



MARCH 2009

**NATIONAL HEALTH INSURANCE —  
A BRIEF HISTORY OF REFORM EFFORTS IN THE U.S.**

**Introduction**

Many believe the United States is on the brink of national health reform. Health care costs seem uncontrollable while 46 million Americans remain uninsured. Millions more are under-insured -- and even more worry that they are under-insured. The quality of health care is in question as more come to realize that the U.S. does not lead the world in the health of its people. These problems resonated during the 2008 presidential campaign where health reform held its own among the top issues, even after the economic crisis began to overshadow the election. Health care and its costs were seen as a large part of Americans' pocketbook concerns. And now a White House Office on Health Reform is being newly established, while seasoned Members of Congress are readying proposals of their own.

The country has been on the verge of national health reform many times before however. In the early 1900s, smaller proposals began to pave the way. In 1912, Theodore Roosevelt's Bull Moose party campaigned on a platform calling for health insurance for industry; and as early as 1915, Progressive reformers ineffectively campaigned in eight states for a state-based system of compulsory health insurance. The prominent reformers of the 1920s, the Committee on the Costs of Medical Care, proposed group medicine and voluntary insurance—modest ideas, but enough to raise opposition, and the term "socialized medicine" was born.

Over the years the American public, as measured in opinion polls as far back as the 1930s, has generally been supportive of the goals of guaranteed access to health care and health insurance for all, as well as a government role in health financing. However, support typically tapered off when reforms were conditioned on individuals needing to contribute more to the costs. While the general public may largely support reforming the health system, no particular approach towards achieving it rises above another in polls—perhaps not surprising given how complicated, yet personal, health care policy is.

Historians debate the many reasons why National health insurance (NHI) proposals have failed, including the complexity of the issues, ideological differences, the lobbying strength of special interest groups, a weakened Presidency, and the decentralization of Congressional power. While short of NHI, major health reforms have been enacted in the past fifty years that have proved to be broadly popular and effective in improving access to health care for millions through Medicare, Medicaid and the Children's Health Insurance Program. Important lessons can be gleaned from how these major reforms were accomplished, as well as the attempts to achieve NHI—lessons that may lead to new health reform paths while steering us away from previous mistakes.

As the nation prepares for the next opportunity, this issue brief highlights the major national health reform efforts that were undertaken in the 1900s. It describes the economic and political context in which each reform was forwarded and the key reasons it failed to achieve universal coverage.

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<b>1934-1939</b>	<b>NHI and the New Deal</b>
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## 1934-1939: NHI AND THE NEW DEAL

### **The Economy**

The Great Depression (1929-1939) had been preceded by a period of growing income inequality and a shrinking middle class. The worst years were 1933-34 with unemployment as high as 25 percent. Income disparities in access to health care had grown much worse, medical costs were rising, and sickness became a leading cause of poverty. More physician and hospital care went unpaid and welfare agencies began to help pay for medical costs for the poor.

### **Origin of Health Reform**

Citizen groups were organizing—workers and the unemployed, veterans, the elderly, and others—calling for government relief, including government-sponsored health protection. However unemployment, not NHI, was their top priority. In his first term, President Roosevelt appointed a Committee on Economic Security which was to report with a program that addressed old-age and unemployment issues, as well as medical care and health insurance (1934). This committee worked in private, without soliciting public input, and recognized from the start that NHI was of lower priority than a retirement benefit and unemployment insurance. While NHI made it into a preliminary report, it was left out of the final Social Security bill. After the Social Security Act was passed however, a second group of federal agency representatives was convened in 1937 (the Technical Committee on Medical Care) to advance health reform again.

### **Elements of Reform**

Both committees called for a state-run system with compulsory health insurance for state residents, but states could choose whether to participate. The federal government was to provide some subsidies and set state minimum standards. There were other goals put forth by the committees as well, including expanding hospitals, public health, and maternal and child services. Recognizing strong opposition from the AMA, the Committees' principles made many assurances that the medical profession would maintain control over the practice of medicine.

## **1934-1939: NHI AND THE NEW DEAL**

### **Congressional Environment**

Large Democratic majorities existed in both the House and Senate. However, worried that major health reform would defeat the entire Social Security proposal and believing NHI might be forwarded later, Roosevelt did not include major health reform in his proposal. The Social Security Act was introduced and passed in both houses with a wide margin in 1935. The second push for NHI, coming from the Technical Committee on Medical Care and momentum from a National Health Conference held in the summer of 1938, also failed. By 1938, southern Democrats aligned with Republicans to oppose government expansion, in part to protect segregation, making additional New Deal social reforms nearly impossible to pass.

### **Opposition**

An increasingly powerful AMA opposed NHI efforts believing physicians would lose their autonomy, be required to work in group practice models and be paid by salary or capitated methods. In addition, business and labor groups were not supportive, nor was the emerging private health insurance industry.

### **Health Reform's Defeat**

Recommendations from the Committee on Economic Security on health insurance to the President were never made public, fearing its opposition would weaken the Social Security bill. While NHI was not included in the Social Security Act, it did however provide matching funds to states for expanded public health and maternal and child health services. Roosevelt believed NHI could be achieved after the Social Security Act passed however. Following the National Health Conference, President Roosevelt wanted to make NHI an issue in future elections, but failed to do so in either 1938 or 1940. By 1938, Congress was no longer supportive of further government expansion.

## 1945-1950: NHI AND THE FAIR DEAL

### **The Economy**

During World War II, the War Labor Board ruled in 1943 that certain work benefits, including health insurance coverage, should be excluded from the period's wage and price controls. Using generous health benefits then to draw workers, employers began to bolster group health insurance plans.<sup>1</sup> The economy expanded greatly following WW II, building and responding to the needs of growing families, in an era when American capitalism flourished. Large American businesses (e.g., U.S. Steel, GM, AT&T) faced little competition and were sufficiently profitable that unions could successfully negotiate for greater fringe benefits, including health insurance.

### **Origin of Health Reform**

Roosevelt had indicated he wanted to press for health insurance once the war was over, as part of an economic bill of rights. Three months after World War II ended, President Truman picked up the mantle, calling upon Congress to pass a national program to ensure the right to medical care, part of his "Fair Deal" agenda.

### **Elements of Reform**

Reformers had shifted away from a state-administered system and were proposing that health insurance be national, universal, comprehensive, and run as part of Social Security. These elements were built into earlier Senate legislation (the Wagner-Murray-Dingell bill of 1943), and became the major NHI legislation of the Truman era. Truman's own plan proposed a single insurance system that would cover all Americans with public subsidies to pay for the poor. Medical services were to be unchanged, with doctors and hospitals allowed to choose their payment method. Truman also prioritized hospital construction and expansion which Congress actually did pass in separate legislation in 1946 (the Hill-Burton Act).

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## 1945-1950: NHI AND THE FAIR DEAL

### Congressional Environment

Challenged by the transition from a war-time economy, Truman lost the public's confidence. The Republicans gained the majority in both houses of Congress in 1946, creating the perception that the President was a lame duck. Truman then campaigned in 1948 promising to extend the New Deal and targeted the Republican Congress for opposing NHI. Not only did Truman win the election with a mandate from the people for NHI, but Congress also swung back to a Democratic majority. It was not enough, however. Southern Democrats in key leadership positions blocked Truman's initiatives, partly in fear that federal involvement in health care might lead to federal action against segregation at a time when hospitals were still separating patients by race.

### Support/Opposition

Labor unions were somewhat split on government-sponsored insurance. The AFL-CIO and United Auto Workers backed Truman's NHI proposal, but at the same time, the UAW accepted General Motors' offer to pay for health benefits and pensions. As workers gained better benefits from their employers, unions believed they could negotiate even more in the future.

The AMA vigorously opposed the Truman plan, ramping up its public campaign and lobbying after Truman was re-elected—using the fear message of “socialized medicine.” Following the AMA's campaign, and as anticommunist sentiment rose, public support for NHI dropped markedly in 1949. Other groups only supported voluntary and private insurance, including the American Hospital Association, American Bar Association, Chamber of Commerce and the National Grange, as well as most of the nation's press.

### Health Reform's Defeat

Opponents were effective in eroding public support using the fear of government control and socialism at a time when communism was growing in Germany and China in the late 1940s. Meanwhile, businesses along with labor unions were growing the private, employer-based health insurance plans we have today. While Democrats held the majority in Congress in 1950, Republicans made enough gains to prevent progress on NHI.

## **1960 – 1965: THE GREAT SOCIETY – MEDICARE AND MEDICAID**

### **The Economy**

Productivity swelled in the 1960s as did the middle class, with a well-educated workforce financed by the G.I. bill and following the peak of labor union membership in the 1950s. President Kennedy sought to accelerate economic growth through increased government spending and decreased taxes. From this base, Johnson began to build a "Great Society".

### **Origin of Health Reform**

The failure of universal health insurance in the early 1950s as employer-based coverage was growing tempered health reformists. However, as private plans increasingly began to use "experience rating" to set health premiums, those who were retired and sicker found it harder to get affordable coverage. While Eisenhower proposed measures to reinsure private insurance companies and then later, permit small companies to pool their resources to expand coverage, the elderly and poor became the focus for health reformers. Congress passed the Kerr-Mills Act in 1960, giving states federal grants to cover health care for the elderly poor. But this proved ineffective when by 1963, only 28 states chose to participate and many of them had not budgeted sufficiently.

### **Elements of Reform**

When the House Ways and Means Committee began its work on the Medicare proposal from the White House in 1965, there were two other proposals on the table as well: an expansion of Kerr-Mills ("Eldercare, supported by AMA) and a proposal for federal subsidies to purchase private coverage ("Bettercare" from the insurer Aetna).

Elements of each were eventually merged into a single bill with three layers: Medicare Part A to pay for hospital care and limited skilled nursing and home health care, optional Medicare Part B (paid in part by premiums) to help pay for physician care, and Medicaid, a totally separate program to assist states in covering not only long-term care for the poor but also to provide health insurance coverage for certain classes of the poor and disabled. The final bill left the elderly in need of private coverage for some services such as prescription drugs, long-term care, and eyeglasses. No government cost controls were enacted and the government even distanced itself by selecting "fiscal intermediaries" (largely Blue Cross insurance organizations) to apply their standards of "reasonableness" for physician fees.

## **1960 – 1965: THE GREAT SOCIETY – MEDICARE AND MEDICAID**

### **Congressional Environment**

Congressional Democrats began to advocate for health coverage for the elderly in the late 1950s. In 1962, President Kennedy supported legislation (Medicare) for hospital coverage for seniors under Social Security, but opposing southern Democrats in the House blocked it. After Johnson's landslide election in 1964, he made Medicare his highest legislative priority and acted quickly. The election also brought a large liberal Democratic majority to both houses of Congress. Firmly influenced by President Johnson, Wilbur Mills, a southern Democrat and Chair of the House Ways and Means Committee who had opposed Medicare, changed his position and crafted the Medicare and Medicaid legislation. Potential Senate opposition was deftly managed by Johnson to ensure passage.

### **Support/Opposition**

Labor unions (recognizing the high cost of insuring retirees) and civil rights organizations endorsed coverage for the elderly. The AFL-CIO created the National Council of Senior Citizens (comprised of retired union members) to campaign for Medicare as other senior citizens also organized for rallies and marches to demonstrate their support. The American Hospital Association and the health insurance industry acknowledged that care for the elderly was costly and unprofitable and would thus require government support. The AMA opposed Medicare, again characterizing it as socialized medicine, and created a political action arm to increase lobbying efforts.

### **Health Reform's Success**

Both Medicare and Medicaid were incorporated in the Social Security Act as it was signed by President Johnson in July 1965, with Truman by his side. The confluence of presidential leadership and urgency, Johnson's political skills in working with a large Congressional Democratic majority, growing civil rights awareness, public support, and the support of hospitals and the insurance industry contributed to the achievement of the most significant health reform of the century. The federal agencies that now estimate the economic costs of legislation did not yet exist. Cost projections, while considered, were not as central to the Congressional debate as they would become later.

## 1970-1974: COMPETING NHI PROPOSALS

### **The Economy**

The economy continued to grow but inflation was becoming a serious problem and rising health care costs were becoming a growing concern. In 1971, President Nixon instituted wage and price freezes in an effort to curb inflation. With the implementation of Medicare and Medicaid, health care costs had grown rapidly from 4 percent of the federal budget in 1965 to 11 percent by 1973, while millions of those under age 65 still had no health coverage. Under the wage and price controls, medical care was singled out for specific limits on annual increases in physician and hospital charges. These were lifted in 1974, over a year after most other economic controls had ended. An era of health care regulation began, leading to certificate-of-need programs, state hospital rate-setting, requirements on HMOs (in return for support to help them expand) and health planning to control growth.

### **Origin of Health Reform**

Sen. Ted Kennedy, supported by the elderly and the labor-led Committee for National Health Insurance, held hearings around the country and issued a report entitled, "The Health Care Crisis in America" generating support for his NHI plan. President Nixon countered with his own plan in 1971.

### **Elements of Reform**

Kennedy's original idea—the "Health Security Act"—was a universal single-payer plan, with a national health budget, no consumer cost-sharing, and was to be financed through payroll taxes. In 1974, Nixon expanded upon his own proposal. His Comprehensive Health Insurance Plan (CHIP) called for universal coverage, voluntary employer participation, and a separate program for the working poor and the unemployed, replacing Medicaid. Requiring employers to contribute 65 percent of the premium cost was controversial, but fundamental to the plan's financing. Taxing employer health premiums as personal income had also been proposed as another source of revenue for CHIP, but Nixon overruled the idea. Democratic Sens. Long (chair of Senate Finance) and Ribicoff had their own incremental plan to provide catastrophic illness coverage and federalize Medicaid (1970). Other serious health care proposals also surfaced, complicating negotiations and splintering support.

## 1970-1974: COMPETING NHI PROPOSALS

### **Congressional Environment**

Rep. Mills, still chairing House Ways and Means, again took up the cause by cosponsoring Nixon's CHIP. Realizing the potential for universal coverage, Kennedy then teamed with Mills to produce a middle-ground bill with an employer mandate and personal cost-sharing, using private insurers as intermediaries—but distinct from CHIP in requiring employees to participate and it was to be financed by a payroll tax. Sen. Long rejected the Kennedy-Mills bill, but agreed that he would not block the progress of health reform on its way to any future conference committee. Republican legislators were divided, feeling the need to support CHIP or a catastrophic coverage plan in order to block even broader NHI, while other Republicans wanted neither but were muted by the President's goals. By the spring of 1974 there was bipartisan support for health reform, with no members wanting to be seen blocking it.

### **Support/Opposition**

The Washington Business Group on Health and the Chamber of Commerce endorsed Nixon's plan. The insurance industry believing NHI loomed, supported more incremental reforms. Labor groups chose not to support the Kennedy-Mills compromise, believing that a larger Democratic majority in the next Congress would make for a stronger (less compromised) and veto-proof bill. The AMA continued to lobby against NHI, but after the Medicare experience, did not try to defeat it altogether. As for Nixon's CHIP, the AMA tag of socialized medicine failed to fit, given Nixon's anti-Communist credentials.

### **Health Reform's Defeat**

Those supporting NHI in 1974 were more bipartisan and willing to compromise than in any other NHI effort. However, the wide mix of competing proposals complicated the legislative process, while the Watergate hearings that led to Nixon's resignation dominated Congress, eroded presidential leadership and overshadowed any action on NHI. Despite President Ford's support for NHI legislation in 1974, and Rep. Mills drafting yet another compromise bill that encompassed principles from CHIP and both Kennedy's and Long's plan—the bill never reached the House floor for lack of committee consensus. When personal problems and scandal forced Mills to leave Congress, the coalitions he had built did not hold and the opportunity for health reform in this era passed.

## 1976-1979: COST-CONTAINMENT TRUMPS NHI

### **The Economy**

Stagflation—stagnant economic growth and continuing inflation, combined with increasing unemployment—characterized the period. President Carter attempted to jump-start the economy through tax cuts, and voluntary wage and price guidelines, but they were not effective.

### **Origin of Health Reform**

In response to President Ford's decision to withdraw his administration's NHI plan, believing that it would make inflation worse, Carter pledged as a presidential candidate to support a comprehensive NHI plan. Once in office however, President Carter shifted priorities to emphasize health care cost containment, specifically hospital cost control, and said that NHI would have to wait until costs were checked and the economy was stronger—and then should be phased in. Sen. Kennedy disagreed, grew impatient waiting for the administration's plan, and drafted another proposal.

