be realized. Governors, public task forces, and other policymakers have also looked carefully and often creatively at cost reduction options in many areas, including: payment for and management of chronic conditions (Pennsylvania), disease management, scope of practice expansions (Pennsylvania), transparency of pricing and electronic medical records (California), and other areas. But there is little evidence that such proposals will bear significant fruit in the near term. Reform advocates in several states emphasized that significant cost reductions will require delivery system changes which, they anticipate, will encounter strong resistance from providers.

The introduction of high deductibles offers one mechanism of reducing premiums, even if it does not reduce long-term costs. Governor Schwarzenegger advocated such an approach but found that the option attracts stiff opposition from labor, consumer groups, and Democrats, especially when proposed for low-income individuals. If not applicable to low-income individuals, the capacity of high deductibles to reduce government subsidies and thus ease the costs of expanded coverage is extremely limited.

The Policy Development Process

According to several observers, almost all of the governors in the study states underwent a learning process that led to an enhanced understanding of the relationships between major elements of the health reform landscape, particularly the central link between coverage expansions and the need to restrain growth in health care costs. These learning processes included private efforts to improve gubernatorial understanding and develop internal strategies and more public efforts to solicit input from public and stakeholder constituencies.

The Private Education of Governors

In all five states, the governors reportedly spent considerable time with a small group of highly knowledgeable and experienced advisors, formulating an appropriate reform approach. The private tutorials generally resulted in a greater appreciation of how matters of coverage expansion relate to cost. Discussions in different states also focused on the intricacies of market reform, individual and employer mandates, purchasing pools, and Medicaid funding.

In California, Governor Schwarzenegger concluded that the “system” was broken and needed comprehensive reform. In Pennsylvania, Governor Rendell moved from a preference for federal intervention to an appreciation of the impact of rising costs on small business (thought to be the engine of Pennsylvania's economy) and the need for state intervention. In

Illinois

Illinois' recent coverage expansion effort began with passage of the Health Care Justice Act of 2004, in which then State Senator Barack Obama played a major role. That law articulated the goal of universal access to high-quality, affordable health care, and established the Adequate Health Care Task Force (AHCTF) to construct a plan for achieving this objective. Beginning in August 2005, the Task Force met with health care stakeholders, held public hearings, and evaluated several health care reform proposals. In January 2007, after an eighteen month process, the Task Force issued their recommendations. Key features of the AHCTF plan included an individual mandate, a pay-or-play requirement on employers, subsidies for low-income individuals, and reform of the health insurance market.^a

Momentum for major coverage expansion was amplified by the state's successful implementation of All Kids, the nation's first universal coverage program for children. Signed into law in 2006, All Kids made children's health insurance available to all Illinois families irrespective of income, health status, or immigration status.^b

In March 2007, then Governor Rod Blagojevich (D) announced his coverage expansion plan known as Illinois Covered. Though the governor's proposal drew on many provisions of the AHCTF plan, Illinois Covered did not include some of the Task Force's recommendations. The most notable difference was the absence of an individual mandate in the governor's plan. His plan sought to increase coverage through the expansion of both public programs and private insurance. Illinois Covered expanded eligibility for existing public programs and created programs to cover categories of low-income adults not previously served in the state. The plan sought to increase private coverage by offering premium subsidies to households with incomes below 400 percent FPL, and requiring that all companies selling managed care plans in the state to offer a new a state-regulated product called Illinois Covered Choice. The new product would be offered on a guaranteed-issue basis and priced using modified community rating. Illinois Covered sought to increase private coverage among young adults by allowing them to remain covered as dependants under their parents' policies until the age of 30.

More controversial than Gov. Blagojevich's coverage expansion plan was a proposed gross receipts tax which would have, in part, paid for the program. That proposal drew vigorous opposition, especially from the business and insurance communities. In May 2007, the tax was overwhelmingly rejected by the Illinois legislature. The governor proposed a scaled-back version of his Illinois Covered plan in July 2007 which relied on a 3 percent payroll tax on employers who spend less than 4 percent of payroll on health care benefits. It was also funded by federal Medicaid and SCHIP funds and money appropriated from the state general fund.^c

The new version of Illinois Covered drew some support in the provider and business communities, although insurers remained firmly opposed, and the medical society continued to express concerns.^{d,e,f} Democrats held majorities in both legislative houses, but the governor had extremely strained relations with House Speaker Michael Madigan and many cite that relationship as a primary cause of the failure of the scaled-down proposal.^g Illinois did, however, enact a law enabling many young adults, up to age twenty-six, to stay on their parent's insurance plans.^h

a State of Illinois Adequate Healthcare Task Force. 2007. *Final Report*. Available online at www.idph.state.il.us/hcja/AHCTF%20Final%20Report%201.26.07.pdf.

b Coughlin T.A., and Cohen M. 2007. *A Race to the Top: Illinois's All Kids Initiative*. Kaiser Family Foundation. Washington DC. Available online at www.kff.org/uninsured/7677.cfm.

c Meitrodt, J., "Health care plan revived." *Chicago Tribune*, July 21, 2007.

d Illinois State Medical Society, 2007. "Illinois State Medical Society Affirms Support for Universal Access to Insurance Coverage; Voices Concern Regarding Illinois Covered Plan as Currently Written." Press release, April 25. Available online at www.isms.org/newsroom/newsrelease/nr2007_0503.html.

e Illinois State Association of Health Underwriters. "Illinois Covered." Position paper. Available online at www.isahu.com/documents/ISAHU_Illinois_Covered_position_statement.pdf.

f Illinois Chamber of Commerce. "2007 Key Legislation" available online at www.ilchamber.org/Government_affairs/Key_legislation/key_legis_2007.html.

g Wills, C., "Illinois Democrats turn on each other." *USA Today*, July 10.

h Since the failure of this 2007-08 attempt to expand health coverage in Illinois, Governor Blagojevich was indicted on federal corruption charges and removed from office by the state legislature.

Massachusetts, Governor Romney charged a team with addressing and remedying problems with the state's uncompensated care pool and then recognized that the state's health care problems had larger tentacles requiring broader reforms, including imposition of an individual mandate. In New York, Governor Spitzer conducted internal discussions for several months before announcing a public input-seeking strategy.

