# California's Near Miss

## Understanding the policies and politics of the proposed ABx1-1 legislation

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# About Community Catalyst

Community Catalyst is a national non-profit advocacy organization dedicated to quality affordable health care for all. Since 1997, Community Catalyst has been working to build the consumer and community leadership required to transform the American health system. With the belief that this transformation will happen when consumers are fully engaged and have an organized voice, Community Catalyst works in partnership with national, state and local consumer organizations, policymakers, and foundations, providing leadership and support to change the health care system so it serves everyone—especially vulnerable members of society.

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California's most recent attempt to enact a broad expansion of health insurance coverage met its final road-block in the 2007 legislative session this January. In mid-December, months of intense negotiations between the Democratic State Legislature and the Republican Governor culminated in a promising compromise: the Health Security and Cost Reduction Act (ABx1-1). ABx1-1 aimed to expand health care coverage to 70% of California's 5.1 million uninsured through several different health policy reforms, including Medicaid/SCHIP expansions, individual and employer mandates, premium subsidies for low-income adults, the creation of a California-wide purchasing pool, and other private market reforms. Although it passed the state Assembly in late December, ABx1-1 was rejected by the Senate Health Committee in late January 2008.

This paper examines the California experience, and endeavors to draw lessons for other state and national health reform efforts. The first section of this paper describes the stalled legislation and what it would have accomplished. The next section addresses the strengths and weaknesses of the policy itself. Finally, the last section analyzes the politics surrounding the reform, and identifies four political strategy lessons for advocates attempting to move a health reform agenda on either the state or the national level.

## WHAT THE LEGISLATION WOULD HAVE ACCOMPLISHED:

### Expand public coverage

ABx1-1 contained significant expansions in California's public programs. The bill would have opened Healthy Families (the state's SCHIP program) to children in families earning up to 300% of the Federal Poverty Level (FPL), whereas current regulations cap enrollment at 250% FPL. The legislation would also have eliminated all citizen and immigration-status requirements for Healthy Families, enabling children of undocumented immigrants to enroll. The combination of these two eligibility changes would have resulted in almost one million additional children obtaining insurance through the Healthy Families program[1].

The legislation also contained significant public program expansions for adults. Currently, only parents earning below 100% FPL qualify for Medi-Cal (the state's Medicaid program.) ABx1-1 would have expanded public coverage to both parents and childless adults earning up to 250% FPL. This expansion would have resulted in an additional 420,000 adults enrolled in public insurance[2]. The legislation specified that adults under 150% FPL on public coverage should not face any out-of-pocket costs, and that adults between 150 and 250% FPL could face premiums and co-pays for public insurance totaling no more than 5% their income.

[1] This estimate is drawn from Jonathan Gruber's analysis, *Population Movement Estimates for Health Care Reform under ABx1-1 with the Voter Initiative*, released Jan 11 2008, available at http://www.calhealthreform.org/pdf/GruberAnalysis011108.pdf

[2] Ibid

**Require residents to obtain basic health insurance**

The proposed California legislation, like the Massachusetts health reform enacted in 2006, would have required almost all residents to obtain a basic level of health insurance by a specified date. Both California and Massachusetts assigned the decision on what constitutes the minimum acceptable level of health insurance to a state board[3].

The key difference between the Massachusetts and California mandates is the enforcement mechanism. Under ABx1-1, a state board would have automatically enrolled uninsured individuals in the cheapest plan that met the minimum standards. The board would also have developed a plan for how the State could collect money from individuals who then failed to pay the premiums associated with their plan. In Massachusetts, on the other hand, individuals who remain uninsured after the mandate has taken effect are subject to a tax penalty, worth at most half of the cost of a health insurance premium, but they are not enrolled in an insurance plan.

ABx1-1 excused some individuals from the mandate. The legislation specifically exempted individuals under 250% FPL who would not have qualified for public coverage and for whom the cheapest health insurance premium would have cost more than 5% of their income. This group would have consisted largely of undocumented immigrants and childless adults who had been offered unaffordable ESI. A state board would also have developed a waiver process for granting temporary and permanent exemptions to other individuals who face financial barriers or other hardships that prevent them from obtaining health insurance[4].

**Make health insurance more affordable for the working uninsured**

In order to help low and middle-income adults afford health insurance, ABx1-1 established tax credits to subsidize premiums. These tax credits would only have been granted to individuals between 250 and 400% FPL whose employers did not offer health insurance and who purchased insurance from a newly established purchasing pool. For individuals between 250 and 300% FPL, the amount of the subsidy would have been equal to the premium costs in excess of 5.5% of their income. The subsidy would then have decreased on a sliding scale between 300% and 400% FPL[5]. The legislation would also have set aside an unspecified amount of money to subsidize health coverage for early retirees above 400% FPL who face higher premiums because of their age. By contrast,

[3] In California, the legislation specified that doctor, hospital and preventive services must be covered. The board's decision could have included additional minimum scope of services, deductibles, co-payments and coverage or services outside the deductible.

[4] In developing these guidelines, the board could have taken into account the total out-of-pocket costs (premiums, deductibles, co-pays…) associated with the available health plans, and unexpected circumstances like fires or changes in family situations, among other variables.

[5] For every 2% that the individual's income exceeded 300% FPL, the amount of the subsidy would be reduced by 1%.

Massachusetts' health reform only offered premium subsidies for individuals up to 300% FPL[6].

ABx1-1 would also have made insurance more affordable for working Californians by requiring that employers establish Section 125 tax-free accounts that enable employees to pay their premium shares on a pretax basis.