### **Elements of Reform**

Sen. Kennedy's new proposal called for private insurance plans to compete for customers who would receive a card to use for hospital and physicians' care. The cost of the card would vary by income and employers would bear the bulk of the cost for their workers, with the government picking up costs for the poor. Insurers would be paid based on actuarial risk, and payments to providers set through negotiated rates.

Carter's plan, released a month after Kennedy's plan, proposed that businesses provide a minimum package of benefits, public coverage for the poor and aged be expanded, and a new public corporation be created to sell coverage to everyone else. It was not to go into effect until 1983.

## 1976-1979: COST-CONTAINMENT TRUMPS NHI

### **Congressional Environment**

Neither the Kennedy nor Carter proposals had much of a chance. Despite a Democratic Congress, conservatism was on the rise. Congressional committees had been reformed in the wake of Watergate with the intention of decentralizing and redistributing the power of chairmen which required more coalition building in order to pass bills. For example, bills reported by the Ways and Means Committee could now be amended by any member on the House floor, and jurisdiction over health reform was now spread over four as opposed to two committees. After three years of effort, a hospital cost-containment bill was unable to make it through Congress.

### **Support/Opposition**

NHI was not the priority it once had been, leaving special interest groups with much less to lobby for or against. Hospitals however, in an effort to fend off cost containment legislation, initiated a "voluntary effort" to control their costs. It proved to be short-lived and unsuccessful, leaving policymakers to find a way to control hospital costs through new regulation.

### **Health Reform's Defeat**

NHI efforts were completely stalled in the face of an economic recession, inflation, and uncontrollable health care costs. Debate on hospital cost-containment during this period however laid the foundation for the Medicare Prospective Payment System enacted in 1983 which changed the way the government paid for hospital care in a major way—from a charge-based system to a predetermined, set rate based on the patient's diagnosis.

## **1992-1994: THE HEALTH SECURITY ACT**

### **The Economy**

Under the Reagan administration's policies in the 1980s—that included substantial tax cuts, large increases in defense spending and moderate cuts in domestic programs—federal debt reached record levels. The Federal Reserve Board succeeded in acting to control inflation, and after a severe 1981-82 recession, levels of unemployment decreased over the 1980s. Health care costs continued to escalate rapidly up to and through this period. Even some in the business sector came to accept that fundamental health reform was needed as the health care sector grew to comprise 12 percent of the nation's GDP in 1990. The income gap between the lower and upper classes was widening and a recession in 1990-91 added to financial insecurity, eventually focusing the 1992 presidential campaign on the economy.

### **Origin of Health Reform**

Public opinion polls in the early 1990s found more Americans worrying about losing their health benefits and not being able to pay their medical bills in the future. The come-from-behind election to the U.S. Senate of Pennsylvania's Harris Wofford in a special election in 1991 based on his advocacy for health reform convinced many that the time was ripe for a renewed national health reform effort. A large and varied mix of proposals surfaced: market-oriented reforms expanding the private system, public single-payer plans, employer mandates (play-or-pay), and from President Bush, health care tax credits and purchasing pools. As the 1992 election approached, the "managed competition" approach gained traction and eventually was favored by President Clinton. The new president initially hoped to send Congress a health reform plan within one hundred days of taking office.

### **Elements of Reform**

Clinton's plan, the Health Security Act, called for universal coverage, employer and individual mandates, competition between private insurers, and was to be regulated by government to keep costs down. Under managed competition private insurers and providers would compete for the business of groups of businesses and individuals in what were called "health-purchasing alliances". Every American would have a "health security card".

## 1992-1994: THE HEALTH SECURITY ACT

### **Congressional Environment**

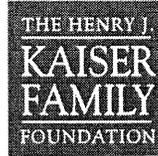
Congressional leaders waited as the Health Care Task Force, chaired by First Lady Hillary Clinton and managed by presidential aide Ira Magaziner, processed the input from 34 closed working groups comprised of over 600 experts, aides, and officials. Not until after the budget was passed were copies of the complex plan shared and presented by the President before a joint session of Congress in September 1993. While the Democrats held the majority in both houses, they were divided on some issues, including how to achieve health reform. They sponsored other NHI bills, including a single-payer bill backed by labor and various consumer and advocacy groups (Rep. McDermott and Sen. Wellstone) and a managed competition plan without universal coverage and price controls (Rep. Cooper)—both of which splintered the support of Democratic lawmakers, interest groups and the general public.

### **Support/Opposition**

Support for the complex Clinton plan from key stakeholders was often conditional. Some labor unions and other public health advocacy groups did not want to be seen as opposed to Clinton's plan, yet backed the single-payer bill. Not wanting to organize public campaigns against Clinton, they hoped to affect change from inside. Many groups supported pieces of the plan, but held back their support wanting to modify the parts they opposed. The Health Insurance Association of America (HIAA) and the National Federation of Independent Businesses (NFIB) led the opposition. HIAA worried that its smaller members would be forced out of business and NFIB believed the employer mandate would create a hardship for small businesses and their workers. Both ran effective phone and letter-writing campaigns to Congress. HIAA also produced television ads that got widespread media coverage, depicting a middle-class couple feeling threatened by health reform.

### **Health Reform's Defeat**

President Clinton, having been elected with less than a majority of votes, lacked the large electoral mandate typically required to achieve sweeping change and any prospects for success were further weakened by his administration's strategy for managing the bill through Congress. The size and complexity of the plan (nearly 1400 pages) not only slowed its passage through Congress but also made it difficult to generate popular activism. The opposition was effectively organized and the divided Democratic majority in Congress could not muster enough votes to pass a bill. However, incremental reform was not dead. In 1997, with a Republican Congress and bipartisan support, the Children's Health Insurance Program was enacted, building on the Medicaid program to provide health coverage to more low-income children.



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Challenged by the transition from a war-time economy, Truman lost the public's confidence. The Republicans gained the majority in both houses of Congress in 1946, creating the perception that the President was a lame duck. Truman then campaigned in 1948 promising to extend the New Deal and targeted the Republican Congress for opposing NHI. Not only did Truman win the election with a mandate from the people for NHI, but Congress also swung back to a Democratic majority. It was not enough, however. Southern Democrats in key leadership positions blocked Truman's initiatives, partly in fear that federal involvement in health care might lead to federal action against segregation at a time when hospitals were still separating patients by race.

### Support/Opposition

Labor unions were somewhat split on government-sponsored insurance. The AFL-CIO and United Auto Workers backed Truman's NHI proposal, but at the same time, the UAW accepted General Motors' offer to pay for health benefits and pensions. As workers gained better benefits from their employers, unions believed they could negotiate even more in the future.

The AMA vigorously opposed the Truman plan, ramping up its public campaign and lobbying after Truman was re-elected—using the fear message of “socialized medicine.” Following the AMA's campaign, and as anticommunist sentiment rose, public support for NHI dropped markedly in 1949. Other groups only supported voluntary and private insurance, including the American Hospital Association, American Bar Association, Chamber of Commerce and the National Grange, as well as most of the nation's press.

### Health Reform's Defeat

Opponents were effective in eroding public support using the fear of government control and socialism at a time when communism was growing in Germany and China in the late 1940s. Meanwhile, businesses along with labor unions were growing the private, employer-based health insurance plans we have today. While Democrats held the majority in Congress in 1950, Republicans made enough gains to prevent progress on NHI.

## **1960 – 1965: THE GREAT SOCIETY – MEDICARE AND MEDICAID**

### **The Economy**

Productivity swelled in the 1960s as did the middle class, with a well-educated workforce financed by the G.I. bill and following the peak of labor union membership in the 1950s. President Kennedy sought to accelerate economic growth through increased government spending and decreased taxes. From this base, Johnson began to build a "Great Society".

### **Origin of Health Reform**

The failure of universal health insurance in the early 1950s as employer-based coverage was growing tempered health reformists. However, as private plans increasingly began to use "experience rating" to set health premiums, those who were retired and sicker found it harder to get affordable coverage. While Eisenhower proposed measures to reinsure private insurance companies and then later, permit small companies to pool their resources to expand coverage, the elderly and poor became the focus for health reformers. Congress passed the Kerr-Mills Act in 1960, giving states federal grants to cover health care for the elderly poor. But this proved ineffective when by 1963, only 28 states chose to participate and many of them had not budgeted sufficiently.

### **Elements of Reform**

When the House Ways and Means Committee began its work on the Medicare proposal from the White House in 1965, there were two other proposals on the table as well: an expansion of Kerr-Mills ("Eldercare, supported by AMA) and a proposal for federal subsidies to purchase private coverage ("Bettercare" from the insurer Aetna).

Elements of each were eventually merged into a single bill with three layers: Medicare Part A to pay for hospital care and limited skilled nursing and home health care, optional Medicare Part B (paid in part by premiums) to help pay for physician care, and Medicaid, a totally separate program to assist states in covering not only long-term care for the poor but also to provide health insurance coverage for certain classes of the poor and disabled. The final bill left the elderly in need of private coverage for some services such as prescription drugs, long-term care, and eyeglasses. No government cost controls were enacted and the government even distanced itself by selecting "fiscal intermediaries" (largely Blue Cross insurance organizations) to apply their standards of "reasonableness" for physician fees.

## 1960 – 1965: THE GREAT SOCIETY – MEDICARE AND MEDICAID

### **Congressional Environment**

Congressional Democrats began to advocate for health coverage for the elderly in the late 1950s. In 1962, President Kennedy supported legislation (Medicare) for hospital coverage for seniors under Social Security, but opposing southern Democrats in the House blocked it. After Johnson's landslide election in 1964, he made Medicare his highest legislative priority and acted quickly. The election also brought a large liberal Democratic majority to both houses of Congress. Firmly influenced by President Johnson, Wilbur Mills, a southern Democrat and Chair of the House Ways and Means Committee who had opposed Medicare, changed his position and crafted the Medicare and Medicaid legislation. Potential Senate opposition was deftly managed by Johnson to ensure passage.

### **Support/Opposition**

Labor unions (recognizing the high cost of insuring retirees) and civil rights organizations endorsed coverage for the elderly. The AFL-CIO created the National Council of Senior Citizens (comprised of retired union members) to campaign for Medicare as other senior citizens also organized for rallies and marches to demonstrate their support. The American Hospital Association and the health insurance industry acknowledged that care for the elderly was costly and unprofitable and would thus require government support. The AMA opposed Medicare, again characterizing it as socialized medicine, and created a political action arm to increase lobbying efforts.

### **Health Reform's Success**

Both Medicare and Medicaid were incorporated in the Social Security Act as it was signed by President Johnson in July 1965, with Truman by his side. The confluence of presidential leadership and urgency, Johnson's political skills in working with a large Congressional Democratic majority, growing civil rights awareness, public support, and the support of hospitals and the insurance industry contributed to the achievement of the most significant health reform of the century. The federal agencies that now estimate the economic costs of legislation did not yet exist. Cost projections, while considered, were not as central to the Congressional debate as they would become later.

## 1970-1974: COMPETING NHI PROPOSALS

### **The Economy**

The economy continued to grow but inflation was becoming a serious problem and rising health care costs were becoming a growing concern. In 1971, President Nixon instituted wage and price freezes in an effort to curb inflation. With the implementation of Medicare and Medicaid, health care costs had grown rapidly from 4 percent of the federal budget in 1965 to 11 percent by 1973, while millions of those under age 65 still had no health coverage. Under the wage and price controls, medical care was singled out for specific limits on annual increases in physician and hospital charges. These were lifted in 1974, over a year after most other economic controls had ended. An era of health care regulation began, leading to certificate-of-need programs, state hospital rate-setting, requirements on HMOs (in return for support to help them expand) and health planning to control growth.

### **Origin of Health Reform**

Sen. Ted Kennedy, supported by the elderly and the labor-led Committee for National Health Insurance, held hearings around the country and issued a report entitled, "The Health Care Crisis in America" generating support for his NHI plan. President Nixon countered with his own plan in 1971.

### **Elements of Reform**

Kennedy's original idea—the "Health Security Act"—was a universal single-payer plan, with a national health budget, no consumer cost-sharing, and was to be financed through payroll taxes. In 1974, Nixon expanded upon his own proposal. His Comprehensive Health Insurance Plan (CHIP) called for universal coverage, voluntary employer participation, and a separate program for the working poor and the unemployed, replacing Medicaid. Requiring employers to contribute 65 percent of the premium cost was controversial, but fundamental to the plan's financing. Taxing employer health premiums as personal income had also been proposed as another source of revenue for CHIP, but Nixon overruled the idea. Democratic Sens. Long (chair of Senate Finance) and Ribicoff had their own incremental plan to provide catastrophic illness coverage and federalize Medicaid (1970). Other serious health care proposals also surfaced, complicating negotiations and splintering support.

## 1970-1974: COMPETING NHI PROPOSALS

### **Congressional Environment**

Rep. Mills, still chairing House Ways and Means, again took up the cause by cosponsoring Nixon's CHIP. Realizing the potential for universal coverage, Kennedy then teamed with Mills to produce a middle-ground bill with an employer mandate and personal cost-sharing, using private insurers as intermediaries—but distinct from CHIP in requiring employees to participate and it was to be financed by a payroll tax. Sen. Long rejected the Kennedy-Mills bill, but agreed that he would not block the progress of health reform on its way to any future conference committee. Republican legislators were divided, feeling the need to support CHIP or a catastrophic coverage plan in order to block even broader NHI, while other Republicans wanted neither but were muted by the President's goals. By the spring of 1974 there was bipartisan support for health reform, with no members wanting to be seen blocking it.

### **Support/Opposition**

The Washington Business Group on Health and the Chamber of Commerce endorsed Nixon's plan. The insurance industry believing NHI loomed, supported more incremental reforms. Labor groups chose not to support the Kennedy-Mills compromise, believing that a larger Democratic majority in the next Congress would make for a stronger (less compromised) and veto-proof bill. The AMA continued to lobby against NHI, but after the Medicare experience, did not try to defeat it altogether. As for Nixon's CHIP, the AMA tag of socialized medicine failed to fit, given Nixon's anti-Communist credentials.

### **Health Reform's Defeat**

Those supporting NHI in 1974 were more bipartisan and willing to compromise than in any other NHI effort. However, the wide mix of competing proposals complicated the legislative process, while the Watergate hearings that led to Nixon's resignation dominated Congress, eroded presidential leadership and overshadowed any action on NHI. Despite President Ford's support for NHI legislation in 1974, and Rep. Mills drafting yet another compromise bill that encompassed principles from CHIP and both Kennedy's and Long's plan—the bill never reached the House floor for lack of committee consensus. When personal problems and scandal forced Mills to leave Congress, the coalitions he had built did not hold and the opportunity for health reform in this era passed.

## **1976-1979: COST-CONTAINMENT TRUMPS NHI**

### **The Economy**

Stagflation—stagnant economic growth and continuing inflation, combined with increasing unemployment—characterized the period. President Carter attempted to jump-start the economy through tax cuts, and voluntary wage and price guidelines, but they were not effective.

### **Origin of Health Reform**

In response to President Ford's decision to withdraw his administration's NHI plan, believing that it would make inflation worse, Carter pledged as a presidential candidate to support a comprehensive NHI plan. Once in office however, President Carter shifted priorities to emphasize health care cost containment, specifically hospital cost control, and said that NHI would have to wait until costs were checked and the economy was stronger—and then should be phased in. Sen. Kennedy disagreed, grew impatient waiting for the administration's plan, and drafted another proposal.

### **Elements of Reform**

Sen. Kennedy's new proposal called for private insurance plans to compete for customers who would receive a card to use for hospital and physicians' care. The cost of the card would vary by income and employers would bear the bulk of the cost for their workers, with the government picking up costs for the poor. Insurers would be paid based on actuarial risk, and payments to providers set through negotiated rates.

Carter's plan, released a month after Kennedy's plan, proposed that businesses provide a minimum package of benefits, public coverage for the poor and aged be expanded, and a new public corporation be created to sell coverage to everyone else. It was not to go into effect until 1983.

## **1976-1979: COST-CONTAINMENT TRUMPS NHI**

### **Congressional Environment**

Neither the Kennedy nor Carter proposals had much of a chance. Despite a Democratic Congress, conservatism was on the rise. Congressional committees had been reformed in the wake of Watergate with the intention of decentralizing and redistributing the power of chairmen which required more coalition building in order to pass bills. For example, bills reported by the Ways and Means Committee could now be amended by any member on the House floor, and jurisdiction over health reform was now spread over four as opposed to two committees. After three years of effort, a hospital cost-containment bill was unable to make it through Congress.

### **Support/Opposition**

NHI was not the priority it once had been, leaving special interest groups with much less to lobby for or against. Hospitals however, in an effort to fend off cost containment legislation, initiated a "voluntary effort" to control their costs. It proved to be short-lived and unsuccessful, leaving policymakers to find a way to control hospital costs through new regulation.