Public and Stakeholder Input Processes

Several governors or other reform-minded entities (California is something of an exception) established various public processes—commissions, task forces, roadmap studies—to air issues, generate new ideas, better understand the connections between the parts, build public support for the coming reform effort, or perform due political diligence in creating a sense that leaders were attentive to the issues. In this respect, four of the five study states pursued a public, sometimes commission-driven process that, as John McDonough and colleagues have described, has become fairly commonplace in the current wave of reform.¹³

In New York, Governor Spitzer tapped his health commissioner and insurance superintendant to lead a Partnership for Coverage that conducted hearings around the state, soliciting views on options for achieving universal coverage and contracted with the Urban Institute to model coverage proposals. The influential United Hospital Fund also developed and widely distributed a roadmap to expanded coverage.

In Massachusetts, the BCBS Foundation produced a widely respected series of roadmaps to expanded coverage, outlining demographic and other baseline information related to coverage issues. The roadmaps, it is widely reported, proved extremely valuable in providing the groundwork and data for policymaker analysis.

In Illinois, legislation authored by then State Senator Barack Obama gained approval in 2004 that established a broad-based task force to study expanded coverage. The task force conducted 22 hearings at which over 400 individuals testified and then developed a proposal, most of which was accepted by Governor Blagojevich.

In Pennsylvania, the governor created a 101-member advisory committee to assist him in developing a reform proposal. It is important to note that the committee included 16 members appointed by the four caucuses of the state legislature. At the same time, the committee did not include the statewide heads of stakeholder associations who, it was feared, would be tied to established, lowest-common-denominator positions. The proposals generated by the advisory committee formed the basis of Governor Rendell's reform proposals.

California did not engage in a public input process. However, the California HealthCare Foundation, following on the Massachusetts success, funded an analysis of what a reform proposal might look like in California and an options paper describing various reform approaches, all of which included an individual mandate.

In addition to these private and public education efforts, several states sought and received top-flight consultation from national experts, sometimes funded by government agencies or foundations. In the latter case, these efforts included infusions of expertise in challenging policy areas such as individual and group market reforms (Pennsylvania) and extensive assistance with financial modeling (California).

In almost every case, participants in and/or observers of these public processes saw significant value in the processes' goal of advancing reform. Many reform participants suggested that the public processes produced a positive impact, generating momentum for legislative success such as the Illinois All Kids success, the Massachusetts compromise, and

Pennsylvania's public program expansions. The exception may be New York, where some noted that hearings conducted by the Partnership for Coverage brought together the usual stakeholders and produced the usual analysis. Nevertheless, some described the process as politically necessary and, to that extent, valuable.

A second and more interesting exception—at least with respect to public processes—is California, where virtually the entire policymaking process was a strikingly private one, from soliciting input to crafting policy. Some believed the private process was essential to shielding potentially delicate reform discussions from stakeholder efforts to pick the pieces apart. Others believed that the product and outcome might have differed if the policymaking process had been subject to full public scrutiny, with legislators playing a substantial role in generating supportive coalitions and seeking stakeholder compromise.

Lessons from Public and Private Input Processes

The public and private processes of seeking (or at minimum, providing the appearance of seeking) input from experts and stakeholders suggest several potential lessons. First, reform advocates apparently felt a need to pursue at least the appearance of seeking stakeholder and other input and of building a knowledge and research base from which to pursue reform. Conceivably, such processes may reflect a subtle but growing consensus that reform success will more likely be achieved through an evidence-based, consensus-building process than through the efforts of one side to overpower the other.

A second lesson, as noted, may be the apparent benefit of information-gathering processes, at least for governors, as an initial step in developing a greater appreciation of the interrelationships between and among the pieces of the health care reform puzzle. Policymakers who undertake reform with a specific goal are likely to discover that addressing the front-and-center question requires attention to a wide variety of sometimes intractable dilemmas.

Massachusetts

Massachusetts's recent and successful effort to expand health care coverage began in November 2004, when Senate President Robert Travaglini (D) announced his intention to reduce the state's uninsured population by half. In April of the following year, he introduced legislation outlining his plan. It proposed an increase in Medicaid reimbursement to hospitals and community clinics, encouraged the development of high-deductible, low-premium plans by insurance companies, funded an expansion of Medicaid, and imposed penalties on companies whose uninsured employees obtained uncompensated care.^a

In June 2005, then Massachusetts Governor Mitt Romney (R) announced details of his own plan, which would expand health coverage to all Bay Staters. The hallmark of the governor's proposal was inclusion of an individual mandate. Framing the health care coverage issue in terms of personal responsibility, the administration plan proposed that, similar to automobile insurance, all residents must obtain health coverage. To enable those low-income individuals to obtain coverage, Governor Romney proposed a program to subsidize premiums for those with incomes below 300 percent FPL.^b Governor Romney's plan also allowed insurance companies to develop discounted plans, with less comprehensive benefits than would be otherwise required by the state's insurance regulations. These new insurance products would be available to small business, part-time workers, the self-employed, and individuals not offered employer-based coverage.^c

In October 2005, House Speaker Salvatore DiMasi (D) proposed a third plan. The speaker's proposal included the Commonwealth Connector (an organization to connect individuals and small businesses with appropriate insurance products), an individual mandate, an expansion of Medicaid, and increased Medicaid reimbursement. The plan also called for merging of the small group and individual insurance markets, and a tax equal to 5 to 7 percent of payroll, with company-provided health care coverage deductible against the tax.^d

In addition to the clearly broad political support for reform, there were significant incentives for a compromise to be reached. The Centers for Medicare and Medicaid Services (CMS) had threatened to withdraw \$1.2 billion (\$385 million annually over three years) of federal funding which the state was using to pay providers for uncompensated care unless Massachusetts redirected the money to expand coverage. In addition, two separate coalitions of health care advocates (Health Care for Massachusetts and Affordable Care Today) were actively, and successfully, collecting signatures for ballot amendments that would achieve universal coverage.^e This combination of pressures aligned the reform interest of a number of critical stakeholders. The potential loss of federal funds could be catastrophic to the provider community. The business community was threatened by the possibility of a ballot initiative which might hang the financial burden of coverage on employers.

In April 2006, a compromise plan which incorporated aspects of each of the political leaders' proposal was passed by both chambers of the legislature. The plan expanded Medicaid and SCHIP programs in the state and increased provider reimbursement. It included an individual mandate and a \$295 per employee fee on companies that employed more than 10 workers and did not offer coverage. The plan also merged the small group and individual markets and created a "connector" to help Bay Staters find appropriate coverage. When signing the bill, Governor Romney employed a line-item veto on the \$295 employer assessment, a number of expansions in Medicaid benefits, and coverage for legal immigrants. However, by June, the legislature overrode all of the governor's vetoes.

