

## **Lessons Learned from Health Care Reform Efforts in California**

### **BACKGROUND**

Health care reform was put into a legislative bill that would provide coverage for 3.7 million of California's 6.6 million uninsured residents, increase Medi-Cal payments to hospitals to the maximum amount allowed under federal law, establish market reforms, require transparency from providers and payers, prohibit balance billing for emergency services in non-contract situations, promote wellness and prevention, and require employers and individuals to pay fees to the state if they failed to comply with their respective coverage mandates.

Primary financing would come from a four percent tax on hospitals' net revenues, \$.75 tax on each pack of cigarettes, premiums from employers and individuals, federal matching funds and minor support from the state.

The tax on hospitals would benefit only hospitals, paying the state share for federal Medicaid matching funds, and also paying for the hospital portion of premiums for the newly insured Californians.

Permanent protections for hospitals would have been assured through a ballot initiative, preserving Medi-Cal payments to hospitals at the highest level allowed under federal law. Failure of the initiative by the voters would have made the state legislation null and void.

The bill passed the Assembly on a party line vote but was killed in the Senate Health Committee. All Republicans voted Nay, one Democrat voted Aye and the remaining Democrats abstained or voted Nay.

### **LESSONS LEARNED**

#### **I. External Environment**

1. The age-old axiom was reaffirmed yet again – “Politics trump policy almost all of the time.”
2. Special interests will go to extraordinary means to defeat a measure that they perceive is a core threat to their financial or business goals (tobacco, one payer, etc.).
3. The business community stands firm on principles and perceived detrimental impacts on employers.
4. Organized labor was split. Some unions saw it as a step to single payer and were willing to wink at their long standing policy position, hoping to parlay it into a single payer plan in the future.

5. Money talks. Opponents channeled hundreds of thousands of dollars to key elected officials and their political committees, personal causes, foundations and advertising. Additionally, the cost of the plan and projected deficits, combined with economic hard times, put health care reform under a dark cloud (the devil they know is better than the unknown).
6. Political leaders are key. Personal and political conflicts among leaders are difficult to overcome.
7. Underfunding is no longer a shell game in the legislative/public arena. Research and facts compiled by objective, independent organizations and the non-partisan Legislative Analyst demonstrated that the proposal was underfunded by at least \$300 million annually, with the deficit increasing in the out years.
8. Media counts. Many printed and electronic media outlets supported the goal but questioned details of the plan. Public opinion moved from overwhelming support to less than majority support.
9. A house of straw that is built on sand cannot withstand continuing assaults from multiple directions and sources. The proposal had conceptual weaknesses and practical holes. Some financing assumptions were flawed. Data was extrapolated in questionable ways. The result was skepticism, a perception on which the opponents capitalized.
10. One superstar cannot overcome the forces of multiple self-interests, political and public division/opposition, underfunding in overt and covert ways, and political ideology. The Governor, who has star power seldom held by an elected official, could not bring opposing factions together.

## II. Internal Considerations

1. Hospitals that are threatened will go to extraordinary means to improve their financial position.
2. Ideas that are created during crisis take on an independent life of their own (for example, hospital tax).
3. External circumstances can create internal conflicts when external problems are owned by internal members.
4. Leadership and unity are critical.
5. Transparency, participation and consensus are essential.

## III. Implications and Conclusions

1. "Health Care Reform" means something different to each stakeholder.
2. Broad societal conditions, politics and issues overshadow controversial narrow priorities.
3. Major efforts that are unsuccessful lead to incrementalism.
4. Wild cards can reverse policy directions, especially if politically charged.
5. Being "at the ready" with principles, policy, proposal(s) and compromises is fundamental to success.

IV. Essential Factors for National or State Health Care Reform

1. Absence of more compelling, conflicting or competing issues (social, economic, domestic/foreign policy, etc.).
2. Alienation of voters/insured population from their health care coverage and services.
3. Political consensus on source and magnitude of the problem and solution, including financing.
4. Acceptance of solution by major stakeholders.
5. Leadership (political, major stakeholder, etc.).
6. Wild card – Leadership of President and compromise in U.S. Senate.

V. Related Issues

1. Cost containment
2. Social goals and access
3. System dysfunction
4. Special interests
5. Threats to status quo

VI. Putting the Pieces Together

1. Coverage and financing options
2. Benefit design
3. Alignment of incentives (hospitals, physicians, payers, patients)
4. Reducing fragmentation and siloism
5. Shared responsibility
6. Transparency
7. Administrative simplification
8. Wellness, prevention, chronic care and end of life care