### **Health Reform's Defeat**

NHI efforts were completely stalled in the face of an economic recession, inflation, and uncontrollable health care costs. Debate on hospital cost-containment during this period however laid the foundation for the Medicare Prospective Payment System enacted in 1983 which changed the way the government paid for hospital care in a major way—from a charge-based system to a predetermined, set rate based on the patient's diagnosis.

## **1992-1994: THE HEALTH SECURITY ACT**

### **The Economy**

Under the Reagan administration's policies in the 1980s—that included substantial tax cuts, large increases in defense spending and moderate cuts in domestic programs—federal debt reached record levels. The Federal Reserve Board succeeded in acting to control inflation, and after a severe 1981-82 recession, levels of unemployment decreased over the 1980s. Health care costs continued to escalate rapidly up to and through this period. Even some in the business sector came to accept that fundamental health reform was needed as the health care sector grew to comprise 12 percent of the nation's GDP in 1990. The income gap between the lower and upper classes was widening and a recession in 1990-91 added to financial insecurity, eventually focusing the 1992 presidential campaign on the economy.

### **Origin of Health Reform**

Public opinion polls in the early 1990s found more Americans worrying about losing their health benefits and not being able to pay their medical bills in the future. The come-from-behind election to the U.S. Senate of Pennsylvania's Harris Wofford in a special election in 1991 based on his advocacy for health reform convinced many that the time was ripe for a renewed national health reform effort. A large and varied mix of proposals surfaced: market-oriented reforms expanding the private system, public single-payer plans, employer mandates (play-or-pay), and from President Bush, health care tax credits and purchasing pools. As the 1992 election approached, the "managed competition" approach gained traction and eventually was favored by President Clinton. The new president initially hoped to send Congress a health reform plan within one hundred days of taking office.

### **Elements of Reform**

Clinton's plan, the Health Security Act, called for universal coverage, employer and individual mandates, competition between private insurers, and was to be regulated by government to keep costs down. Under managed competition private insurers and providers would compete for the business of groups of businesses and individuals in what were called "health-purchasing alliances". Every American would have a "health security card".

## 1992-1994: THE HEALTH SECURITY ACT

### **Congressional Environment**

Congressional leaders waited as the Health Care Task Force, chaired by First Lady Hillary Clinton and managed by presidential aide Ira Magaziner, processed the input from 34 closed working groups comprised of over 600 experts, aides, and officials. Not until after the budget was passed were copies of the complex plan shared and presented by the President before a joint session of Congress in September 1993. While the Democrats held the majority in both houses, they were divided on some issues, including how to achieve health reform. They sponsored other NHI bills, including a single-payer bill backed by labor and various consumer and advocacy groups (Rep. McDermott and Sen. Wellstone) and a managed competition plan without universal coverage and price controls (Rep. Cooper)—both of which splintered the support of Democratic lawmakers, interest groups and the general public.

### **Support/Opposition**

Support for the complex Clinton plan from key stakeholders was often conditional. Some labor unions and other public health advocacy groups did not want to be seen as opposed to Clinton's plan, yet backed the single-payer bill. Not wanting to organize public campaigns against Clinton, they hoped to affect change from inside. Many groups supported pieces of the plan, but held back their support wanting to modify the parts they opposed. The Health Insurance Association of America (HIAA) and the National Federation of Independent Businesses (NFIB) led the opposition. HIAA worried that its smaller members would be forced out of business and NFIB believed the employer mandate would create a hardship for small businesses and their workers. Both ran effective phone and letter-writing campaigns to Congress. HIAA also produced television ads that got widespread media coverage, depicting a middle-class couple feeling threatened by health reform.

### **Health Reform's Defeat**

President Clinton, having been elected with less than a majority of votes, lacked the large electoral mandate typically required to achieve sweeping change and any prospects for success were further weakened by his administration's strategy for managing the bill through Congress. The size and complexity of the plan (nearly 1400 pages) not only slowed its passage through Congress but also made it difficult to generate popular activism. The opposition was effectively organized and the divided Democratic majority in Congress could not muster enough votes to pass a bill. However, incremental reform was not dead. In 1997, with a Republican Congress and bipartisan support, the Children's Health Insurance Program was enacted, building on the Medicaid program to provide health coverage to more low-income children.

**Informational Hearing**

*Assembly Health Committee*  
*Dave Jones, Chair*

**The Environment for State Health Reform: What is Next?**

**Tuesday, March 10, 2009**  
**1:30 p.m. – 3:45 p.m.**

**State Capitol**  
**Room 4202**

Many state and federal health care reform efforts have focused on coverage – what to do about the uninsured. The current discussions at the federal level, and in many states, have increasingly also focused on the interrelated issues of *coverage*, *cost* and *quality* and the growing awareness that the health care delivery system – not just the health care coverage system, needs reform. Still, most long-term observers recognize that in order to address cost, efficiency and quality, major progress will need to be made in reducing the number of uninsured persons. Reducing and eliminating the number of persons without health care coverage is an essential element in addressing many of the inefficiencies and costs in the current system, including those that result from uncompensated health care costs and cost-shifting to other purchasers because of services provided to uninsured and underinsured persons, inadequate access to timely primary, preventive and specialty health care for many people and the use of expensive emergency and inpatient services that might otherwise be avoided through improved and timely access to care.

This background paper is focused on the current state of coverage in California and strategies and opportunities for health care reform, beginning with a discussion of coverage, but with acknowledgement of the broader challenges facing the health care financing and delivery system.

**I. CALIFORNIA'S UNINSURED**

According to the California HealthCare Foundation (CHCF),\* over the past 20 years, the percent of uninsured Californians under age 65 has continued to rise as employer-sponsored health

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\* **Data Note:** There are two primary data sources profiling the nature and extent of California's uninsured population: a data set developed by the Employee Benefit Research Institute's analysis of the U.S. Bureau of the Census Current Population Survey, on which CHCF relies, and a data set developed by the UCLA Center for Health Policy Research based on the annual California Health Interview Survey. The resulting number and type of data available vary slightly between the two data sets, but the broad profile and conclusions drawn, and the trends observed over time, are essentially consistent and compatible.

insurance has declined.<sup>1</sup> CHCF reported that between 1987 and 2007, employer-sponsored coverage in California declined by almost 8%. Although CHCF found that increased enrollment and eligibility for Medi-Cal (California's Medicaid program), and growth in individually purchased coverage, partially offset the decline in employer-sponsored coverage, more than 20% of Californians under age 65 remained uninsured during some part of 2007. CHCF found that from 2000 to 2007, the likelihood of being uninsured rose for all age groups, except children aged 20 and under, and the near elderly, those aged 55-64. During this period, CHCF reports that the largest increase of uninsured persons has come in the 45 to 54 age group.

The problem, though national, is more prominent in California, which has a lower percentage of individuals with employer-sponsored coverage and a higher proportion of uninsured. California has the eighth largest proportion of uninsured in the nation. Because of California's large population, the number of people without insurance during some part of the year — 6.6 million — is the highest of any state. Of the uninsured in California, 5.3 million were adults and 1.3 million were children.

CHCF reported findings also reveal:

- Sixteen percent of California's uninsured are children and 70% of uninsured children are in families where the head of the household has a year round, full-time job;
- Workers in private businesses of all sizes are experiencing an increased likelihood of being uninsured, although the percentage of uninsured workers is most pronounced in businesses with fewer than ten employees;
- Sixty-nine percent of uninsured families in California have incomes below \$50,000, 38% have family incomes below \$25,000, and 54% of the uninsured have annual incomes below 200% of the Federal Poverty Level (FPL) (\$18,310 for a family of three in 2009);<sup>2</sup> and,
- Nearly 60% of the uninsured in California are Latino. However, unlike Latinos, whose high rate of being uninsured (30% in 2007) has slightly declined over the last seven years, the likelihood of being uninsured increased during the same period for African Americans, Whites and Asians.

Potential Impact of the Current Economic Slowdown. In light of the current economic downturn in California and nationally, the ranks of the uninsured can be expected to grow as individuals who are laid off or experience reduced work hours lose employer-sponsored health coverage. Losing a job often means losing health insurance for the worker and the family. In considering the potential impact of the declining economy, a recent Kaiser Family Foundation (KFF) report estimated that an increase in the national unemployment rate from 4.6% to 7% would result in 5.9 million Americans losing employer coverage, an additional 2.4 million individuals on public programs and an additional 2.6 million uninsured, a 6% increase in the number of uninsured nationally.<sup>3</sup> The report estimated that at 10% unemployment nationally, 13.2 million people would lose employer coverage, 5.4 million would be added to public programs, and the number of uninsured would increase by 5.8 million, or 13%. By way of illustration, California's current unemployment rate is 10.1%. Using the KFF estimates, if California experienced a 13% increase

in the number of uninsured over the 2007 levels, the latest year for which data is available, an additional 858,000 Californians could become uninsured as a result of the current economic crisis. This magnitude of increase means that California's current number of uninsured could be well above 7 million.

## II. CURRENT SOURCES OF HEALTH CARE COVERAGE

The vast majority of Californians who do have health coverage obtain coverage through their employer or as dependents of an employee. Fifty-seven percent of Californians have employment based coverage; 16% get coverage through state public programs, such as Medi-Cal and the Healthy Families Program (HFP); 3.3% through federal coverage programs, Medicare and veteran's coverage programs; and, an estimated 8.7% purchase coverage through the private individual insurance market. CHCF also reports that the sources of coverage shifted among Californians during the period 1987–2007. Employer-sponsored coverage declined as a source of coverage from 64.6% to 56.7%, while government-sponsored coverage increased from 15.7% to 18.4% and individually purchased coverage increased from 6.8% to 8.0%. During that time, the percentage of uninsured increased from 17.6% to 20.2%.

### Employer-Sponsored Coverage

According to CHCF, over the three-year period 2005-2007, an estimated 17.9 million Californians were covered by employer-sponsored health coverage, 9.2 million as employees (51%) and 8.7 million (49%) as dependents. However, there are differences in the availability of job-based coverage offered by employers. While only 59% of employers with 3-9 employees offer coverage, large employers above 200 employees approach 99-100% that offer coverage.<sup>4</sup> The probability of California firms offering coverage also varies widely by workforce and wage characteristics. While 76% of higher-wage firms offer coverage, only 27% of low-wage firms offer coverage. Firms with many part-time workers offer coverage at a lower rate (53%) than firms with fewer part-time workers (71%).

### Existing Public Coverage

The Governor's 2009 Budget estimates 942,000 children will be enrolled in HFP by June 30, 2010, and approximately 7.1 million individuals will be enrolled in Medi-Cal on that date. The 2007 California Health Interview Survey conducted by the UCLA Center for Health Policy Research found that, of the individuals who were uninsured *at the time of the survey*, 683,000 were children and 4.1 million were adults.<sup>5</sup> Slightly over one half (56%) of the 683,000 children were eligible for either Medi-Cal or HFP, but only 6.6% of adults were eligible for Medi-Cal.

As a result of case law, and state and federal laws, eligibility rules for Medi-Cal are complex and based on multiple factors primarily related to income, property, household composition, residency, age and/or health condition. There are currently more than 170 "aid codes," or eligibility categories, in Medi-Cal. Generally speaking, low-income citizen children are eligible for Medi-Cal as follows: infants in families with incomes less than 200% FPL; one to five year olds at 133% FPL or less; and, six to 18 year olds at 100% FPL or less. Low-income adults can be eligible for Medi-Cal under a variety of programs primarily designed for disabled persons.

Generally speaking, adults between the ages of 21 and 65, without children, who are not pregnant, blind or, disabled, and who do not have one of several specific health care needs outlined in statute (such as dialysis, tuberculosis, breast and cervical cancer treatment, etc.) are not currently eligible for Medi-Cal. Federal Medicaid funds are not available for full coverage of undocumented persons in Medi-Cal.

HFP currently covers children in families with incomes that are less than or equal to 250% FPL but too high to qualify for Medi-Cal, (except for children up to age 2 born to women enrolled in the Access for Infants and Mothers Program). HFP applies income deductions that are applicable to children for Medi-Cal purposes in determining that a family's income does not exceed 250% FPL for purposes of HFP eligibility. Federal State Children's Health Insurance Program (SCHIP) funds are not available for full coverage of undocumented children in HFP.

### **Individually Purchased Coverage**

While the majority of those with health insurance obtain that coverage on the job, individual coverage is the main alternative for those not covered through employment and who are ineligible for publicly subsidized health coverage. CHCF reports that, over the three-year period 2005-2007, an estimated 2.8 million people in California were covered in the individual health insurance market. According to CHCF, the costs of coverage and care represent a large share of income in this market.<sup>6</sup> In 2006, CHCF found that a single person with median household income (\$30,623) buying coverage in the individual market would have spent 16% of income on health care expenses. In addition, those purchasing coverage through the individual market bear a greater share of the costs of care. Insurance covered 54.6% percent of a typical consumer's medical bills in the individual market, compared to 83.3% of costs for those covered by a plan through a small employer group. For those individuals with chronic conditions, annual out-of-pocket medical expenses are high. For example, CHCF found that in 2006, a person with diabetes spent an estimated \$3,275 — above and beyond the health insurance premium — if covered through the individual market, compared to \$1,101 if covered through a small group.

According to the Kaiser Family Foundation (KFF), the individual insurance market can be a difficult place to buy coverage, especially for people who are in less-than-perfect health. Access to and the cost of coverage is very much dependent on a person's health status, age, place of residence, and other factors. Common circumstances leading people to seek such coverage include self-employment, early retirement, working part-time, divorce or widowhood, or "aging off" a parent's policy. Insurance carriers in the individual market often decline to cover people who have pre-existing medical conditions, and even when they offer coverage, frequently impose severe limitations on the coverage for any expenses related to the pre-existing condition or charge more to individuals because of their medical history. This can price insurance out of the reach of many consumers in poor health or create significant gaps in coverage for individuals who end up with exclusions related to prior illnesses or very limited benefits.

### **III. OPTIONS AND APPROACHES FOR EXPANDING HEALTH CARE COVERAGE**

A wide range of policies and strategies, and combinations of specific strategies, to cover the uninsured have been put forward at both the state and federal levels. The proposals range from

incremental changes to major restructuring of the health care system.

At the state level, states have considered and implemented a variety of strategies.<sup>7</sup> In an effort to expand access to coverage, many states have sought waivers from the federal Centers for Medicare and Medicaid Services to expand their Medicaid and/or SCHIP programs to populations that typically are not eligible to receive benefits. States have also focused on strategies designed to lower the effective price of coverage, either by making reduced-price coverage available or by providing subsidies or incentives for the purchase of private insurance. Other strategies that states have used include reinsurance (discussed below), high-risk pools, broadening requirements for dependent coverage, and group purchasing arrangements.

Increasingly, policymakers have come to understand that the challenges states face in reforming health care cannot be addressed simply by focusing on coverage and access issues. However, there is also increasing recognition that coverage expansions are necessary to have an effective and efficient health care system.<sup>8</sup> Consequently, many states are combining coverage expansions with strategies aimed at improving the health care delivery and financing system while controlling costs as well. Likewise, states are demonstrating an increasing awareness that reform efforts targeted to cost containment can also promote healthy behaviors and more effective management of chronic conditions.

In *Approaches to Covering the Uninsured: A Guide*, KFF suggests that the variety of policy strategies and approaches to solving the problem of the uninsured can be organized into four categories, which may be proposed in some combination:

- Strengthen current coverage arrangements;
- Improve the affordability of coverage;
- Improve the availability of coverage; and,
- Change the tax treatment [or] financing of health insurance.<sup>9</sup>

### **Strengthening Current Coverage Arrangements**

One approach to increasing the number of individuals with health insurance is to build on and expand one or more of the current sources of coverage. This approach would involve efforts to expand employment-based coverage, expansion of existing public coverage programs and/or potential reforms to strengthen the individual health insurance market.<sup>10</sup>

*Build on Employment Coverage.* According to KFF, there are two basic ways to build on the employment-based coverage system: mandates and incentives. Employer mandates require all employers (or some subset of employers) to offer health coverage to their workers. Alternatively, rather than mandating employer coverage, either a pay or play, or an employer spending obligation, may require employers to pay a specified minimum amount toward employee health coverage or pay a similar amount to a designated public fund or program that will make health coverage available to workers. When states consider establishing employer health care obligations, the proposals must be crafted in the context of the federal Employee Retirement Income Security Act of 1974 (ERISA). ERISA generally allows states to regulate the business of health insurance but generally prohibits states from requiring employers to

provide health care coverage or specifying the benefits that must be provided by employers. ERISA has been the subject of a number of court decisions. ERISA presents complex legal considerations for states looking to include employer financing in initiatives to expand access to health care.