By almost all indices, the Massachusetts reform has proved successful. Reports from late 2008 indicate that the state's uninsurance rate has fallen to 2.6 percent of the population, the lowest rate in the nation. However, the greater-than-expected enrollment rate has produced cost growth challenges, with first year costs rising from an anticipated \$472 million to \$630 million.^f Massachusetts legislators have now turned their attention to cost containment and quality improvement within the health care system.

a Little, T.H., "Building a Consensus for Health Care Reform in Massachusetts: Policymakers and the 'Hero Opportunity' in the Bay State." State Legislative Leaders Foundation, 2007. Available online at www.slf.org/media/file/16.134.pdf.

b Appleby, J., "Mass. Gov. Romney's health care plan says everyone pays." *USA TODAY*, June, 2005.

c Greenberge, S.S., "Healthcare reform efforts win praise as 'great beginning'" *Boston Globe*, April 7, 2005.

d Little, 2007.

e Wielawski, I.M., 2007. "Forging consensus: the path to health reform in Massachusetts" Blue Cross Blue Shield of Massachusetts Foundation. Available at www.bcbsmafoundation.org/foundationroot/en_US/documents/ForgingConsensus.pdf.

f "Charting a Course: Preparing for the Future, Learning from the Past," State Coverage Initiatives, January, 2009.

A third lesson may be that, given the perceived value of input-gathering processes, especially processes that engage the public, health care reform takes time—time to formulate policy and perhaps even more time to attempt to negotiate alliances and navigate legislative minefields. The Massachusetts process, as McDonough and colleagues suggest, took years, not months.¹⁴ In contrast, California's effort—compounded by budget fights, the challenge of bringing reluctant constituencies to a new compromise, and the struggle with many technical challenges—simply ran out of time. Clearly, the danger is that reform efforts do not always have the luxury of time. Competing agendas, limited windows of opportunity, changing economic circumstances, and a range of demands on policymakers may not be conducive to multi-year reform efforts.

Stakeholder Groups: Stability and Change

As underscored by studies of earlier coverage expansion efforts, the history of failed coverage expansions is a history of health care stakeholders' power. Stakeholders have at their disposal a wide array of strategies and tools for defeating or overturning coverage expansion proposals: contributions to political candidates, especially those serving on relevant legislative committees; massive direct and indirect lobbying efforts; direct-to-consumer advertising; and the ability to finance ballot campaigns aimed at defeating reform proposals or overturning legislatively approved coverage expansions.¹⁵

The five states' experience confirms that reform opponents still maintain the built-in legislative advantages offered to the opposition by America's Madisonian system of separation and sharing of power. Those seeking significant coverage expansions through legislation, like reform advocates in most policy areas, must swim upstream. Still, some evidence suggests that shifts in positioning might benefit the reform side. The following brief review of key stakeholder group positioning emphasizes the

potential for change in stakeholder positions and conflicts within the stakeholder community.

Employers

As suggested, employer associations have continued their effective opposition of employer requirements and may have even improved their positioning regarding potentially adverse impacts of such requirements. However, indications suggest that some larger employers are becoming somewhat receptive to shared responsibility. Some believe that the costs of inadequate Medicaid payments and the costs of treating the uninsured are being shifted to them. Some see the value in imposing a level playing field on non-insuring competitors. Some may believe that their coverage is attracting dependents who might, under an employer requirement, be insured by others.

In California, Governor Schwarzenegger won support for his proposal—at least in principle—from several significant employer organizations,¹⁶ although some stepped back as the size of the employer requirement expanded. Analysts in New York suggest that large employers in the New York City metropolitan area (not upstate) might take a similar view. In Illinois as well, reform advocates expect that some large employers might accept some level of requirement, though that possibility was never tested. In Massachusetts, a variety of factors tempered the opposition of the employer community, particularly the hospital community's business leaders, to the modest employer requirement.

In general, however, potential business support for a modest employer requirement is overshadowed by the ardent advocacy of state trade associations, which tend to defend longstanding, lowest-common-denominator positions. Moreover, a quiet willingness of some larger employers to entertain a level of employer requirement may be muted by a reluctance to break ranks with the larger business community. "The business community," one California advocate suggested, "has as much class consciousness as labor."

Interestingly, even business leaders who announced support for Governor Schwarzenegger's proposals talked about shared responsibility and requirements on individuals but seemed unwilling to acknowledge publicly that they were tacitly approving the employer requirement. Such reluctance may undercut even the subtle strategy of winning some employer support for employer requirements and using that support to depict the employer community as, at least, divided on the issue.

Finally, even those employers potentially open to some requirement fear open-ended commitments. Consequently, employer acceptance of modest requirements may depend on some guarantee of cost control or limits on the expansion of employer requirements. In California, the issue of limits arose in the context of whether a majority or two-thirds legislative vote would be required to raise the employer requirement. In Illinois, supporters of an employer requirement proposed deposit of the associated funds into a self-contained trust structured such that increases would be difficult to achieve.

Labor

Our review found significant differences within the labor community. Long the national leader in coverage expansion advocacy, much of organized labor appears highly skeptical of or outright opposed to the shared responsibility construct which, when actually applied, usually involves less onerous requirements on employers and more substantial contributions from individuals. Labor views, however, differ by state and by union. SEIU, the dominant union in the health care industry, has many low-wage and uninsured members and may, therefore, be more supportive of compromise options. By contrast, higher-wage unions, many represented by AFL-CIO federations, appear more skeptical, more concerned about reduced employer requirements and the slippery slope away from employer-based coverage, and more concerned (as buyers of health care) about rising costs.

New York

In his January 2007 State of the State address, then Governor Eliot Spitzer (D) designated expanding access to health care a priority issue for his administration. He proposed two strategies for reducing the number of uninsured in the state. New York would guarantee access to health insurance coverage for all 500,000 uninsured children in the state. In addition, Mr. Spitzer promised a streamlined system of enrollment for Medicaid which would extend coverage to 900,000 uninsured Medicaid-eligible individuals in the state.^a

Over the course of the 2007-08 legislative session, New York State took a number of incremental steps to expand coverage. In July 2007, the state enacted legislation allowing businesses to purchase insurance for eligible low-income employees through the state's Family Health Plus program. The program, funded with state and Medicaid funds, provides coverage to uninsured parents and childless adults with incomes below 150 percent FPL and 100 FPL percent respectively.^b Under the new law the state shares premium costs with employers for workers who meet the program's eligibility criteria.