Financial incentives for employers to increase coverage usually take the form of tax credits, which offer subsidies for employers providing coverage. Financial incentives may be focused on assisting smaller or lower wage firms or targeted to employers who have not previously provided coverage. Targeting financial incentives for employer coverage necessarily involves consideration of how to balance the goal of expanding coverage with whether the incentives reward or penalize employers already contributing to the cost of employee health coverage.

*Build on Public Coverage.* Another way to build on the current sources of coverage is to expand existing publicly funded coverage programs. In California, the largest public coverage programs are Medi-Cal and HFP. Expansion of public programs at the state level builds on the existing state and federal infrastructure which already exists and has the potential to increase federal funding for the state's coverage effort. Expansions of coverage can increase income eligibility for groups that are currently covered, such as children, pregnant women, parents of covered children and/or low-income seniors and persons with disabilities. States can also consider development of federal Medicaid waiver programs that reduce or eliminate some of the categorical eligibility constraints in the federal program, allowing states to cover everyone at or below a certain income threshold. In addition to expanding eligibility, states may also implement outreach and enrollment strategies to increase the number of low-income eligible children and other groups who are eligible for the existing programs but not enrolled.

*Build on Individual Private Coverage.* The third approach to building on current sources of coverage is to enact reforms that strengthen the effectiveness of the individual private insurance market in meeting the coverage needs of uninsured persons. Individually purchased health insurance is currently the only source of coverage for those who do not have job-based coverage or who are not eligible for public coverage programs. The regulatory reform efforts affecting individual coverage attempt to address problems in the existing market. For example, the individual market is characterized by lack of availability or wide pricing differentials for those with pre-existing medical conditions or who are considered by health insurers to be potentially high-risk. The benefit offerings in the individual market are often complicated and difficult to understand, the coverage options may be less comprehensive for many and for many individual insurance products, there is a very low share of premium dollars that actually go to paying for medical services, as opposed to administrative costs and profits, compared to employer coverage.<sup>11</sup>

Elements of individual market reform might include one or more of the following: guaranteed issue and renewal, requiring health insurers to offer and renew coverage without regard to the health status of the individual purchaser; rating requirements which limit or prohibit premium variations in the market based on factors such as age, gender, geography or health status; standardization of benefit designs and/or establishing minimum benefit levels that health insurers must offer; establishing minimum medical loss ratios (the percent of premium that must be spent on medical care); and/or establishing and funding separate coverage programs for high-risk

persons and persons with pre-existing conditions, sometimes referred to as a "high-risk pool." In California, the Major Risk Medical Insurance Program (MRMIP), administered by the Managed Risk Medical Insurance Board (MRMIB) serves as the health insurer of last resort for individuals denied private individual coverage.

### **Improving the Affordability of Coverage**

According to KFF, no coverage expansion is feasible or sustainable if the affordability of coverage is not addressed.<sup>12</sup> While broad-based cost containment strategies, and an array of policies and programs to reduce health care costs and health care cost inflation, will likely be considered in any health reform effort, focusing on affordability as a way to cover more uninsured people generally leads to consideration of two basic strategies: subsidies for coverage and/or offering lower-cost coverage products.

*Offer Subsidies.* The most direct method for making coverage more affordable is to provide direct financial assistance to help individuals and families purchase coverage in the form of subsidies. According to KFF, the most common mechanisms proposed for subsidies are tax deductions, refundable tax credits, or direct subsidies. Subsidies can be made available to individuals based on income level, based on a sliding scale related to income, or calculated as a percent of premium for purchased coverage.

*Offer Less Expensive Products.* This strategy is to allow and/or facilitate the design and offering of less expensive insurance products. Generally speaking, health coverage products with lower premiums cover fewer benefits and require consumers to pay higher cost sharing in the form of deductibles, copayments, coinsurance and other out-of-pocket costs, including covering out-of-pocket the costs for health care services not covered in a more limited benefit plan. Understanding the impact that lower cost and lower benefit plans have on affordability of coverage necessarily requires consideration of the total out-of-pocket costs individuals will bear, including both premium payments and the cost-sharing elements of the plan.

*Provide for Reinsurance.* Another strategy to improve affordability of coverage is to provide some form of reinsurance, subsidy and/or pooling for high cost claims. The goal of reinsurance is to lower overall health insurance premiums by subsidizing in some way, such as direct state subsidy, purchase of reinsurance, or pooled payments across all purchasers, the costs associated with high cost individuals and catastrophic cases. The concept of reinsurance flows from the persistent data which shows that a very small proportion of any population (10-20%) accounts for the bulk of health care costs (80-90%), regardless of source and type of coverage. Higher costs are generally incurred by the health care system for persons with debilitating and often multiple chronic illnesses, people with cancer, premature babies or individuals with other life-threatening diseases, people needing end-of-life care and victims of terrible accidents.

### **Improve the Availability of Coverage**

In order to ensure broad coverage, health insurance must be readily available as well as affordable. Generally speaking, large employers are able to purchase or provide health care coverage for their workers, but the markets for small employers and individuals present barriers

to affordability and, in the case of the individual market, many potential buyers will be locked out of the market entirely because of their health status or prior claims history.

Create Or Provide Access To Large Purchasing Pools. One way to address the problems of availability and affordability of coverage, particularly for small employers and individuals, is to establish new or provide access to existing large purchasing arrangements. These arrangements have many names: purchasing cooperatives, exchanges, pools, or connectors. Purchasing cooperatives may be proposed on a state, regional or national basis. The idea is that the cooperatives arrange for or offer coverage for all eligible employers and individuals and by virtue of the number of purchasers buying together are better able to negotiate or offer lower prices than small employers or individuals might obtain on their own.

Mandate Individual Coverage. One way to ensure individuals have coverage is to establish a legal requirement that every resident obtain adequate private health insurance coverage, typically referred to as an individual mandate. Proponents of the individual mandate argue that mandates respond to a legitimate concern about "free riders," uninsured persons who nonetheless receive treatment when they get sick, in emergency rooms and through other uncompensated or reduced cost care, resulting in additional costs being passed on to taxpayers, purchasers and individuals with insurance. Proponents argue that those most likely to go without health insurance are the young and relatively healthy and that for these young, healthy individuals, going without health insurance is often a logical economic decision. The problem with their choice, proponents argue, is that it leads to a form of adverse selection. Allowing the young and healthy to stay out of the insurance pool typically results in higher insurance premiums for those who do buy coverage because the remaining insurance pool is older and more costly to insure. Finally, proponents argue that in the context of an individual mandate it is possible to impose stricter rules on insurance carriers, such as requiring them to guarantee issue of coverage to everyone, because concerns about potential adverse selection are reduced.

Opponents of an individual mandate argue that individuals, including young and healthy persons, are most likely uninsured because they cannot afford to buy meaningful coverage or are being denied private coverage because of pre-existing health conditions. Opponents argue that imposing a mandate does nothing by itself to significantly improve affordability and that the majority of uninsured persons will need some form of subsidy or government-sponsored health plan in order to comply with a mandate. Mandate opponents argue that requiring individuals to buy coverage on their own is inefficient, does not have the same tax advantages otherwise available for employer coverage, has higher selling costs and reduces the purchasing clout typically associated with buying group health insurance. Opponents are also concerned that a mandate can only be enforced through punitive and costly penalties or expensive government bureaucracies that come at the expense of the programs that actually provide health coverage. Finally, some opponents of the mandate view the requirements as unacceptably providing the health insurance industry with a captive market that must seek out and purchase their product.

Expand High-Risk Pools. Another strategy KFF identifies as a way to reform the underlying individual market and improve the availability of coverage is to establish or build on high-risk pools. High-risk pools currently operate in 34 states, including California, and provide health coverage to individuals considered medically uninsurable (or who meet other eligibility

requirements) and who are generally unable to purchase private individual coverage. Theoretically, allowing insurers to exclude such individuals from coverage keeps average premiums in the remaining market lower, while still ensuring that those who are most likely to need protection have a viable coverage option.

California's program for medically uninsurable persons, MRMIP, provides individual coverage through private health plans for those whose applications for private individual coverage are rejected by health insurers because of the individual's health history or health status. MRMIP is administered by the MRMIB, which also administers HFP. MRMIP subscribers pay relatively high premiums, which are set in statute at 125-137.5% of private market rates, and receive coverage that includes an annual benefit cap of \$75,000 per year. Premiums vary based on the age and region of the subscriber and the health plan they choose. MRMIP has served nearly 100,000 individuals since its inception in 1991 but, for much of that time, there has been a waiting list for the program. MRMIP premiums are subsidized through the Cigarette and Tobacco Surtax Fund (Proposition 99). Because the Proposition 99 appropriation (approximately \$40 million per year) is limited, the total number of individuals who can participate in MRMIP depends on available funding.

### **Change the Tax Treatment of Health Insurance**

Most of the major policy choices related to the tax treatment of health insurance surround the way that the health benefits are treated for purposes of federal taxes. The federal tax code currently provides an incentive for employers and employees to arrange for health care coverage in the workplace because employer payments for health care are tax-deductible for employers and not treated as taxable income for employees. Since the 1950s, these tax incentives have encouraged and subsidized the employment-based insurance market, making it the dominant source of coverage. Among other things, the treatment of existing tax benefits for employer-sponsored coverage has been criticized as subsidizing employers and employees with the richest benefits and those at the highest incomes, while disadvantaging those without employer coverage who purchase coverage on their own and must pay full premiums with after-tax dollars.<sup>13</sup> Incremental approaches to changing the tax treatment of health benefits include providing the same tax benefit for individual purchasers as those receiving employment-based coverage and capping the amount of employer benefits not subject to taxes.

### **Moving Away from an Employer-Based Coverage System**

Another set of broader changes would move entirely away from the current employer-based delivery system for health care coverage.

One strategy toward that end would replace that tax preference for employer-sponsored coverage with a tax credit or tax deduction for individually purchased coverage. One advantage of this approach is that a refundable tax credit is available whether a person owes taxes or not and could be made available even for those who do not pay taxes and are at lower income levels.<sup>14</sup> One potential disadvantage is that this approach relies on an individual health insurance market that has significant constraints and limitations, including notably higher administrative and marketing

costs, and the loss of group purchasing opportunities that can reduce premium costs.

*Single-Payer Health Care.* Single-Payer health care would essentially replace current sources of coverage and financing of health care for those under age 65 with a government-organized plan, funded in whole or in part through public financing. Instead of financing health care through employer and employee premiums, Single-Payer health care proposals generally assume funding through income, payroll and other general taxes. Proponents of Single-Payer argue that such a plan would guarantee coverage for everyone, and provide coverage in a manner that would be more efficient, and less costly, than the present system. This approach is sometimes referred to as "Medicare for everyone." Generally speaking, Single-Payer health care anticipates that the government would finance the care, with the health care delivery system remaining largely private. In most Single-Payer proposals, private health insurers would be able to sell "add on" and supplemental coverage, but would otherwise be excluded from maintaining a private market for basic health insurance. As KFF points out, the transformation of the health care financing and delivery system envisioned by a Single-Payer approach would require major cultural and administrative shifts for government, providers, insurers and the public.

#### IV. RELATED LEGISLATION

- 1) AB 1314 (Jones) would require the Department of Health Care Services, in consultation with the Legislature, to develop and submit a waiver to the federal government that would accomplish various objectives, including but not limited to, expanding health care coverage to low-and moderate-income children and adults, reducing the number of uninsured and maximizing federal funds.
- 2) SB 1 (Steinberg) would: a) expand Medi-Cal and HFP eligibility to cover all children regardless of immigration status with family incomes at or below 300% FPL; b) established a HFP Buy-In Program for children in families with incomes above 300% FPL; c) establish various presumptive eligibility programs; and d) streamline enrollment and retention with the goal of keeping more children covered.
- 3) SB 56 (Alquist) would make legislative findings and declarations regarding health care coverage and would declare the intent of the Legislature to enact and implement comprehensive reforms in the state's health care delivery system, as specified.
- 4) SB 92 (Aanestad) would establish the Healthcare Restoration Act (Act), and would use tax credits, health savings accounts, reinsurance products, tort reform, and electronic medical records to make reforms to California's health care system. The Act also makes significant changes to Medi-Cal.
- 5) SB 810 (Leno) would establish the California Healthcare System to be administered by the newly created California Healthcare Agency under the control of a Healthcare Commissioner appointed by the Governor and subject to confirmation by the Senate. SB 810 would make all California residents eligible for specified health care benefits under the California Healthcare System, which would, on a single-payer basis, negotiate for or set fees for health care services provided through the system and pay claims for those services. SB 810 would

establish a Premium Commission to recommend premiums to support the program and remaining elements of the proposal would only become operative on the date the Secretary of California Health and Human Services notifies the Legislature, as specified, that sufficient funding exists to implement the program.

## **V. PREVIOUS LEGISLATION**

- 1) AB 1 X1 (Nunez) of 2007 would have enacted the California Health Care Reform and Cost Control Act and created the California Cooperative Health Insurance Purchasing Program (Cal-CHIPP), a state health care purchasing program to provide coverage to specified employees, individuals eligible for new expanded public coverage and individuals who would have been newly eligible for a tax credit to defray health insurance costs. AB 1 X1 would have also established various health cost containment measures and private insurance market reforms and included several financing elements that would have been subject to voter approval on the November 2008 statewide ballot. AB 1 X1 failed passage in the Senate Health Committee.
- 2) AB 8 X1 (Villines) of 2007 proposed multiple, diverse strategies to address health care costs and access, including: tax incentives and government programs to promote and facilitate consumer-directed health care and employer-sponsored insurance; allowing the sale of out-of-state health plans and policies not subject to any California law or regulation; increasing Medi-Cal provider reimbursement rates and creating an income tax credit for physicians who provide unreimbursed care for the uninsured; establishing a mechanism for financial aid for training physician assistants; and, requiring foundation conversions to provide direct medical care. AB 8 X1 was not heard in the Assembly Health Committee at the author's request.
- 3) AB 1 (Laird and Dymally) and SB 32 (Steinberg), two similar bills introduced in 2007, would have: a) expanded Medi-Cal and HFP eligibility to cover all children regardless of immigration status with family incomes at or below 300% FPL; b) established a HFP Buy-In Program for children in families with incomes above 300% FPL; c) established various presumptive eligibility programs; and streamlined enrollment and retention with the goal of keeping more children covered. Both bills passed the Legislature but were not sent to the Governor.
- 4) AB 2 (Dymally) of 2007 would have revised and restructured MRMIP, which provides subsidized individual health care coverage for medically uninsurable persons. AB 2 would have secured additional funding and coverage for MRMIP-eligible persons by requiring all health plans and health insurers selling individual coverage in the state to accept assignment of such persons or to support the costs of MRMIP through a per person fee on individual health plan contracts and policies. AB 2 would also have enacted specified program changes related to eligibility, benefits and program administration. AB 2 was vetoed by Governor Schwarzenegger.
- 5) AB 8 (Nunez) of 2007 would have established the California Cooperative Health Insurance Purchasing Program (Cal-CHIPP) as a state purchasing pool administered by MRMIB, to negotiate and contract with health plans and health insurers to provide health insurance for

- employees (and their dependents) of employers who elected to pay a fee to the state in lieu of making expenditures for health care for their employees equal to a specified percent of wages paid by the employer. AB 8 excluded very small and low-income employers. AB 8 also would have extended coverage to parents and children under 300% FPL through Medi-Cal and HFP, and covered the children regardless of immigration status. Finally, AB 8 included health insurance market reforms, uniform benefit designs and specific cost containment strategies. AB 8 was vetoed by Governor Arnold Schwarzenegger.
- 6) SB 48 (Perata) of 2007 would have established the Health Insurance Connector as a health insurance purchasing pool administered by MRMIB, and would have required employers to spend a designated amount on health care for employees or elect to have that health coverage provided through the Connector. SB 48 mandated that all employed persons have health insurance either through their employer or purchased on their own. The mandate covers all workers and their families. SB 48 would have extended coverage to parents and children under 300% FPL through Medi-Cal and HFP and included health insurance reforms in the state purchasing program and numerous cost containment strategies. SB 48 was amended to deal with another subject.
  - 7) In 2007, Assembly Republicans introduced a 17 bill package of proposed reforms that included access to health savings accounts, decreased regulation of insurers, fewer insurance mandates, and a state insurance exchange for individuals, expanded state tax deductions for medical expenses, and combined health and workers compensation insurance policies. Eight of these bills were not heard at the authors' request. Of the remaining bills, two were passed by the Assembly, AB 1559 (Berryhill), Chapter 712 of 2007, which expands nursing education programs, and AB 1304 (Smyth), related to seismic upgrades of hospitals, which was not heard in Senate Health Committee at the request of the author.
  - 8) In 2007, Senate Republicans introduced a series of bills and a reform plan that would have relied on tax incentives, redirection of existing health program funding and increased availability of community and primary care clinics to expand access to health care. The proposals included seeking voter approval to redirect existing tobacco tax revenues away from existing programs to children's coverage and would have reduced Medi-Cal benefits with the stated goal to make them more like what employed persons have in their job-based coverage; increased Medi-Cal provider rates over eight years; and reduced regulation of health insurance carriers to allow greater flexibility in the health insurance market.
  - 9) SB 840 (Kuehl) of 2007 would have created the California Healthcare System (CHS), a Single-Payer health care system, administered by the California Healthcare Agency established in SB 840, to provide health insurance coverage to all California residents. SB 840 would have required the CHS to become operative when the Secretary of Health and Human Services determined the Healthcare Fund established for the program had sufficient revenues for implementation. SB 840 was vetoed by Governor Schwarzenegger.
  - 10) SB 1014 (Kuehl) of 2007 would have funded the health care system proposed in SB 840 (Kuehl) through income, self-employment, and payroll taxes. No vote was taken on SB 1014

in the Senate Revenue and Taxation Committee.