New York also fulfilled Governor Spitzer's promise to streamline Medicaid enrollment, by expanding and simplifying eligibility, and reducing administrative barriers associated with eligibility and enrollment.

The most visible of the state's incremental coverage expansions came in the state's effort to expand enrollment its SCHIP program. When the Centers for Medicare and Medicaid Services (CMS) denied the state's request to raise the maximum family income for subsidized coverage from 250 percent to 400 percent FPL, the state implemented the expansion with state funds.^c

In addition to taking incremental steps towards coverage expansion, the Spitzer Administration initiated a process to design a plan to achieve universal coverage in the state. In May 2007, Governor Spitzer directed the state's Health Commissioner and Insurance Superintendent to launch the *Partnership for Coverage*, which would be responsible for developing a plan to achieve universal coverage in New York. Between September and December 2007, the *Partnership for Coverage* held public hearings throughout the state to receive input from stakeholders and the public. In March 2008, the Partnership contracted with Urban Institute to model various proposals for universal coverage.

In that same month, March 2008, Governor Spitzer resigned from his office due to ethical violations and was replaced by David Patterson. In May 2009, the new governor offered a new series of incremental expansions relating to COBRA and young adult dependents.^d However, efforts to achieve comprehensive coverage expansions are on hold as the state awaits the outcome of the national health reform debate.

a Spitzer E., "State of the State Address: One New York," January 3, 2007. Available online at www.ny.gov/keydocs/NYS-SoS-2007.pdf. .

b State Coverage Initiatives, October 2006, "Coverage Profile: New York." Available online at www.statecoverage.net/profiles/newyork.htm.

c "Charting a Course: Preparing for the Future, Learning from the Past," State Coverage Initiatives, January, 2009.

d "Governor Patterson Introduces Legislation to Make Health Insurance More Affordable and Improve Access to Care," May 15, 2009, www.ny.gov/governor/press/press_0515092.html.

In both California and Massachusetts, labor was divided along SEIU versus AFL-CIO interests, as noted above. In California, SEIU supported the final agreement only after the dramatic intervention of SEIU's national President Andy Stern while the state labor federation remained officially neutral but more actively opposed. Similarly, in Massachusetts, SEIU supported reform while the Massachusetts AFL-CIO chapter remained neutral to opposed. Perhaps expressing the concerns of many in organized labor, the chapter argued, "We are particularly concerned about the implementation of the individual mandate contained in the legislation. Our concern is that it will lead to an even more precipitous decline in employer-provided health care."¹⁷

Reports of labor support from Illinois are mixed, with some knowledgeable observers suggesting that support was lukewarm, perhaps owing to the well-reported tensions between the speaker and governor and possibly stemming from perceptions that strong support for the governor would adversely affect other more pressing legislative goals. Pennsylvania unions were, from all reports, strong supporters of the governor's efforts.

To some extent, the conflict within labor may pit ideology (universal coverage) against specific interest group need (what is in it for us?). Coverage expansion proposals that require less of employers may appeal to the ideology, but not to labor organizations whose members are already well-insured via employer-based programs and whose goal is to secure those arrangements into the future.

Clearly, the actual or potential crack in support among most longstanding and politically potent supporters of coverage expansions poses a serious threat to those advocating expansions. It may give rise to conflicts between centrist efforts focused on shared responsibility and interests determined to maintain or expand the current status of employer-based coverage.

Insurers

Insurer positions also vary by state and by business and market strategy. If, however, dissatisfaction in the labor camp poses a major threat to reform advocates, the budding interest in reform among some health plans may offer a major opportunity. Those who rely heavily on underwriting in the small-group and individual markets (mostly for-profits) assume (correctly, we think) that coverage expansion reforms will jeopardize their marketplace share or strategies.¹⁸ These insurers—particularly in Pennsylvania and California—maintained aggressive anti-reform postures.

In several states, however, insurers played significant, supportive roles in furthering reform. Leaders of the Blue Cross Blue Shield Association effectively promoted the final compromise in Massachusetts. The Blues in Pennsylvania also demonstrated considerable support. In California, the state's two largest nonprofit insurers, Kaiser and Blue Shield, and one for-profit, Health Net, all supported the reform cause as did a host of Medicaid plans.

The reasons behind the support may vary. Some may see benefits in the increased revenue from higher numbers of insured individuals, even if the increase comes, as it almost inevitably will, with rigorous regulatory requirements. Other insurers may see reform leading to marketplace advantages. Those less reliant on underwriting may be comfortable with the imposition of restraints on those who depend on it. Perhaps, too, some fear a wave of more plan-hostile proposals lurking in the wake of failed coverage expansion efforts. And, lest we be too cynical regarding health plan support, it is important to note that the CEOs of the three most supportive California plans were longstanding supporters of coverage expansions.¹⁹ Whatever the reasons, if coverage expansions do not threaten the insurance model and control the level of regulation, insurer support might remain unchanged or even grow.²⁰

Physicians

Perhaps surprisingly, reports from most states suggest that physicians have not been particularly prominent on one side or the other of reform. The reasons might be state-specific. In Massachusetts, physician organizations did not object to reform; indeed, the package included Medicaid fee increases. Still, according to reports, physicians did not demonstrate support in any meaningful way. In New York, physicians reportedly have been more concerned with medical malpractice issues, perhaps as a means of justifying worries about payments, and therefore are not critical players in the coverage expansion issue. In Illinois, while the state's medical society officially supports universal coverage, it expressed several concerns about reform proposals, including reimbursement rates and requirements that physicians accept the insurance product offered to the uninsured.²¹ In Pennsylvania, longstanding differences over malpractice have created a cool relationship between physicians and Governor Rendell. Those differences were exacerbated by the governor's eventual decision to use excess funds from an account created to subsidize malpractice insurance as a program revenue source. In California, the state medical association, which wields considerable clout and previously lent strong support to coverage expansions, remained largely neutral and ultimately assumed an opposition position. Views differ as to the cause for the shift in position, ranging from the death of a liberal legislative advocate, to the dominance of the association by specialists who saw more potential pain than gain, to broader fears that new government commitments to the uninsured would foreshadow new government regulations on providers.