- 11) SB 840 (Kuehl) of 2006, a Single-Payer bill, was vetoed by Governor Schwarzenegger. In his veto message, the Governor argued that SB 840 would result in an extraordinary redirection of public and private funding and a vast new bureaucracy, and that the preferable approach would be to promote personal responsibility and to build on the private and public systems already in place.
- 12) SB 921 (Kuehl), introduced in 2003, would have established a Single-Payer health care system in California. SB 921 passed the Senate and the Assembly Health Committee and died in the Assembly Appropriations Committee.
- 13) SB 2 (Burton), Chapter 673, Statutes of 2003, enacted the Health Insurance Act of 2003, a "pay-or-play" approach, to provide health coverage to employees (and in some cases their dependents) who do not receive job-based coverage and who work for large and medium employers. SB 2 was repealed by Proposition 72, a voter referendum on the November 2004 ballot.

## SOURCES

<sup>1</sup> *Snapshot of California's Uninsured*, California HealthCare Foundation, December 2008, obtained on-line at [www.chcf.org](http://www.chcf.org).

<sup>2</sup> Department of Health and Human Services, *2009 Poverty Guidelines*, Published in the Federal Register: January 23, 2009, (Volume 74, Number 14).

<sup>3</sup> Holahan, J and Bowen Garrett, A, *Rising Unemployment, Medicaid and the Uninsured*, Kaiser Commission on Medicaid and the Uninsured, January 2009, obtained on-line at [www.kff.org](http://www.kff.org).

<sup>4</sup> California Employer Health Benefits Survey, California HealthCare Foundation, December 2008, obtained on-line at [www.chcf.org](http://www.chcf.org).

<sup>5</sup> Brown ER, Lavarreda SA, Peckham E and Chia YJ, *Nearly 6.4 Million Californians Lacked Health Insurance in 2007 – Recession Likely to Reverse Small Gains in Coverage*, Los Angeles, CA: UCLA Center for Health Policy Research, December 2008.

<sup>6</sup> Snapshot -- Health Insurance: Can Californians Afford It? California HealthCare Foundation, June 2008 obtained on-line at [www.chcf.org](http://www.chcf.org).

<sup>7</sup> Published on *State Coverage Initiatives* (<http://www.statecoverage.org>), an initiative of the Robert Wood Johnson Foundation, managed by Academy Health.

<sup>8</sup> Ibid.

<sup>9</sup> Tolbert, J., Ebeler J., and Schwartz T., *Approaches to Covering the Uninsured: A Guide*, Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, December 2008.

<sup>10</sup> Ibid.

<sup>11</sup> Ibid.

<sup>12</sup> Ibid.

<sup>13</sup> Ibid.

<sup>14</sup> Ibid.



**Informational Hearing**

*Assembly Health Committee*  
*Dave Jones, Chair*

**The Environment for State Health Reform: What is Next?**

**Tuesday, March 10, 2009**  
**1:30 p.m. – 3:45 p.m.**

**State Capitol**  
**Room 4202**

Many state and federal health care reform efforts have focused on coverage – what to do about the uninsured. The current discussions at the federal level, and in many states, have increasingly also focused on the interrelated issues of *coverage*, *cost* and *quality* and the growing awareness that the health care delivery system – not just the health care coverage system, needs reform. Still, most long-term observers recognize that in order to address cost, efficiency and quality, major progress will need to be made in reducing the number of uninsured persons. Reducing and eliminating the number of persons without health care coverage is an essential element in addressing many of the inefficiencies and costs in the current system, including those that result from uncompensated health care costs and cost-shifting to other purchasers because of services provided to uninsured and underinsured persons, inadequate access to timely primary, preventive and specialty health care for many people and the use of expensive emergency and inpatient services that might otherwise be avoided through improved and timely access to care.

This background paper is focused on the current state of coverage in California and strategies and opportunities for health care reform, beginning with a discussion of coverage, but with acknowledgement of the broader challenges facing the health care financing and delivery system.

**I. CALIFORNIA'S UNINSURED**

According to the California HealthCare Foundation (CHCF),\* over the past 20 years, the percent of uninsured Californians under age 65 has continued to rise as employer-sponsored health

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\* **Data Note:** There are two primary data sources profiling the nature and extent of California's uninsured population: a data set developed by the Employee Benefit Research Institute's analysis of the U.S. Bureau of the Census Current Population Survey, on which CHCF relies, and a data set developed by the UCLA Center for Health Policy Research based on the annual California Health Interview Survey. The resulting number and type of data available vary slightly between the two data sets, but the broad profile and conclusions drawn, and the trends observed over time, are essentially consistent and compatible.

insurance has declined.<sup>1</sup> CHCF reported that between 1987 and 2007, employer-sponsored coverage in California declined by almost 8%. Although CHCF found that increased enrollment and eligibility for Medi-Cal (California's Medicaid program), and growth in individually purchased coverage, partially offset the decline in employer-sponsored coverage, more than 20% of Californians under age 65 remained uninsured during some part of 2007. CHCF found that from 2000 to 2007, the likelihood of being uninsured rose for all age groups, except children aged 20 and under, and the near elderly, those aged 55-64. During this period, CHCF reports that the largest increase of uninsured persons has come in the 45 to 54 age group.

The problem, though national, is more prominent in California, which has a lower percentage of individuals with employer-sponsored coverage and a higher proportion of uninsured. California has the eighth largest proportion of uninsured in the nation. Because of California's large population, the number of people without insurance during some part of the year — 6.6 million — is the highest of any state. Of the uninsured in California, 5.3 million were adults and 1.3 million were children.

CHCF reported findings also reveal:

- Sixteen percent of California's uninsured are children and 70% of uninsured children are in families where the head of the household has a year round, full-time job;
- Workers in private businesses of all sizes are experiencing an increased likelihood of being uninsured, although the percentage of uninsured workers is most pronounced in businesses with fewer than ten employees;
- Sixty-nine percent of uninsured families in California have incomes below \$50,000, 38% have family incomes below \$25,000, and 54% of the uninsured have annual incomes below 200% of the Federal Poverty Level (FPL) (\$18,310 for a family of three in 2009);<sup>2</sup> and,
- Nearly 60% of the uninsured in California are Latino. However, unlike Latinos, whose high rate of being uninsured (30% in 2007) has slightly declined over the last seven years, the likelihood of being uninsured increased during the same period for African Americans, Whites and Asians.

Potential Impact of the Current Economic Slowdown. In light of the current economic downturn in California and nationally, the ranks of the uninsured can be expected to grow as individuals who are laid off or experience reduced work hours lose employer-sponsored health coverage. Losing a job often means losing health insurance for the worker and the family. In considering the potential impact of the declining economy, a recent Kaiser Family Foundation (KFF) report estimated that an increase in the national unemployment rate from 4.6% to 7% would result in 5.9 million Americans losing employer coverage, an additional 2.4 million individuals on public programs and an additional 2.6 million uninsured, a 6% increase in the number of uninsured nationally.<sup>3</sup> The report estimated that at 10% unemployment nationally, 13.2 million people would lose employer coverage, 5.4 million would be added to public programs, and the number of uninsured would increase by 5.8 million, or 13%. By way of illustration, California's current unemployment rate is 10.1%. Using the KFF estimates, if California experienced a 13% increase

in the number of uninsured over the 2007 levels, the latest year for which data is available, an additional 858,000 Californians could become uninsured as a result of the current economic crisis. This magnitude of increase means that California's current number of uninsured could be well above 7 million.

## II. CURRENT SOURCES OF HEALTH CARE COVERAGE

The vast majority of Californians who do have health coverage obtain coverage through their employer or as dependents of an employee. Fifty-seven percent of Californians have employment based coverage; 16% get coverage through state public programs, such as Medi-Cal and the Healthy Families Program (HFP); 3.3% through federal coverage programs, Medicare and veteran's coverage programs; and, an estimated 8.7% purchase coverage through the private individual insurance market. CHCF also reports that the sources of coverage shifted among Californians during the period 1987–2007. Employer-sponsored coverage declined as a source of coverage from 64.6% to 56.7%, while government-sponsored coverage increased from 15.7% to 18.4% and individually purchased coverage increased from 6.8% to 8.0%. During that time, the percentage of uninsured increased from 17.6% to 20.2%.

### Employer-Sponsored Coverage

According to CHCF, over the three-year period 2005-2007, an estimated 17.9 million Californians were covered by employer-sponsored health coverage, 9.2 million as employees (51%) and 8.7 million (49%) as dependents. However, there are differences in the availability of job-based coverage offered by employers. While only 59% of employers with 3-9 employees offer coverage, large employers above 200 employees approach 99-100% that offer coverage.<sup>4</sup> The probability of California firms offering coverage also varies widely by workforce and wage characteristics. While 76% of higher-wage firms offer coverage, only 27% of low-wage firms offer coverage. Firms with many part-time workers offer coverage at a lower rate (53%) than firms with fewer part-time workers (71%).

### Existing Public Coverage

The Governor's 2009 Budget estimates 942,000 children will be enrolled in HFP by June 30, 2010, and approximately 7.1 million individuals will be enrolled in Medi-Cal on that date. The 2007 California Health Interview Survey conducted by the UCLA Center for Health Policy Research found that, of the individuals who were uninsured *at the time of the survey*, 683,000 were children and 4.1 million were adults.<sup>5</sup> Slightly over one half (56%) of the 683,000 children were eligible for either Medi-Cal or HFP, but only 6.6% of adults were eligible for Medi-Cal.

As a result of case law, and state and federal laws, eligibility rules for Medi-Cal are complex and based on multiple factors primarily related to income, property, household composition, residency, age and/or health condition. There are currently more than 170 "aid codes," or eligibility categories, in Medi-Cal. Generally speaking, low-income citizen children are eligible for Medi-Cal as follows: infants in families with incomes less than 200% FPL; one to five year olds at 133% FPL or less; and, six to 18 year olds at 100% FPL or less. Low-income adults can be eligible for Medi-Cal under a variety of programs primarily designed for disabled persons.

Generally speaking, adults between the ages of 21 and 65, without children, who are not pregnant, blind or, disabled, and who do not have one of several specific health care needs outlined in statute (such as dialysis, tuberculosis, breast and cervical cancer treatment, etc.) are not currently eligible for Medi-Cal. Federal Medicaid funds are not available for full coverage of undocumented persons in Medi-Cal.

HFP currently covers children in families with incomes that are less than or equal to 250% FPL but too high to qualify for Medi-Cal, (except for children up to age 2 born to women enrolled in the Access for Infants and Mothers Program). HFP applies income deductions that are applicable to children for Medi-Cal purposes in determining that a family's income does not exceed 250% FPL for purposes of HFP eligibility. Federal State Children's Health Insurance Program (SCHIP) funds are not available for full coverage of undocumented children in HFP.

### **Individually Purchased Coverage**

While the majority of those with health insurance obtain that coverage on the job, individual coverage is the main alternative for those not covered through employment and who are ineligible for publicly subsidized health coverage. CHCF reports that, over the three-year period 2005-2007, an estimated 2.8 million people in California were covered in the individual health insurance market. According to CHCF, the costs of coverage and care represent a large share of income in this market.<sup>6</sup> In 2006, CHCF found that a single person with median household income (\$30,623) buying coverage in the individual market would have spent 16% of income on health care expenses. In addition, those purchasing coverage through the individual market bear a greater share of the costs of care. Insurance covered 54.6% percent of a typical consumer's medical bills in the individual market, compared to 83.3% of costs for those covered by a plan through a small employer group. For those individuals with chronic conditions, annual out-of-pocket medical expenses are high. For example, CHCF found that in 2006, a person with diabetes spent an estimated \$3,275 — above and beyond the health insurance premium — if covered through the individual market, compared to \$1,101 if covered through a small group.

According to the Kaiser Family Foundation (KFF), the individual insurance market can be a difficult place to buy coverage, especially for people who are in less-than-perfect health. Access to and the cost of coverage is very much dependent on a person's health status, age, place of residence, and other factors. Common circumstances leading people to seek such coverage include self-employment, early retirement, working part-time, divorce or widowhood, or "aging off" a parent's policy. Insurance carriers in the individual market often decline to cover people who have pre-existing medical conditions, and even when they offer coverage, frequently impose severe limitations on the coverage for any expenses related to the pre-existing condition or charge more to individuals because of their medical history. This can price insurance out of the reach of many consumers in poor health or create significant gaps in coverage for individuals who end up with exclusions related to prior illnesses or very limited benefits.

### **III. OPTIONS AND APPROACHES FOR EXPANDING HEALTH CARE COVERAGE**

A wide range of policies and strategies, and combinations of specific strategies, to cover the uninsured have been put forward at both the state and federal levels. The proposals range from

incremental changes to major restructuring of the health care system.

At the state level, states have considered and implemented a variety of strategies.<sup>7</sup> In an effort to expand access to coverage, many states have sought waivers from the federal Centers for Medicare and Medicaid Services to expand their Medicaid and/or SCHIP programs to populations that typically are not eligible to receive benefits. States have also focused on strategies designed to lower the effective price of coverage, either by making reduced-price coverage available or by providing subsidies or incentives for the purchase of private insurance. Other strategies that states have used include reinsurance (discussed below), high-risk pools, broadening requirements for dependent coverage, and group purchasing arrangements.

Increasingly, policymakers have come to understand that the challenges states face in reforming health care cannot be addressed simply by focusing on coverage and access issues. However, there is also increasing recognition that coverage expansions are necessary to have an effective and efficient health care system.<sup>8</sup> Consequently, many states are combining coverage expansions with strategies aimed at improving the health care delivery and financing system while controlling costs as well. Likewise, states are demonstrating an increasing awareness that reform efforts targeted to cost containment can also promote healthy behaviors and more effective management of chronic conditions.

In *Approaches to Covering the Uninsured: A Guide*, KFF suggests that the variety of policy strategies and approaches to solving the problem of the uninsured can be organized into four categories, which may be proposed in some combination:

- Strengthen current coverage arrangements;
- Improve the affordability of coverage;
- Improve the availability of coverage; and,
- Change the tax treatment [or] financing of health insurance.<sup>9</sup>

### **Strengthening Current Coverage Arrangements**

One approach to increasing the number of individuals with health insurance is to build on and expand one or more of the current sources of coverage. This approach would involve efforts to expand employment-based coverage, expansion of existing public coverage programs and/or potential reforms to strengthen the individual health insurance market.<sup>10</sup>

*Build on Employment Coverage.* According to KFF, there are two basic ways to build on the employment-based coverage system: mandates and incentives. Employer mandates require all employers (or some subset of employers) to offer health coverage to their workers. Alternatively, rather than mandating employer coverage, either a pay or play, or an employer spending obligation, may require employers to pay a specified minimum amount toward employee health coverage or pay a similar amount to a designated public fund or program that will make health coverage available to workers. When states consider establishing employer health care obligations, the proposals must be crafted in the context of the federal Employee Retirement Income Security Act of 1974 (ERISA). ERISA generally allows states to regulate the business of health insurance but generally prohibits states from requiring employers to

provide health care coverage or specifying the benefits that must be provided by employers. ERISA has been the subject of a number of court decisions. ERISA presents complex legal considerations for states looking to include employer financing in initiatives to expand access to health care.

Financial incentives for employers to increase coverage usually take the form of tax credits, which offer subsidies for employers providing coverage. Financial incentives may be focused on assisting smaller or lower wage firms or targeted to employers who have not previously provided coverage. Targeting financial incentives for employer coverage necessarily involves consideration of how to balance the goal of expanding coverage with whether the incentives reward or penalize employers already contributing to the cost of employee health coverage.

*Build on Public Coverage.* Another way to build on the current sources of coverage is to expand existing publicly funded coverage programs. In California, the largest public coverage programs are Medi-Cal and HFP. Expansion of public programs at the state level builds on the existing state and federal infrastructure which already exists and has the potential to increase federal funding for the state's coverage effort. Expansions of coverage can increase income eligibility for groups that are currently covered, such as children, pregnant women, parents of covered children and/or low-income seniors and persons with disabilities. States can also consider development of federal Medicaid waiver programs that reduce or eliminate some of the categorical eligibility constraints in the federal program, allowing states to cover everyone at or below a certain income threshold. In addition to expanding eligibility, states may also implement outreach and enrollment strategies to increase the number of low-income eligible children and other groups who are eligible for the existing programs but not enrolled.

*Build on Individual Private Coverage.* The third approach to building on current sources of coverage is to enact reforms that strengthen the effectiveness of the individual private insurance market in meeting the coverage needs of uninsured persons. Individually purchased health insurance is currently the only source of coverage for those who do not have job-based coverage or who are not eligible for public coverage programs. The regulatory reform efforts affecting individual coverage attempt to address problems in the existing market. For example, the individual market is characterized by lack of availability or wide pricing differentials for those with pre-existing medical conditions or who are considered by health insurers to be potentially high-risk. The benefit offerings in the individual market are often complicated and difficult to understand, the coverage options may be less comprehensive for many and for many individual insurance products, there is a very low share of premium dollars that actually go to paying for medical services, as opposed to administrative costs and profits, compared to employer coverage.<sup>11</sup>

Elements of individual market reform might include one or more of the following: guaranteed issue and renewal, requiring health insurers to offer and renew coverage without regard to the health status of the individual purchaser; rating requirements which limit or prohibit premium variations in the market based on factors such as age, gender, geography or health status; standardization of benefit designs and/or establishing minimum benefit levels that health insurers must offer; establishing minimum medical loss ratios (the percent of premium that must be spent on medical care); and/or establishing and funding separate coverage programs for high-risk

persons and persons with pre-existing conditions, sometimes referred to as a "high-risk pool." In California, the Major Risk Medical Insurance Program (MRMIP), administered by the Managed Risk Medical Insurance Board (MRMIB) serves as the health insurer of last resort for individuals denied private individual coverage.

### **Improving the Affordability of Coverage**

According to KFF, no coverage expansion is feasible or sustainable if the affordability of coverage is not addressed.<sup>12</sup> While broad-based cost containment strategies, and an array of policies and programs to reduce health care costs and health care cost inflation, will likely be considered in any health reform effort, focusing on affordability as a way to cover more uninsured people generally leads to consideration of two basic strategies: subsidies for coverage and/or offering lower-cost coverage products.

*Offer Subsidies.* The most direct method for making coverage more affordable is to provide direct financial assistance to help individuals and families purchase coverage in the form of subsidies. According to KFF, the most common mechanisms proposed for subsidies are tax deductions, refundable tax credits, or direct subsidies. Subsidies can be made available to individuals based on income level, based on a sliding scale related to income, or calculated as a percent of premium for purchased coverage.

*Offer Less Expensive Products.* This strategy is to allow and/or facilitate the design and offering of less expensive insurance products. Generally speaking, health coverage products with lower premiums cover fewer benefits and require consumers to pay higher cost sharing in the form of deductibles, copayments, coinsurance and other out-of-pocket costs, including covering out-of-pocket the costs for health care services not covered in a more limited benefit plan. Understanding the impact that lower cost and lower benefit plans have on affordability of coverage necessarily requires consideration of the total out-of-pocket costs individuals will bear, including both premium payments and the cost-sharing elements of the plan.

*Provide for Reinsurance.* Another strategy to improve affordability of coverage is to provide some form of reinsurance, subsidy and/or pooling for high cost claims. The goal of reinsurance is to lower overall health insurance premiums by subsidizing in some way, such as direct state subsidy, purchase of reinsurance, or pooled payments across all purchasers, the costs associated with high cost individuals and catastrophic cases. The concept of reinsurance flows from the persistent data which shows that a very small proportion of any population (10-20%) accounts for the bulk of health care costs (80-90%), regardless of source and type of coverage. Higher costs are generally incurred by the health care system for persons with debilitating and often multiple chronic illnesses, people with cancer, premature babies or individuals with other life-threatening diseases, people needing end-of-life care and victims of terrible accidents.

### **Improve the Availability of Coverage**

In order to ensure broad coverage, health insurance must be readily available as well as affordable. Generally speaking, large employers are able to purchase or provide health care coverage for their workers, but the markets for small employers and individuals present barriers

to affordability and, in the case of the individual market, many potential buyers will be locked out of the market entirely because of their health status or prior claims history.

Create Or Provide Access To Large Purchasing Pools. One way to address the problems of availability and affordability of coverage, particularly for small employers and individuals, is to establish new or provide access to existing large purchasing arrangements. These arrangements have many names: purchasing cooperatives, exchanges, pools, or connectors. Purchasing cooperatives may be proposed on a state, regional or national basis. The idea is that the cooperatives arrange for or offer coverage for all eligible employers and individuals and by virtue of the number of purchasers buying together are better able to negotiate or offer lower prices than small employers or individuals might obtain on their own.

Mandate Individual Coverage. One way to ensure individuals have coverage is to establish a legal requirement that every resident obtain adequate private health insurance coverage, typically referred to as an individual mandate. Proponents of the individual mandate argue that mandates respond to a legitimate concern about "free riders," uninsured persons who nonetheless receive treatment when they get sick, in emergency rooms and through other uncompensated or reduced cost care, resulting in additional costs being passed on to taxpayers, purchasers and individuals with insurance. Proponents argue that those most likely to go without health insurance are the young and relatively healthy and that for these young, healthy individuals, going without health insurance is often a logical economic decision. The problem with their choice, proponents argue, is that it leads to a form of adverse selection. Allowing the young and healthy to stay out of the insurance pool typically results in higher insurance premiums for those who do buy coverage because the remaining insurance pool is older and more costly to insure. Finally, proponents argue that in the context of an individual mandate it is possible to impose stricter rules on insurance carriers, such as requiring them to guarantee issue of coverage to everyone, because concerns about potential adverse selection are reduced.

Opponents of an individual mandate argue that individuals, including young and healthy persons, are most likely uninsured because they cannot afford to buy meaningful coverage or are being denied private coverage because of pre-existing health conditions. Opponents argue that imposing a mandate does nothing by itself to significantly improve affordability and that the majority of uninsured persons will need some form of subsidy or government-sponsored health plan in order to comply with a mandate. Mandate opponents argue that requiring individuals to buy coverage on their own is inefficient, does not have the same tax advantages otherwise available for employer coverage, has higher selling costs and reduces the purchasing clout typically associated with buying group health insurance. Opponents are also concerned that a mandate can only be enforced through punitive and costly penalties or expensive government bureaucracies that come at the expense of the programs that actually provide health coverage. Finally, some opponents of the mandate view the requirements as unacceptably providing the health insurance industry with a captive market that must seek out and purchase their product.

Expand High-Risk Pools. Another strategy KFF identifies as a way to reform the underlying individual market and improve the availability of coverage is to establish or build on high-risk pools. High-risk pools currently operate in 34 states, including California, and provide health coverage to individuals considered medically uninsurable (or who meet other eligibility

requirements) and who are generally unable to purchase private individual coverage. Theoretically, allowing insurers to exclude such individuals from coverage keeps average premiums in the remaining market lower, while still ensuring that those who are most likely to need protection have a viable coverage option.

California's program for medically uninsurable persons, MRMIP, provides individual coverage through private health plans for those whose applications for private individual coverage are rejected by health insurers because of the individual's health history or health status. MRMIP is administered by the MRMIB, which also administers HFP. MRMIP subscribers pay relatively high premiums, which are set in statute at 125-137.5% of private market rates, and receive coverage that includes an annual benefit cap of \$75,000 per year. Premiums vary based on the age and region of the subscriber and the health plan they choose. MRMIP has served nearly 100,000 individuals since its inception in 1991 but, for much of that time, there has been a waiting list for the program. MRMIP premiums are subsidized through the Cigarette and Tobacco Surtax Fund (Proposition 99). Because the Proposition 99 appropriation (approximately \$40 million per year) is limited, the total number of individuals who can participate in MRMIP depends on available funding.

### **Change the Tax Treatment of Health Insurance**

Most of the major policy choices related to the tax treatment of health insurance surround the way that the health benefits are treated for purposes of federal taxes. The federal tax code currently provides an incentive for employers and employees to arrange for health care coverage in the workplace because employer payments for health care are tax-deductible for employers and not treated as taxable income for employees. Since the 1950s, these tax incentives have encouraged and subsidized the employment-based insurance market, making it the dominant source of coverage. Among other things, the treatment of existing tax benefits for employer-sponsored coverage has been criticized as subsidizing employers and employees with the richest benefits and those at the highest incomes, while disadvantaging those without employer coverage who purchase coverage on their own and must pay full premiums with after-tax dollars.<sup>13</sup> Incremental approaches to changing the tax treatment of health benefits include providing the same tax benefit for individual purchasers as those receiving employment-based coverage and capping the amount of employer benefits not subject to taxes.

### **Moving Away from an Employer-Based Coverage System**

Another set of broader changes would move entirely away from the current employer-based delivery system for health care coverage.

One strategy toward that end would replace that tax preference for employer-sponsored coverage with a tax credit or tax deduction for individually purchased coverage. One advantage of this approach is that a refundable tax credit is available whether a person owes taxes or not and could be made available even for those who do not pay taxes and are at lower income levels.<sup>14</sup> One potential disadvantage is that this approach relies on an individual health insurance market that has significant constraints and limitations, including notably higher administrative and marketing

costs, and the loss of group purchasing opportunities that can reduce premium costs.

*Single-Payer Health Care.* Single-Payer health care would essentially replace current sources of coverage and financing of health care for those under age 65 with a government-organized plan, funded in whole or in part through public financing. Instead of financing health care through employer and employee premiums, Single-Payer health care proposals generally assume funding through income, payroll and other general taxes. Proponents of Single-Payer argue that such a plan would guarantee coverage for everyone, and provide coverage in a manner that would be more efficient, and less costly, than the present system. This approach is sometimes referred to as "Medicare for everyone." Generally speaking, Single-Payer health care anticipates that the government would finance the care, with the health care delivery system remaining largely private. In most Single-Payer proposals, private health insurers would be able to sell "add on" and supplemental coverage, but would otherwise be excluded from maintaining a private market for basic health insurance. As KFF points out, the transformation of the health care financing and delivery system envisioned by a Single-Payer approach would require major cultural and administrative shifts for government, providers, insurers and the public.

#### IV. RELATED LEGISLATION

- 1) AB 1314 (Jones) would require the Department of Health Care Services, in consultation with the Legislature, to develop and submit a waiver to the federal government that would accomplish various objectives, including but not limited to, expanding health care coverage to low-and moderate-income children and adults, reducing the number of uninsured and maximizing federal funds.
- 2) SB 1 (Steinberg) would: a) expand Medi-Cal and HFP eligibility to cover all children regardless of immigration status with family incomes at or below 300% FPL; b) established a HFP Buy-In Program for children in families with incomes above 300% FPL; c) establish various presumptive eligibility programs; and d) streamline enrollment and retention with the goal of keeping more children covered.
- 3) SB 56 (Alquist) would make legislative findings and declarations regarding health care coverage and would declare the intent of the Legislature to enact and implement comprehensive reforms in the state's health care delivery system, as specified.
- 4) SB 92 (Aanestad) would establish the Healthcare Restoration Act (Act), and would use tax credits, health savings accounts, reinsurance products, tort reform, and electronic medical records to make reforms to California's health care system. The Act also makes significant changes to Medi-Cal.
- 5) SB 810 (Leno) would establish the California Healthcare System to be administered by the newly created California Healthcare Agency under the control of a Healthcare Commissioner appointed by the Governor and subject to confirmation by the Senate. SB 810 would make all California residents eligible for specified health care benefits under the California Healthcare System, which would, on a single-payer basis, negotiate for or set fees for health care services provided through the system and pay claims for those services. SB 810 would

establish a Premium Commission to recommend premiums to support the program and remaining elements of the proposal would only become operative on the date the Secretary of California Health and Human Services notifies the Legislature, as specified, that sufficient funding exists to implement the program.

## **V. PREVIOUS LEGISLATION**

- 1) AB 1 X1 (Nunez) of 2007 would have enacted the California Health Care Reform and Cost Control Act and created the California Cooperative Health Insurance Purchasing Program (Cal-CHIPP), a state health care purchasing program to provide coverage to specified employees, individuals eligible for new expanded public coverage and individuals who would have been newly eligible for a tax credit to defray health insurance costs. AB 1 X1 would have also established various health cost containment measures and private insurance market reforms and included several financing elements that would have been subject to voter approval on the November 2008 statewide ballot. AB 1 X1 failed passage in the Senate Health Committee.
- 2) AB 8 X1 (Villines) of 2007 proposed multiple, diverse strategies to address health care costs and access, including: tax incentives and government programs to promote and facilitate consumer-directed health care and employer-sponsored insurance; allowing the sale of out-of-state health plans and policies not subject to any California law or regulation; increasing Medi-Cal provider reimbursement rates and creating an income tax credit for physicians who provide unreimbursed care for the uninsured; establishing a mechanism for financial aid for training physician assistants; and, requiring foundation conversions to provide direct medical care. AB 8 X1 was not heard in the Assembly Health Committee at the author's request.
- 3) AB 1 (Laird and Dymally) and SB 32 (Steinberg), two similar bills introduced in 2007, would have: a) expanded Medi-Cal and HFP eligibility to cover all children regardless of immigration status with family incomes at or below 300% FPL; b) established a HFP Buy-In Program for children in families with incomes above 300% FPL; c) established various presumptive eligibility programs; and streamlined enrollment and retention with the goal of keeping more children covered. Both bills passed the Legislature but were not sent to the Governor.
- 4) AB 2 (Dymally) of 2007 would have revised and restructured MRMIP, which provides subsidized individual health care coverage for medically uninsurable persons. AB 2 would have secured additional funding and coverage for MRMIP-eligible persons by requiring all health plans and health insurers selling individual coverage in the state to accept assignment of such persons or to support the costs of MRMIP through a per person fee on individual health plan contracts and policies. AB 2 would also have enacted specified program changes related to eligibility, benefits and program administration. AB 2 was vetoed by Governor Schwarzenegger.
- 5) AB 8 (Nunez) of 2007 would have established the California Cooperative Health Insurance Purchasing Program (Cal-CHIPP) as a state purchasing pool administered by MRMIB, to negotiate and contract with health plans and health insurers to provide health insurance for

employees (and their dependents) of employers who elected to pay a fee to the state in lieu of making expenditures for health care for their employees equal to a specified percent of wages paid by the employer. AB 8 excluded very small and low-income employers. AB 8 also would have extended coverage to parents and children under 300% FPL through Medi-Cal and HFP, and covered the children regardless of immigration status. Finally, AB 8 included health insurance market reforms, uniform benefit designs and specific cost containment strategies. AB 8 was vetoed by Governor Arnold Schwarzenegger.