However, some associations of primary care physicians have supported reform, perhaps reflecting the elevated position of prevention and primary care that often attaches to coverage expansion proposals. Such was certainly the case in Illinois and California; in the latter case, support

Pennsylvania

Governor Edward Rendell (D) began developing a plan to expand health care coverage in December 2005. In an effort build consensus around a reform, the administration invited representatives from health care stakeholder groups and legislators from each caucus to serve on committees which advised the governor's staff on health care issues. These committees made recommendations regarding quality, cost containment, public financing, and small employer concerns, which were integrated in to a comprehensive plan called *Prescription for Pennsylvania*. Governor Rendell unveiled the health reform package January 2007.^a

The *Prescription for Pennsylvania* is comprised of initiatives targeting quality, affordability, accessibility, and cost of the state's health care system. To expand coverage to uninsured adults Governor Rendell proposed the creation of a new regulated insurance product for the uninsured, and the implementation of new regulations in the small group and individual health insurance markets. The governor proposed to scrap adultBasic, the existing state-run program providing coverage to low-income adults, which serves 52,000 individuals and maintains a waitlist of 96,000. In its place the plan proposed a better-funded public-private partnership which would expand coverage through a new insurance product called *Cover All Pennsylvanians* (CAP). Under the governor's proposal, the state would contract with private companies to provide CAP enrollees with a defined benefit package. Premiums would be subsidized for those with household incomes below 300 percent FPL. Additionally, the health care reform package sought to increase access to coverage through the introduction of guaranteed issue, underwriting reform, and an 85 percent minimum medical loss ratio in the small group and individual health insurance market.^b

While Governor Rendell was able to find support for several of his health system improvement and cost containment initiatives, he has not been able to persuade the legislature to pass his coverage expansion agenda.^c The most significant obstacle to passage of the governor's CAP program has been funding. Early financing strategies relied, in part, on a 3 percent payroll tax for which Governor Rendell failed to win support even among many Democrat legislators. As 2007 drew to a close, the governor proposed an alternative funding mechanism that included an increased cigarette tax, new taxes on cigars and smokeless tobacco, and use of surplus funds in the Health Provider Retention Account.^d In an effort to pressure opponents to support the proposal, Governor Rendell refused to renew medical malpractice insurance subsidies for physicians in the state until the legislature passed his coverage expansion.

In March 2008, the Democrat-controlled House of Representatives passed bills to create a program very similar to Rendell's CAP plan, known as Pennsylvania Access to Basic Care (PA ABC).^e The House PA ABC program had more restrictive eligibility requirements and a greater degree of cost sharing than the governor's CAP proposal. In April 2008, the House also passed a bill which would impose the governor's proposed minimum medical loss ratio requirement and underwriting reforms in the small group and individual insurance markets.^f However, Pennsylvania's Republican-controlled Senate did not bring either bill to a vote, and there has been no further significant action on comprehensive coverage expansions.

a Fahy, J. "Rendell plan would widen health insurance." *Pittsburgh Post-Gazette*, December 18, 2006.

b For more see Governor's Prescription for Pennsylvania Web site at www.rxforpa.com, and FamiliesUSA. 2007. "Pennsylvania's 2007 Health Care Proposal: Prescription for Pennsylvania." Available online at www.familiesusa.org/assets/pdfs/state-expansion-pa.pdf.

c Commonwealth of Pennsylvania. 2007. "First pieces of Governor Rendell's 'Prescription for Pennsylvania' signed into law." Press Release, July 20. Available online at www.state.pa.us/papower/cwp/view.asp?A=11&Q=465657.

d The Health Care Provider Retention Account is state fund that funded by a \$0.25 cigarette tax that has been used to subsidize malpractice insurance for physicians in Pennsylvania

e Fahy, J., "House OKs health care, bill, but fat in the Senate is in doubt." *Pittsburgh Post-Gazette*, March 18, 2008.

f Fahy, J., "House OKs limits on health insurance" *Pittsburgh Post-Gazette*, April 2, 2008.

also came from the association of large medical groups that support California's medical group delivery model.²² To date, however, few of the supportive physician organizations have wielded much political clout.

Hospitals

Hospitals rank as central institutions in their communities and sometimes in a state's business community, as is most evident in Massachusetts and perhaps to a lesser degree in New York. In both states, hospital associations, dominated by prominent academic institutions, were or will be central players in coverage expansion efforts. Accounts from Massachusetts all point to the pivotal roles played by Jack Connors and Dr. James Mongan of Partners Healthcare in brokering the Massachusetts compromise.²³ Their involvement highlighted the unique leadership of the Boston hospital community within the business community, with Dr. Mongan also serving as chair of the Greater Boston Chamber of Commerce.²⁴ In addition, in both Massachusetts and New York, stringent regulation and critical relationships between hospitals and government programs, including Medicare, render hospitals particularly connected to and comfortable with the policymaking process.

In New York, that connection may be further fortified by historically close relationships between the New York City area's hospital association and SEIU, the dominant union for health workers in a state in which health represents a large portion of union members. In other states, hospital associations generally supported coverage expansions and lent tacit endorsement of associated employer requirements. Still, hospital associations, while potentially influential, represent different categories of hospitals, each with unique goals and needs. For example, safety net hospitals, long the champion of the uninsured, may experience conflicts with reform goals. As the number of uninsured declines, these hospitals may be pressed to release resources. Such takeaways never come easy, even for those who favor the ultimate goal. For- and not-for-profit

hospitals, rural and urban hospitals, chain and stand-alone hospitals may also have competing views and needs. The result of such internal diversity is usually moderation and caution, and sometimes stalemate.

Tensions can also emerge between cost control and hospital goals. As is likely the case with physicians and health plans, hospital support for reform may depend on perceptions of an expanding rather than contracting pie.

Political Leadership

In her 1998 review of lessons learned from reasonably successful state coverage expansion efforts, Pamela Paul-Shaheen emphasized the critical need for the entrepreneurial leadership of individuals with "vision, pragmatism, and dedication to guide the way."²⁵ In our review, we found some support for that conclusion, although the definition of effective or successful leadership may largely be a matter of perception. There is little question, for example, that in the Massachusetts case the aforementioned hospital leaders provided visionary and pragmatic leadership. At the other extreme, many believed that Illinois Governor Blagojevich failed on measures of pragmatism and coalition building with legislators and interest groups. In California and Pennsylvania, the verdicts are more controversial. Here we offer a few of the more striking findings.

Clearly, leadership matters. In every state, the political and policy choices made by key individuals were critical in determining outcomes. Governor Schwarzenegger, for example, is credited with, among other things, placing health reform on the state agenda and generating some business support. At the same time, he earned low grades for allowing his relationships with Republicans to deteriorate and then recognizing too late that he could secure no Republican votes. Illinois Governor Blagojevich is widely criticized for proposing a highly unpopular gross receipts tax from which his reform goals never recovered.

Policymaker relationships also matter. In at least three of the five states reviewed tensions between political leadership went well beyond normal political or policy bounds and, in at least two of the five (Illinois and California), it may have had significant impacts on reform outcomes. Antagonism between Governor Blagojevich and House Speaker Michael Madigan was widely reported, and tensions between Democratic legislative leaders in California also produced major complications and breakdowns in communication. In New York, relations between Governor Spitzer and state Senate leadership were marked by considerable and public discord. By contrast, several participants in the Massachusetts reform effort suggest that success there resulted, in part at least, from productive and cordial long-term relationships—some dating back 20 years—that kept all at the table and allowed major players representing hospitals, insurers, the business community, and consumers to bridge differences. Interestingly, in every state, at least one source suggested that the governors failed to pay sufficient attention to legislators and legislative views. Preparation also matters. Virtually all governors received high marks for establishing the public and/or private processes outlined above. Indeed, as suggested by Paul-Shaheen, the emergence of a highly skilled and knowledgeable staffing base drew heavily, in several cases, on nationally recognized expertise and may be a good indicator of states' capacity to address the technical challenges of reform.

Finally, at least in this round of reform, leaders emerged from the executive branch. Governor Romney, according to several informants, was not highly engaged in much of his state's legislative effort but, like the other governors in question, was primarily responsible for placing the reform issue on the state agenda and reportedly played a significant role with state and federal leaders in leveraging the ultimate agreement.²⁶ Other governors played more fully engaged roles in the legislative process and were directly engaged in efforts to broaden and sustain interest group coalitions.

All told, the role of leadership was considerably greater than what is left after assessing policy analysis, stakeholder views, and other matters. There should be no doubt that, in some circumstances, leadership advanced reform efforts; in other circumstances, the failure of leadership resulted in adverse outcomes.

Conclusion: Limits, Prospects, and Opportunities

It would be inappropriate to draw firm conclusions from a study of five states. Despite some common ground and experiences, each state largely tells a unique story. Consequently, policy implications must be limited to judgments regarding pivotal experiences in one or more states or subjective assessments based on overall trends or circumstances.

The effort to draw lessons for future state reform efforts must start with a perhaps discouraging assessment: Massachusetts was more the exception than the rule. Massachusetts brought to the reform effort a wealth of advantages relative to other states. Most important, it faced a policy imperative: shift funds in its uncompensated care pool to a coverage model or lose \$1.2 billion in federal funding over three years. For many stakeholders, that imperative was a powerful incentive.²⁷

In addition, Massachusetts had a low percentage of uninsured individuals (10 percent) relative to the nation as a whole (16 percent); a low percentage of low-income, uninsured individuals (7.4 percent compared to 12.8 percent for the nation); a high average per capita income; and a particularly high percentage of insuring employers.²⁸ Its policymaking community was marked by long-established connections and networks. In short, it had a relatively small problem, much of the money needed to address it, an existing network of stakeholder leaders interested in finding a solution, and a joint financial imperative. No other state reviewed in this paper and few states nationwide have had anywhere near those advantages. The only liability faced by Massachusetts in terms

of coverage expansions was its relatively high premiums. Still, according to all reports, the reform effort almost failed and still faces critical funding challenges.

On the other hand, a review of the experiences of the five states might lead to the conclusion that significant state-based expansions of coverage are possible. Massachusetts succeeded, and California came reasonably close. Pennsylvania and Illinois—while failing to achieve major breakthroughs—have achieved some success in the recent past. New York certainly has the economic and political potential to make progress as evidenced by its willingness to fund SCHIP expansions to 400 percent FPL with state dollars.

Indeed, given a healthier economic climate, a difference in super-majority vote rules, a few changes in political or policy circumstances or decision making, and somewhat more support among a few key interests, all five states might have achieved or could achieve reform in the short term.

Still, little in the states' efforts suggests that a large number of states will achieve and sustain anything close to universal coverage under current circumstances. Moreover, even in states that might achieve progress, rising health care costs or economic downturns will leave state programs in continual jeopardy. Finally, the states reviewed here may be among those with the greatest economic and political capacity to realize success.

Many have asserted that limited chances of success are linked to a lack of political will. At some level, of course, that assertion is true. Given a different set of values and perhaps fewer procedural barriers to political change, coverage expansions might be achievable, via state-based or national reforms. But given relentless increases in health care costs and premiums, the amount of political will now required (at least in terms of the willingness to raise and invest financial resources) is far greater than what might have been the case just five or ten years ago. At the same time, it is possible that growing costs will change the political

calculus as more and more middle-class Americans feel the impact of rising costs through lost wages, rising premiums, and unaffordable deductibles and co-payments.

In any case, it is not at all clear that we will see an emergence of greater levels of political will. Especially if labor organizations retreat on shared responsibility-type reform, the reform movement could lack major stakeholder champions. In this respect, the political challenge for reform might lie not in the strength of the opposition but rather in the weakness of support. Without vigorous support from labor or major sectors of the provider community, it is hard to see how the reform side will generate needed political muscle.

Unquestionably, the greatest impediment to successful state reform efforts is the challenge of securing revenue sources and controlling cost growth. To their credit, most governors highlighted the need for restraining cost growth, but substantial success on the cost front remains elusive. Moreover, required cost control may conflict with the need to strengthen the reform coalition. The most important and most potent possible addition to that coalition is almost certainly the provider community. But providers are far more likely to endorse proposals that promise increases, not decreases, in health care spending. Interestingly, many involved in the Massachusetts reform note that success resulted, in part, from the decision to address access expansions first and cost control later.

Layered atop the economic and financing realities are the several political and policy challenges of coverage expansions. Republican opposition remains solid. As one veteran of the California effort stated, "You can forget everything else; we lost because no Republicans would vote for it." And while public opinion may generally favor coverage expansions, it may not demand them. Calls for change tend to decline in the face of payment mechanisms or uncertainty.²⁹

In addition, the creation of a winning policy compromise remains elusive and perhaps lacks support. When judged against

stakeholder and policymaker perspectives and needs, shared responsibility's three main revenue pillars—employer requirements, an individual mandate, and (probably increased) government contributions—all face considerable resistance. The individual mandate, the preferred approach among many in policy circles, faces strong opposition from many quarters. Opponents raise legitimate concerns about affordability and limited capacity of an individual mandate to reduce government's subsidy burden. As for employer requirements, there is little evidence that reform proponents are in position to enact requirements anywhere near what employers already contribute. Finally, given difficult economic times and strait-jacketed state budgets, it is unlikely that states will discover new revenues or reallocate increased shares of existing revenues. Without major federal intervention, then, state reformers may need to focus on preservation of what exists rather than on hopes of what should be.