- 6) SB 48 (Perata) of 2007 would have established the Health Insurance Connector as a health insurance purchasing pool administered by MRMIB, and would have required employers to spend a designated amount on health care for employees or elect to have that health coverage provided through the Connector. SB 48 mandated that all employed persons have health insurance either through their employer or purchased on their own. The mandate covers all workers and their families. SB 48 would have extended coverage to parents and children under 300% FPL through Medi-Cal and HFP and included health insurance reforms in the state purchasing program and numerous cost containment strategies. SB 48 was amended to deal with another subject.
- 7) In 2007, Assembly Republicans introduced a 17 bill package of proposed reforms that included access to health savings accounts, decreased regulation of insurers, fewer insurance mandates, and a state insurance exchange for individuals, expanded state tax deductions for medical expenses, and combined health and workers compensation insurance policies. Eight of these bills were not heard at the authors' request. Of the remaining bills, two were passed by the Assembly, AB 1559 (Berryhill), Chapter 712 of 2007, which expands nursing education programs, and AB 1304 (Smyth), related to seismic upgrades of hospitals, which was not heard in Senate Health Committee at the request of the author.
- 8) In 2007, Senate Republicans introduced a series of bills and a reform plan that would have relied on tax incentives, redirection of existing health program funding and increased availability of community and primary care clinics to expand access to health care. The proposals included seeking voter approval to redirect existing tobacco tax revenues away from existing programs to children's coverage and would have reduced Medi-Cal benefits with the stated goal to make them more like what employed persons have in their job-based coverage; increased Medi-Cal provider rates over eight years; and reduced regulation of health insurance carriers to allow greater flexibility in the health insurance market.
- 9) SB 840 (Kuehl) of 2007 would have created the California Healthcare System (CHS), a Single-Payer health care system, administered by the California Healthcare Agency established in SB 840, to provide health insurance coverage to all California residents. SB 840 would have required the CHS to become operative when the Secretary of Health and Human Services determined the Healthcare Fund established for the program had sufficient revenues for implementation. SB 840 was vetoed by Governor Schwarzenegger.
- 10) SB 1014 (Kuehl) of 2007 would have funded the health care system proposed in SB 840 (Kuehl) through income, self-employment, and payroll taxes. No vote was taken on SB 1014

in the Senate Revenue and Taxation Committee.

- 11) SB 840 (Kuehl) of 2006, a Single-Payer bill, was vetoed by Governor Schwarzenegger. In his veto message, the Governor argued that SB 840 would result in an extraordinary redirection of public and private funding and a vast new bureaucracy, and that the preferable approach would be to promote personal responsibility and to build on the private and public systems already in place.
- 12) SB 921 (Kuehl), introduced in 2003, would have established a Single-Payer health care system in California. SB 921 passed the Senate and the Assembly Health Committee and died in the Assembly Appropriations Committee.
- 13) SB 2 (Burton), Chapter 673, Statutes of 2003, enacted the Health Insurance Act of 2003, a "pay-or-play" approach, to provide health coverage to employees (and in some cases their dependents) who do not receive job-based coverage and who work for large and medium employers. SB 2 was repealed by Proposition 72, a voter referendum on the November 2004 ballot.

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<sup>5</sup> Brown ER, Lavarreda SA, Peckham E and Chia YJ, *Nearly 6.4 Million Californians Lacked Health Insurance in 2007 – Recession Likely to Reverse Small Gains in Coverage*, Los Angeles, CA: UCLA Center for Health Policy Research, December 2008.

<sup>6</sup> Snapshot -- Health Insurance: Can Californians Afford It? California HealthCare Foundation, June 2008 obtained on-line at [www.chcf.org](http://www.chcf.org).

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<sup>8</sup> Ibid.

<sup>9</sup> Tolbert, J., Ebeler J., and Schwartz T., *Approaches to Covering the Uninsured: A Guide*, Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, December 2008.

<sup>10</sup> Ibid.

<sup>11</sup> Ibid.

<sup>12</sup> Ibid.

<sup>13</sup> Ibid.

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**LAO**

Mac Taylor  
Legislative Analyst

March 10, 2009

2009-10 Budget Analysis Series

# Federal Economic Stimulus Package: Fiscal Effect on California



## SUMMARY

The recently enacted federal economic stimulus package—titled the American Recovery and Reinvestment Act (ARRA)—commits a total of \$787 billion nationwide. As reflected in the figure below, this funding provides: (1) \$330 billion in aid to the states, (2) about \$170 billion for various federal projects and assistance for other non-state programs, and (3) \$287 billion for tax relief.

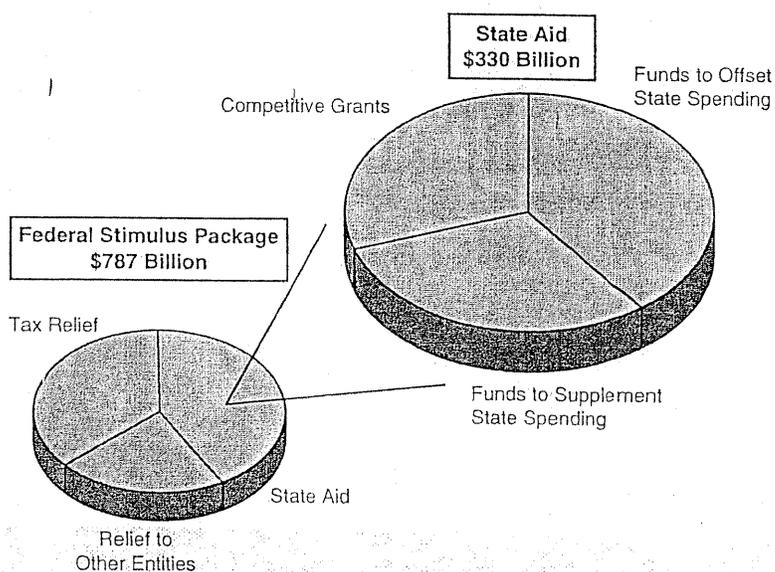
This report focuses on the state aid component of the stimulus package, as it consists of the federal dollars with which the Legislature will be most involved. As the figure shows, the state aid “pie” also consists of three pieces: (1) federal dollars that can be used to address budget shortfalls, (2) funds that supplement existing state spending, and (3) competitive grants. We estimate that California will receive over \$31 billion from the first two components (see table on next page) and billions more in competitive grants.

### The State “Trigger”

A significant portion of the \$31 billion in aid to California will be available to address the state’s budgetary problems. We estimate that, based on the enacted state 2009-10 budget, California can use \$10.4 billion in new federal dollars for this purpose over the life of ARRA. Of that amount, \$8 billion would be available in 2008-09 and 2009-10. The Director of Finance and State Treasurer will determine their own estimate of the latter amount by April 1 of this year. If the amount is less than \$10 billion, then annual state program reductions of nearly \$1 billion and revenue increases of about \$1.8 billion adopted as part of the 2009-10 budget package will go into effect.

Given the state’s continuing economic struggles, however, it is possible that state revenues (and the Proposition 98 minimum funding level) may continue to fall. In that case, it may be possible to use additional federal education dollars for budgetary relief.

**Federal Economic Stimulus Package Provides Significant Aid for States**



### Key Considerations for the Legislature

The Legislature will need to take many actions in the coming months to ensure that the funds are used in ways that meet its priorities and preferences. To assist in this process, we offer the following considerations in making decisions regarding these new federal funds:

- **Maximize the Benefit of Federal Funds to the General Fund Budget.** In this report, we make specific recommendations about how to help the state's budgetary situation under different scenarios.
- **Recognize the Short-Term Nature of New Federal Funds.** Most of the state aid coming to California is intended to *supplement* current state spending. There is the risk, however, that the higher levels of service provided by the federal dollars will create ongoing expectations of state support once the funding expires. We offer strategies to address this risk.
- **Act Quickly in a Handful of Cases.** In certain instances, the state will need to act rapidly to ensure it receives the maximum amount of relief or to use the funds in the most effective way possible. Addressing a Medi-Cal eligibility issue and providing direction on the use of transportation funds are two such examples.
- **Use Next Few Months to Oversee Implementation of New Federal Spending.** For most of the new federal dollars and programs, the Legislature will have more time to take necessary actions. For example, the Legislature can use its budget process to monitor the state's revenue picture and take whatever actions are needed to use federal

### California Will Receive Over \$31 Billion in State Aid

(In Millions)

Program Area	Federal Fiscal Year			Totals
	2008-09	2009-10	2010-11	
Health	\$3,986	\$4,026	\$1,024	\$9,036
Education	—	7,973	—	7,973
Labor and workforce development	3,498	2,420	79	5,997
Social Services	1,500	1,441	577	3,518
Transportation	1,302	1,302	—	2,604
General purpose fiscal stabilization	—	1,100	—	1,100
Resources/environmental	597	—	—	597
Housing programs	381	—	—	381
Criminal justice	264	—	—	264
Other	27	—	—	27
<b>Totals<sup>a</sup></b>	<b>\$11,555</b>	<b>\$18,262</b>	<b>\$1,680</b>	<b>\$31,497</b>

<sup>a</sup> Does not include significant additional federal funds the state is likely to receive from competitive grants.

dollars to keep the 2009-10 budget in balance. Similarly, the Legislature can use policy and budget subcommittee hearings to craft needed legislation; specify its wishes as to how new dollars are to be spent and oversee the administration's plans with regards to the new funds.

## OVERVIEW OF THE AMERICAN RECOVERY AND REINVESTMENT ACT

On February 17, 2009, President Obama signed into law the American Recovery and Reinvestment Act (ARRA) of 2009, H.R. 1. The spending and tax-cut plan is intended to help stabilize state budgets and spur economic growth. The stimulus package commits a total of \$787 billion nationwide, and it will have a significant fiscal impact on California.

### One-Third of the Federal Funding Is for State Aid

Figure 1 shows how ARRA funding falls into three main categories. The stimulus package provides about \$330 billion in federal funds in aid to states. A variety of tax provisions intended to boost the economy will cost the U.S. Treasury \$287 billion more. Finally, about \$170 billion is available to be spent by federal agencies on federal projects or for other non-state programs, such as direct grants to local entities.

### State Aid Comes in a Variety of Forms

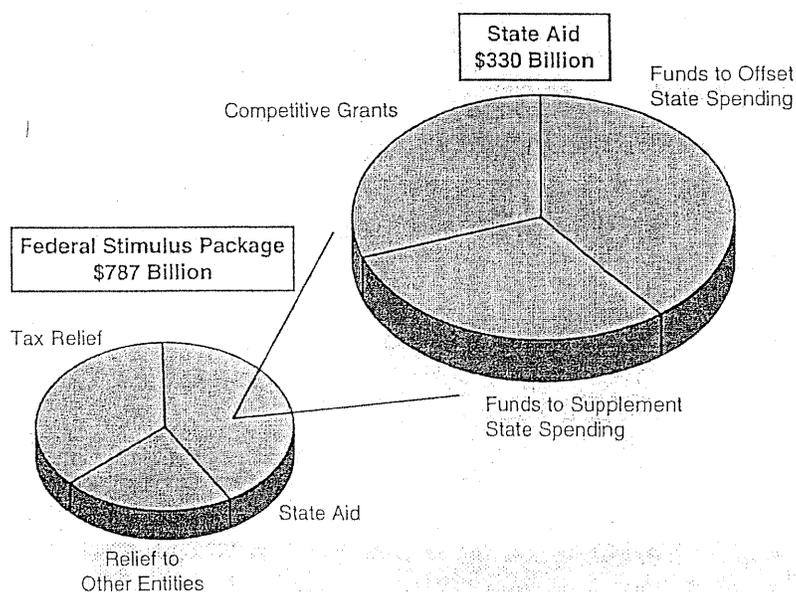
Of the roughly \$330 billion in aid available nationwide for states:

- Almost \$100 billion is available to supplant or offset states' general fund spending.
- As much as \$130 billion will be available to states to supplement or increase state spending on a wide variety of programs.
- States and other entities (such as local governments) will also be able to apply for up to \$100 billion in competitive or discretionary grants.

All of the funding for state relief is provided on a temporary basis and generally will be only available for the next few years.

Figure 1

### Federal Economic Stimulus Package Provides Significant Aid for States



### California Will Receive a Significant Amount of Additional Federal Funds

Of the \$330 billion available under ARRA nationwide for state aid, we estimate that California will receive approximately \$31 billion in additional federal funds during the current and the next two federal fiscal years (FFYs). As Figure 2 shows, the state's health programs will receive the largest share of these federal funds, about \$9 billion, and education-related programs will receive nearly \$8 billion in additional federal funds. These programs are followed by labor and workforce development and social services programs, which will receive about \$6 billion and \$3.5 billion, respectively.

In some of the program areas, the year-by-year flows of funds are estimates and may occur differently than depicted in Figure 2. In addition, this figure does not capture the unknown, but potentially significant additional federal funds that the state is likely to receive when it applies

for competitive grant funding included in ARRA. Finally, given the complexity of this legislation, our estimates of the state's allocations included in this report should be considered preliminary and subject to revision as more information becomes available.

### Some Federal Funds Are Available To Offset General Fund Spending

*2009-10 Budget Package Is Linked to Federal Fiscal Relief.* The Governor signed the *2009-10 Budget Act* and related legislation on February 20, 2009, to address the state's projected \$40 billion shortfall. Based on the administration's estimates, the act assumes that the state will receive \$8 billion in federal stimulus funds to offset General Fund expenditures. The Governor vetoed an additional \$510 million from the universities' budgets in anticipation that even more fiscal relief would be available to backfill that reduction.

*LAO Estimates of Offsets Under Budget Package.* Our estimates of federal funds that can offset General Fund costs under the 2009-10 budget package are similar to the administration's. As Figure 3 shows, we project that state spending would be reduced by almost \$8 billion through 2009-10, with an additional \$2.4 billion in offsets in 2010-11.

These amounts capture offsets in General Fund expenditures that

Figure 2  
California Will Receive Over \$31 Billion in State Aid

(In Millions)

Program Area	Federal Fiscal Year			Totals
	2008-09	2009-10	2010-11	
Health	\$3,986	\$4,026	\$1,024	\$9,036
Education	—	7,973	—	7,973
Labor and workforce development	3,498	2,420	79	5,997
Social Services	1,500	1,441	577	3,518
Transportation	1,302	1,302	—	2,604
General purpose fiscal stabilization	—	1,100	—	1,100
Resources/environmental	597	—	—	597
Housing programs	381	—	—	381
Criminal justice	264	—	—	264
Other	27	—	—	27
<b>Totals<sup>a</sup></b>	<b>\$11,555</b>	<b>\$18,262</b>	<b>\$1,680</b>	<b>\$31,497</b>

<sup>a</sup> Does not include significant additional federal funds the state is likely to receive from competitive grants.

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occur “on the natural” or with the state making relatively minimal changes to existing programs to receive the funds. For example, the single greatest source of relief comes from the increase in the percentage of program costs funded by the federal government for the state’s Medicaid program, known as Medi-Cal in California. This source of funding and the others shown in Figure 3 are discussed in more detail later in this report.

**Federal Stimulus and the State Trigger**

The budget package requires the State Treasurer and the Director of Finance to determine by April 1, 2009 if ARRA makes available by June 30, 2010 additional federal funds that may be used to offset at least \$10 billion in General Fund expenditures. If they determine that federal fiscal relief reaches that \$10 billion threshold, then nearly \$1 billion in cuts to various programs

and a 0.125 percentage point increase in personal income tax rates included in the budget package would trigger off—that is, not go into effect.

**Language Open to Interpretation.** The language in the *2009-10 Budget Act* describing what needs to happen in order for the trigger to be reached is somewhat open to interpretation. For example, the language states that the federal legislation must “make available” by June 30, 2010, federal funds “that may be used” to offset \$10 billion in General Fund expenditures. This wording raises such questions as whether \$10 billion must actually be used to offset state General Fund costs, or whether this requirement would be satisfied if funds of this amount were identified that theoretically could be used in this way.

Our estimate of \$8 billion in federal funds being available to offset General Fund expenditures, shown in Figure 3, excludes offsets

**Figure 3**  
**Stimulus Funds Potentially Available to Offset General Fund Expenditures**

*Based on Enacted Budget Package  
(In Millions)*

Program Area/Provision	State Fiscal Year			2008-09 and 2009-10	All Years
	2008-09	2009-10	2010-11	Combined	
<b>General Purpose</b>					
State Fiscal Stabilization Fund	—	\$1,100	—	\$1,100	\$1,100
<b>Health</b>					
Medi-Cal-related programs	\$2,631	\$3,740	\$1,957	\$6,371	\$8,328
Early Start program	—	53	—	53	53
<b>Labor and Workforce Development</b>					
Workforce Investment Act discretionary funds	—	\$37	\$37	\$37	\$74
Unemployment Insurance—interest relief	—	30	209	30	239
<b>Social Services</b>					
CalWORKs Emergency Fund	\$40	\$200	\$190	\$240	\$430
Foster Care and Adoption Assistance programs	33	45	24	78	102
Department of Child Support Services	22	30	7	52	59
<b>Totals<sup>a</sup></b>	<b>\$2,726</b>	<b>\$5,235</b>	<b>\$2,424</b>	<b>\$7,961</b>	<b>\$10,385</b>

<sup>a</sup> The General Fund impact of the education American Recovery and Reinvestment Act funds is addressed later in this report.

the state might achieve from education-related federal funds. This is because our estimate is based on the level of state revenues assumed in the *2009-10 Budget Act* and the corresponding level of support provided for state education programs. The state's continuing economic struggles, however, suggest that revenues (and the Proposition 98 minimum guarantee) may continue to fall. Under such a scenario, it may be possible to use additional federal education funding to offset

a greater amount of General Fund spending for state education programs, as we discuss in the "Education" section of this report. Ultimately, the interpretation of this provision of statute is a matter for the Director of Finance and the State Treasurer to decide. The administration has indicated that its preliminary conclusion is that the available federal funds will be insufficient to avoid the tax increase and cuts contained in the February budget package.