Moreover, the shared responsibility approach may suffer from the liabilities of many centrist or compromise solutions. Moderation may draw support, but it loses energy which is usually found more toward the ends, rather than the middle, of the political spectrum. To increase that required political energy, shared responsibility advocates may need to guarantee more shared gain and less shared pain. From the perspective of national universal coverage, then, the stark reality is that even if some states achieve substantial progress, imagining anything close to a fifty-state movement, requires a truly optimistic leap.

Opportunities and Strategies for the Future

The foregoing analysis paints a somewhat bleak picture for state coverage expansions, at least in the short term. Even in a positive economic climate, the financing, policy and political challenges are substantial. In the current economic downturn, most states will be extremely hard-pressed to fund significant reform expansions, even with increased federal assistance. While some opportunities to build broader support coalitions have

emerged, multiple key stakeholders are likely to remain wary of major change, and will maintain the political and legislative tools to resist, or at least limit the scope, of reform options. Prospects for significant cost control remain elusive and fraught with political and policy challenges.

However, the reform landscape is not without some opportunities and strategic options for a more favorable scenario, especially at the federal level.

The most compelling opportunity, one of those factors noted by Paul-Shaheen as associated with reform success,³⁰ comes with the potential for strong national leadership in the White House. Clearly, President Obama and Democratic Congressional leaders have an opportunity to harness the current economic crisis and growing public uncertainty into a compelling case for reform. Such a case entails both cost and access components. The cost component, front and center in the new President's analysis, emphasizes the connection between the nation's economic health and reform, including cost control, of the health care system. The access component—part of, but less visible in, Obama's analysis—could build on growing middle class concerns relating to rising costs and the potential loss of insurance. As Jacob Hacker has opined in outlining reform strategies, "Don't forget fear."³¹

The emergence of opportunity at the federal level will further blur an already hazy distinction between federal and state leadership in health reform. It is easy to envision various blends of state and federal responsibility. Reform might, as outlined by many policy analysts, take the form of federal financial support and maximum state flexibility regarding paths to coverage expansion.³² We can also foresee reform based on the building blocks of Medicaid, CHIP, and Medicare. Whatever the federalism blend, state reform will be federal reform and vice versa. Almost all the proposals currently before policymakers include some blend of increased federal financing for improved access to insurance (almost certainly accompanied by the imposition of additional federal

requirements) and regulation by the states. What almost certainly will be required in the mix, as Alan Weil wisely suggests, is a national strategy, not just national funding, for coverage expansions.³³ "It is one thing," Weil concludes, "to provide states with a constrained set of policy tools and financial resources with the hope that states can develop and enact universal coverage proposals... It is something else to adopt a coherent national strategy."³⁴

State and federal reform must also address the compelling need for cost control, a task in which state may be partners but which will require federal leadership. The president and Congress could borrow a page from recent state experiences that have taught that reform takes time. Responsible delivery system reforms are unlikely to fund the early years of a coverage expansion, but they could generate significant long-term savings and help to maintain a stakeholder coalition for reform. Bipartisan political leadership from committed governors such as Rendell and Schwarzenegger might also prove effective.

Whether cost containment efforts take place on the federal or state level, policymakers could work to ensure that those asked to increase financial commitments can be offered some guarantee that their commitments will not be open-ended. Such mechanisms may not only allay some stakeholders' fears but may also intensify the pressure on government to restrain cost growth.

On the stakeholder front, reform advocates—state and federal—need to review various means of securing broader support. The first challenge may lie in securing the traditional labor and consumer group bases, and maintaining that support as inevitable centrist demands require compromise with long-held objectives. Reform advocates will also need to turn principled support of some health plans and of some hospital and physician groups into active support for specific reforms. Here it is important to note that the price of that support is likely to be higher program expenditures, modest levels of delivery system change, and limited cost containment.

If larger associations appear resistant, reform advocates and political leaders must seek the support of, and offer visibility to, subgroups of the health care sector, e.g., primary care physicians, that may see benefit in coverage expansions and have less fear of negative economic consequences. The same logic applies to the business community.

At the policy level, history suggests caution regarding the capacity of any set of policies to solidify a formidable reform coalition. At the core of the challenge is the wariness of various entities regarding financing options and the impact of reform on stakeholders' bottom lines. But the shared responsibility construct may offer some opportunity. In some states and at

the federal level, increased commitments from some employers might be achievable, along with some movement toward more individual responsibility. Indeed, movement toward mandating employer and individual responsibility may be linked. Stakeholder groups favoring each approach might be willing to offer more as they see the other side's players doing the same. On the individual responsibility side, Obama's concept (advocated during the campaign) of a requirement on parents to insure children might be an effective starting point.

Finally, there is the matter of ERISA. It is all too obvious that, especially if states are expected to take the lead, Congress needs to amend ERISA to clarify, at a minimum,

what states may and may not do. State advocates would prefer maximum freedom from ERISA, but clarification of what is permissible or what is a safe harbor would prove helpful.

This outline of needs and options may not differ substantially from many now on political or policy tables. Admittedly, we offer no policy panacea. Perhaps that is the point. In recent years, centrist strategies have been ascendant. Those strategies may depend less on the pursuit of ideological or even strong policy preferences than on effective analyses of what combination of timing, policies, leadership strategies, processes, and stakeholder needs might create new political opportunity. ■

Appendix 1: Comparison of coverage and demographic factors of states included in analysis ^{35, 36, 37, 38}

State	Executive and Legislative Control	Population	Number of Uninsured	Number Insured through Employer	Number Insured through Medicaid	Number Insured through Individual Coverage
California	Governor: Arnold Schwarzenegger (R) House: Democrat (48 -32) Senate: Democrat (25-15)	36.5 Million	6.8 Million (19%)	17.5 Million (49%)	3.2 Million (9%)	2.5 Million (7%)
Illinois	Governor: Rod Blagojevich (D) House: Democrat (67-51) Senate: Democrat (37-22)	12.8 Million	1.8 Million (14%)	7.4 Million (59%)	1.5 Million (12%)	520,000 (4%)
Massachusetts	Governor: Deval Patrick (D) 2007 – Mitt Romney (R) 2003 – 2007 House: Democrat (141-19) Senate: Democrat (35-5)	6.4 Million	620,000 (10%)	3.8 Million (60%)	770,000 (12%)	270,000 (4%)
New York	Governor: David Patterson (D) 2008 – Eliot Spitzer (D) 2007 – 2008 House: Republican(32-20) Senate: Democrat (108-42)	19.3 Million	2.6 Million (14%)	10.0 Million (52%)	2.2 Million (12%)	750,000 (4%)
Pennsylvania	Governor: Edward Rendell (D) House: Democrat(102-101) Senate: Republican (29-21)	12.4 Million	1.2 Million (10%)	7.2 Million (58%)	1.8 Million (15%)	680,000 (6%)