## KEY CONSIDERATIONS FOR THE LEGISLATURE

As noted earlier, the federal economic stimulus package will provide about \$31 billion in additional federal dollars directly to the state for a wide array of programs. In response, the Legislature will need to take many actions in the coming months to ensure that the funds are used in ways that meet its priorities and preferences. To assist in that process, we discuss below some key considerations in making decisions regarding these new federal funds.

**Maximize the Benefit of Federal Funds on the General Fund Budget.** Given both the deteriorating economic situation and the gloomy out-year state budget forecast, we believe the Legislature must maximize the use of stimulus dollars to offset General Fund expenditures. In this report, we make specific recommendations about how to do so. Some federal dollars may only be available for General Fund relief in certain situations (such as certain education funds if state revenues decline further).

**Recognize the Short-Term Nature of New Federal Funds.** Most of the state aid coming to California is intended to *supplement* current state spending. There is the risk, however, that the higher levels of service provided by the federal

dollars will create ongoing expectations of state support once the funding expires. There are ways to limit this risk:

- The Legislature should dedicate this limited-term federal assistance as much as possible to limited-term purposes. For instance, we recommend using some of the education funds to pay for one-time mandate costs and data systems development.
- For ongoing programs receiving supplemental funding, the Legislature could spread out dollars over three years (instead of one or two), thereby reducing the level of new spending. In addition, the Legislature could make explicit that the supplemental funding is in effect only for the duration of the added federal funds.
- The Legislature could also use the near term to explore and implement program reforms that often take several years to achieve savings. For example, the Legislature could expand "pay for performance" programs that provide fiscal incentives

for Medi-Cal providers that could ultimately save tens of millions of dollars annually. By starting now, the state would be more likely to have in place programmatic savings that could offset the loss of supplemental federal funds in the out-years.

**Act Quickly in a Handful of Cases.** In certain instances, the state will need to act rapidly to ensure it receives the maximum amount of relief or to use the funds in the most effective way possible. We have identified the following situations where quick action is needed:

- To receive major new federal funding for the Medi-Cal Program, California must make a change in state law regarding eligibility by July 1, 2009.
- The Legislature should provide direction on its preferred approach to distributing new federal dollars for transportation and input on the federal government's plans regarding the allocation of high-speed rail funds.
- To fully access state clean waters monies, legislation must authorize specific types of financial assistance.

## HEALTH

One of the largest portions of federal fiscal relief to states will come in the form of an increased federal share of costs for state Medicaid programs (known as Medi-Cal in California). Below, we summarize and discuss the increased federal share and other key health-related components of ARRA.

### Increased Federal Share of Funding for Medi-Cal

The federal government pays a certain percentage of the cost of each state's Medicaid

*Use Next Few Months to Oversee Implementation of New Federal Spending.* For most of the new federal dollars and programs, the Legislature will have more time to take necessary actions. For example, the Legislature can use its budgetary process to monitor the state's revenue picture and take whatever actions are needed to use federal dollars in keeping the 2009-10 budget in balance. Similarly, the Legislature can use policy and budget subcommittee hearings to:

- Address any needed legislation related to the use of new federal dollars.
- Oversee departments' plans and efforts in applying for competitive grants and spending supplemental funds.
- Ensure that the use of federal stimulus dollars is consistent with existing state policies.
- Provide any needed assistance to local governments regarding their use of new federal dollars.

Below, we describe by program the additional federal funding the state will be receiving and major issues for legislative consideration.

program. This percentage is known as the federal medical assistance percentage or FMAP. The ARRA temporarily increases the FMAP for all states retroactively to October 2008 and continuing through December 2010, subject to certain requirements and restrictions, which we discuss below. The ARRA provides a base FMAP increase of 6.2 percentage points for all states, plus additional increases determined by a formula that incorporates each state's unemployment rate and current federal share.

**Significant Funding for California.** Based on recent employment data, California likely would qualify initially for the highest unemployment-based FMAP increase available under ARRA. Thus, our preliminary estimate is that Medi-Cal will receive an FMAP increase of 11.6 percentage points, equivalent to \$10.1 billion in additional federal funds for the state through December 31, 2010. This amount will be distributed among several state departments that administer portions of the Medi-Cal Program, as well as to local governments, who also share in the cost of some Medi-Cal services. Figure 7 summarizes our estimates of state and local savings. The state portion of the federal funds, \$8.3 billion, will reduce state General Fund costs over the period.

**Requirements and Restrictions.** In order to receive the enhanced FMAP, states must comply with certain requirements and restrictions. The most significant of these are the following:

- **Eligibility.** States may not receive the FMAP increase after July 1, 2009, unless they maintain eligibility levels and procedures that were in place as of July 1, 2008. The FMAP increase is not available for Medicaid eligibility expansions enacted after July 1, 2008 or for certain health programs that already receive enhanced federal matching funds.
- **“Prompt Pay.”** As of June 1, 2009, states are not eligible for the enhanced FMAP for days during which they do not meet federal prompt pay requirements. These requirements specify, among other provisions, that state Medicaid programs pay 90 percent of noninstitutional medical claims within 30 days. The ARRA would apply these provisions to nursing homes and hospitals as well.
- **“Rainy Day Funds.”** States may not use funds attributable to the increased FMAP as deposits into a rainy day fund or reserve.

**Figure 7**  
**State and Local Savings From Increase in Federal Share of Medi-Cal Costs**

(In Millions)

	2008-09	2009-10	2010-11	Total
<b>State Departments</b>				
Health care services	\$1,973	\$2,838	\$1,482	\$6,293
Social services (IHSS)	282	389	206	876
Developmental services	234	313	163	710
Other departments	143	200	106	449
Subtotals	(\$2,631)	(\$3,740)	(\$1,957)	(\$8,327)
<b>Other Entities</b>				
Local government	\$305	\$408	\$203	\$916
Public hospitals <sup>a</sup>	293	361	179	833
Subtotals	(\$598)	(\$769)	(\$382)	(\$1,749)
<b>Total Federal Fund Relief</b>	<b>\$3,229</b>	<b>\$4,508</b>	<b>\$2,339</b>	<b>\$10,077</b>

<sup>a</sup> Includes University of California hospitals.  
IHSS = In-Home Supportive Services.

**State Currently Does Not Qualify for Enhanced FMAP.** Based on our review of the ARRA provisions affecting Medicaid, California currently does not qualify for the FMAP increase due to a procedural change to Medi-Cal Program eligibility rules the state enacted as part of the 2008-09 Budget

Act. This change required children to submit a midyear status report to confirm their continuing eligibility for Medi-Cal every six months, along with their parents, who were already required to submit this report. In order to receive the new federal funds, the state would need to reverse this policy prior to July 1, 2009. This reversal would result in additional General Fund costs to the state of \$70 million in 2009-10 (as estimated at the enhanced FMAP rate). Based on our review and our discussions with the state Department of Health Care Services (DHCS), which administers Medi-Cal, the state currently meets all other ARRA requirements.

**State Policy Change Needed to Access Increased Federal Funds.** The federal government made increased FMAP funding available as of February 25, 2009 for six months of prior expenses. The department indicated in discussions that it will be ready to begin drawing down the additional funds as soon as mid-March. However, DHCS also reported that it must certify to the federal government that California has reversed

its new midyear status report requirement before the state can access these funds. Therefore, we recommend that the Legislature enact legislation as soon as possible to reverse the children's midyear reporting requirement.

**Other Medicaid Provisions**

In addition to the FMAP enhancement, the federal economic stimulus package includes other funding for state Medicaid programs that we discuss below. We summarize the major provisions in Figure 8. None of these provisions are likely to offset General Fund expenditures in the Medi-Cal Program, but some may increase state costs.

**Health Information Technology (HIT).** The ARRA provides an estimated \$15 billion nationwide over nine years to pay most of the costs to implement and administer electronic health records for qualifying Medicaid providers, such as children's hospitals and physicians who serve a minimum percentage of Medicaid enrollees in their practice. Only technologies that meet

**Figure 8  
Other Key Medicaid Provisions in Federal Economic Stimulus Package**

Provision	Fiscal Effects	
	Nationwide	California
Health information technology	\$2 billion appropriated for grants, \$15 billion estimated spending for Medicaid incentive payments, and \$22 billion for Medicare incentives.	Unknown.
Disproportionate Share Hospital (DSH) funding	Estimated \$548 million.	Direct increase of \$54 million in federal DSH funds for public hospitals. Also results in increase of \$9 million (General Fund) for other hospitals.
Transitional Medi-Cal expansion	Estimated \$1.3 billion.	Costs of \$59 million (General Fund) if California implements optional expansion.
Delay in various Medicaid regulations	Potential savings.	Potential savings.

certain standards will be eligible for funding, and the state would need to administer a HIT oversight program to ensure that providers receiving federal funds adhere to ARRA's specified criteria.

The ARRA provides an estimated \$22 billion nationwide over nine years for similar incentives in the federal Medicare program, and \$2 billion for a variety of grants and other assistance to promote various health information technologies. The grant and other assistance programs require varying levels of nonfederal funding to draw down this federal assistance—in some cases as little as \$1 of nonfederal funding for every \$10 received from the federal government. These nonfederal shares could be provided by states or potentially by local governments or other entities. The federal grants will be awarded based on a competitive application process, and the details of the distribution are not yet established.

In our recent report, the *2009-10 Budget Analysis Series: Health* (see page HE-15), we discuss how increasing the adoption of HIT among health care providers holds the potential to reduce the costs and increase the quality of health care in California. We recommend that the state seek to identify nonstate sources of funding from private health care organizations or provider organizations in order to participate in the proposed HIT programs to the extent possible. We further recommend that the state Office of Health Information Integrity be directed to take the lead in these efforts.

***Disproportionate Share Hospital (DSH) Payment Increase.*** Under the federal DSH program, the federal government provides a pool of funds each year to supplement Medicaid reimbursements to hospitals that serve a disproportionate number of Medicaid or other low-income patients. The ARRA increases DSH funding by

2.5 percent a year for two years. We estimate this will result in additional federal payments of \$54 million over that period to public hospitals in the state, including hospitals operated by the UC. The nonfederal share needed to access these DSH funds is provided by the public hospitals themselves in the form of costs they incur to deliver services. The federal DSH increase will result in automatic increases in payments to certain other hospitals by an estimated \$9 million in General Fund costs (\$24 million total funds) over the next two years due to current provisions in California law.

***Transitional Medi-Cal.*** Current federal law requires states to provide an additional 12 months of coverage to families enrolled in Medi-Cal who increase employment income beyond a certain level. Under the ARRA, for a two-year period ending December 31, 2010, states could elect to (1) loosen restrictions on retaining this Medi-Cal coverage by automatically enrolling these families in 12 months of coverage and (2) waive the minimum enrollment period now needed to qualify for transitional coverage. We estimate that the state would incur General Fund costs of \$59 million (assuming the enhanced FMAP provided in the ARRA) over two years to automatically provide the additional coverage for the approximately 150,000 current transitional enrollees. The state also would incur unknown costs as a result of waiving the minimum enrollment period requirements, as it is unclear how many enrollees might become eligible to receive the extended period of benefits. Given the state's severe fiscal problems, we would recommend that the Legislature not expand this program.

***Delay of Certain Medicaid Regulations.*** The ARRA extends through June 30, 2009, the current moratoria on certain federal regulations

that could otherwise increase state and local costs for the Medi-Cal Program. For example, one regulation would limit the opportunity for the state to use so-called provider taxes to fund rate increases and achieve General Fund savings. It also imposes a new moratorium through June 30, 2009, on a regulation regarding outpatient hospital facility services. Lastly, ARRA expresses Congress' intent that certain pending federal regulations should not be issued. If these federal regulations were in effect, the state and local agencies and health care providers would face potentially significant adverse fiscal impacts.

**Other Health Provisions**

In addition to the Medicaid provisions described above, the federal economic stimulus

package includes additional funding for other health-related provisions. We summarize the most significant of these in Figure 9, and discuss them further below.

**Grant Money for Public Health Centers.** The ARRA provides \$2 billion in grant money nationwide to qualified health centers, including federally qualified health centers. Of the \$2 billion, \$1.5 billion is for construction and renovation of facilities, and the purchase of HIT. The remaining \$500 million is available to support new or existing health center sites or service areas and to provide supplemental payments for spikes in uninsured populations. At the time this report was prepared, the federal government had not established how it would distribute these funds.

**Figure 9  
Other Major Health-Related Provisions in Federal Economic Stimulus Package**

Provision	Fiscal Effects		Available to Offset General Fund Spending?
	Nationwide	California	
Grant money for public health centers	\$2 billion for construction, certain technology, and general purposes.	Unknown.	No
Health workforce funding	\$500 million for health workforce development.	Unknown.	No
Additional federal grants for Early Start program	\$500 million for the federal Individuals with Disabilities Education Act Part C grants.	About \$50 million for the Early Start Program.	Yes
Prevention and Wellness Fund	\$1 billion for various prevention and wellness programs.	\$34 million for vaccinations. Unknown for other programs.	Unknown
Supplemental funding for Women, Infants, and Children	\$500 million for nutrition assistance programs, including \$100 million for information systems.	Unknown.	No
Safe Drinking Water State Revolving Fund	\$2 billion.	\$160 million to the state for drinking water projects that can begin construction before February 17, 2010.	No
Continuing employer-sponsored health coverage (COBRA)	Unknown.	Unknown.	No

COBRA = Consolidated Omnibus Budget Reconciliation Act.

**Health Workforce Funding.** The ARRA provides \$500 million nationwide to support health care workforce development programs. Included in this amount is \$300 million for the federal National Health Service Corps, which provides medical education scholarships and loan replacement funds as well as grants to medical training programs. The Office of Statewide Health Planning and Development currently administers various health care workforce development programs, including medical education support funded in part through \$1 million annually from the National Health Service Corps. At the time this report was prepared, information was unavailable regarding how these funds will be distributed or how much California might receive.

**Additional Federal Grant Funds for Early Start Program.** The ARRA provides about \$50 million in grant funding in FFY 2009-10 for the federal IDEA Part C early intervention programs, known in California as the Early Start program. This funding can likely be used to offset General Fund support of Early Start, which is administered by the state Department of Developmental Services. Some IDEA Part C funds support Early Start requirements in other departments including CDE and the Office of Administrative Hearings. At the time this analysis was prepared, it was unclear what process the federal government will follow to distribute these funds.

**Prevention and Wellness Fund.** The ARRA provides \$1 billion nationwide for prevention and wellness efforts, including: (1) \$50 million to prevent health care-associated infections, (2) \$300 million in grants to state and local health departments to vaccinate certain eligible children and adults, and (3) \$650 million for

clinical and community-based strategies that are proven to reduce chronic disease rates. The state is expected to receive \$34 million of the \$300 million for the vaccination program. A federal spending plan has not yet been announced for the remaining \$700 million. Some funds will likely be distributed through grants, with guidelines for such grants announced by May 2009.

**Supplemental Funding for Women, Infants, and Children (WIC).** The ARRA provides supplemental funding of \$500 million for the WIC nutrition assistance program, including \$100 million for information systems. Although the state-by-state allocation of these funds has not been announced, it is likely that California will receive a portion of this supplemental funding in order to meet the increasing demand for WIC services in the state.

**Safe Drinking Water State Revolving Fund (SDWSRF).** The ARRA provides an estimated \$160 million to the state for "shovel-ready" drinking water projects that can begin construction before February 17, 2010. The state Department of Public Health (DPH) has already begun to solicit applicants and proposals for this funding and anticipates posting a list of eligible projects by April 2009. The DPH anticipates that, once the list is posted, it will begin awarding funding to eligible projects on a first-come, first-served basis until all funds are allocated.

**Provisions to Continue Employer-Sponsored Health Insurance.** The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) allows employees and/or their family members to temporarily extend their coverage in a group health plan when coverage would be lost due to certain events, such as loss of a job. This program can provide coverage up to 36 months. An individual must pay the entire monthly premium.

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Under ARRA, persons who lost employer-based health coverage between September 1, 2008 and January 1, 2010 due to job loss would be eligible for a federal subsidy. The subsidy would last for

nine months and would cover 65 percent of the premium, with the individual responsible for the remaining 35 percent. The subsidy would be phased out for higher-income persons.