State	Median Household Income	Percentage of Population below FPL	DSH Dollars Allotted to State for 2008 Fiscal Year	DSH Dollars per Uninsured Resident	Number Insured through Medicaid
California	\$49,894	13.2%	\$1,032 Million	\$151.76	3.2 Million (9%)
Illinois	\$47,711	11.9%	\$202 Million	\$112.51	1.5 Million (12%)
Massachusetts	\$44,334	9.9%	\$287 Million	\$462.90	770,000 (12%)
New York	\$53,657	14.5%	\$1,513 Million	\$581.92	2.2 Million (12%)
Pennsylvania	\$43,714	11.2%	\$529 Million	\$440.82	1.8 Million (15%)

Endnotes

- 1 Zelman, W. "Swimming Upstream: The Hard Politics of Health Reform in California." State Coverage Initiatives, AcademyHealth, June 2009.
- 2 A draft version of this paper was discussed at a meeting of health policy experts convened by the Commonwealth Fund and AcademyHealth on May 19, 2008. The author is grateful for input provided by all involved.
- 3 For an analysis of ERISA and 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. For discussion of the need for safe harbors, see also Weil, A., "How Far Can States Take Health Reform," *Health Affairs*, Volume 27: 3 (2008), 736-747.
- 4 Butler. See also McDonough, J. E., et al, "A Progress Report on State Health Access Reform," *Health Affairs*, Web Exclusive, January 29, 2008.
- 5 McDonough. See also Weil.
- 6 Interview with Kenneth Thorpe, April 18, 2008.
- 7 See, for example, Wielawski, Irene M., "Forging Consensus: The Path to Health Reform in Massachusetts," Blue Cross Blue Shield of Massachusetts Foundation, July 2007.
- 8 Dubay, Lisa, Moylan, Christina, and Oliver, Thomas R., "Advancing toward Universal Coverage: Are States Able to Take the Lead," *Journal of Health Care Law and Policy*, Volume 7:1 (2004), 1-41.
- 9 See Skocpol, T., and P.S. Keenan, "Cross Pressures: The Contemporary Politics of Health Reform," in D. Mechanic, L. B. Rogut, and D.C. Colby, eds., *Policy Challenges in Modern Health Care*, New Brunswick, NJ: Rutgers University Press, 2006.
- 10 The most obvious example here was the California Nurses Association. It continued to advocate aggressively for the single-payer cause and opposed other reform proposals.
- 11 Estimates of percentage of payroll paid by employers vary considerably. Most estimates range from 10 to 12 percent or close to three times what governors were proposing in the states reviewed here.
- 12 Kaiser Health Tracking Poll: Election 2008 (conducted February 7–16, 2008), Kaiser Family Foundation Health Poll Report, Issue Six, March, 2008.
- 13 McDonough et al.
- 14 McDonough et al.
- 15 Legislation (SB 2) enacting an employer requirement was approved the California legislature in 2003 but overturned in a public referendum in November 2003.
- 16 These included the Greater Los Angeles Chamber of Commerce and the California Retailers Association.
- 17 Little, T. H., "Building a Consensus for Health Care Reform in Massachusetts: Policymakers and the Hero Opportunity in the Bay State." State Legislative Leaders Foundation, 2007.
- 18 Most insurers assume that reform will be accompanied by guarantee issue, community rating-type reforms that reduce or eliminate the freedom to underwrite in the individual market.
- 19 George Halverson of Kaiser, Bruce Bodaken of Blue Shield, and Jay Gellert of Health Net.
- 20 Bodaken, B.G., "Where Does the Insurance Industry Stand on Health Reform Today?" *Health Affairs*, Volume 27: 3 (2008), 667-674.
- 21 "Illinois State Medical Society Affirms Support of Universal Access to Insurance Coverage; Voices Concern Regarding Illinois Covered Plan as Currently Written," Illinois State Medical Society press release, April 25, 2007.
- 22 Senate Health Committee Analysis of Assembly Bill X1 1, California State Legislature, January 23, 2008.
- 23 Wielawski.
- 24 Rowland, C. , "Health Executives Emerge as State's New Power Brokers," *Boston Globe*, March 13, 2006.
- 25 Paul-Shaheen, A. Pamela, "The States and Health Reform: The Road Traveled and Lessons Learned from Seven Who Took the Lead," *Journal of Health Politics, Policy, and Law*, Volume 23: 2 (1998), 319-361.
- 26 Little.
- 27 Wielawski; Rowland.
- 28 Harbage, P., et al, "Lessons from California's Health Reform Efforts for the National Debate," New America Foundation, March 2008. "Statefacts.org," 2006 estimates, Kaiser Family Foundation. See also by Curtis R., and E. Neuschler, "Affording Shared Responsibility for Universal Coverage: Insights from California," *Health Affairs*, Web Exclusive, Volume 28: 3 (2009), 417-430.
- 29 See, for example, ABC News/Kaiser Family Foundation, *USA Today* "Health in America Survey," conducted September 7–12, 2006. In this poll, support for universal health insurance similar to Medicare dropped from 56 to 35 percent when respondents were told that they would have to pay higher taxes or premiums.
- 30 Paul-Shaheen.
- 31 Hacker, J. S., "Putting Politics First," *Health Affairs*, Volume 27: 3 (2008), 718-723.
- 32 See, for example, Oberlander, J., and T.R. Marmor, "The Path to Universal Health Care," in *The Next Agenda: A Blueprint for the New Progressive Movement*, Robert L. Borosage, and Roger Hickey, eds., Westview Press, 2001. See also Dubay, et al.
- 33 Weil.
- 34 Weil.
- 35 United States Census Bureau, 2006 estimates.
- 36 Kaiser Family Foundation, statefacts.org, 2006 estimates.
- 37 United States Census Bureau, 2004 estimates.
- 38 Calculated using FY 2008 DSH allotment (from Kaiser Family Foundation) and 2006 Census estimate of number of uninsured.