Finally, the legislation would have established a state-wide purchasing pool, the California Cooperative Health Insurance Purchasing Program (Cal-CHIPP), somewhat analogous to Massachusetts' Connector. Cal-CHIPP would have negotiated premiums, benefit designs and cost-sharing schedules with private insurance companies who wished to sell their product to Cal-CHIPP. By giving its purchasing pool the ability to negotiate with insurance companies, the legislation would have likely resulted in lower premiums available to working Californians eligible to enroll in Cal-CHIPP.

**Set a minimum employer contribution**

ABx1-1 would have set a minimum employer contribution to employee health care. The Massachusetts Health Reform also established an employer contribution standard, but the two standards differ dramatically in both scale and structure. In Massachusetts, all employers with more than 10 employees face a fine of $295 per employee per year if they don't make a "fair and reasonable" contribution to ESI[7]. By contrast, ABx1-1 set minimum employer contribution levels that ranged from 1% to 6.5% of payroll depending on the company's size[8]. If California employers did not spend that minimum level on their employees' health care, they would have been required to pay the difference into a state fund that subsidized premiums for low-income individuals.

[6] Massachusetts' affordability schedule, however, exempts many low- and middle-income individuals and families.

[7] Employers are considered to have met the "fair and reasonable" standard if they offer to pay at least 33% of their full-time employees' premiums or if at least 25% of their employees are enrolled in group coverage.

[8] Employers with:

- payrolls up to $250,000 would contribute 1% of their payroll,
- payrolls from $250,000-$1 million would contribute 4% of their payroll,
- payrolls from $1 million-$15 million would contribute 6% of their payroll, and
- payrolls in excess of $15 million would contribute 6.5% of their payroll.

**Increase the efficiency and fairness of the private insurance market**

ABx1-1 would have implemented several private market reforms aimed at increasing efficiency and leveling the playing field for disadvantaged Californians in the individual insurance market. These reforms included:

- **Guaranteed Issue**
  ABx1-1 would have made it illegal for insurance companies to deny insurance to individuals based on their medical history or projected medical costs. The legislations would also have outlawed pre-existing condition exclusions. This would have allowed for the eventual elimination of the state's high risk pool and would have ensured that the individual insurance market didn't fail those who need it most.
- **Modified Community Rating**
  ABx1-1 would have ended the practice of pricing sick individuals out of the insurance market. After the four year phase-in period, insurance companies would no longer be allowed to vary their rates based on an individual's health status, although they could still take into account individuals' ages, family size and geography. The legislation charged the Insurance Commissioner and other officials with establishing limits on price differences in premiums charged to older versus younger enrollees.
- **Standardization of insurance products**
  ABx1-1 would have helped shoppers determine which plan best suited their needs by grouping similar products in the individual insurance market and ranking those groups according to the value of their benefit and cost-sharing packages. This would have allowed an "apples to apples" comparison of health plans.
- **Medical Loss Ratios**
  The legislation would have improved the efficiency of the insurance industry by requiring that insurance companies expend at least 85% of their premiums on health care benefits rather than administrative costs or profits.

**Implement other health reforms to strengthen the health care system**

ABx1-1 would have implemented other reforms aimed at improving the quality of the health care system as a whole, as well as rewarding providers who care for more vulnerable patients. These reforms included:

- Increasing Medicaid rates paid to physicians, hospitals, and other providers; they are currently among the lowest in the nation[9]
- Establishing a system of cost and quality public reporting
- Expanding the use of Electronic Medical Records (EMRs)
- Enabling Cal-CHIPP to participate in bulk purchasing of prescription drugs
- Developing plans to collect better data on and to assess racial and ethnic disparities in access and availability of health care
- Facilitating county-run health plans

[9] According to statistics available at http://www.statehealthfacts.org/comparetable.jsp?ind=195&cat=4&sub=51&yr=1&typ=1&sort=245&o=a

**Finance the reforms through a variety of revenue sources**

The funding for these expansions was not allotted in the bill itself; rather, the financing scheme would have been subject to voter approval on a ballot measure in November 2008. Had voters rejected this initiative, ABx1-1 would not have been implemented. The ballot measure would have included:

- **an increase in the tobacco tax** by $1.75/pack
- **the assessment on employers** (as previously described) who did not offer health coverage to their employees
- **a 4% fee on hospitals based on net patient revenues**
- **the re-investment of the county savings** that would have resulted from enrolling people in state-funded or state-subsidized health insurance who would otherwise have been entitled to county-funded health care

The Medicaid and SCHIP expansions would also have brought federal matching funds into the state, so California would not have had to bear the entire responsibility for the cost of public coverage expansions.

## IMPORTANT POLICY LESSONS FROM ABx1-1

Although the stalled California health reform appeared to be more robust in many respects than the Massachusetts health reform, it nevertheless contained some worrisome loopholes that could have left some low-income and vulnerable patients without coverage. The section below reviews the primary strengths and weaknesses of ABx1-1.

**More significant employer standard**

ABx1-1 would have imposed a much stronger financial incentive on employers to offer insurance to their employees than the Massachusetts reform. Because the assessments on employers in Massachusetts who do not offer insurance are far less expensive than the cost of providing health insurance, many employers may choose to pay the fine rather than offer insurance to their employees[10]. ABx1-1, on the other hand, specified contribution levels based on the size of the company's payroll, and would have offered employers the choice of either spending that money on health care for their employees or paying it toward a larger state fund. Since employers would have been likely to prefer spending money on their employees rather than giving money to the state, this mandate structure may have resulted in increased spending on ESI. However, the robust nature of the employer standard may have exposed the law to an increased risk of an ERISA challenge.

[10] There is no evidence so far that Massachusetts employers who already offered coverage before the reforms were implemented have dropped their coverage in favor of paying the employer assessment.

**Purchasing pool armed with real negotiating power**
The real negotiating power for both the Massachusetts' Connector and California's Cal-CHIPP lies in the subsidized market. In the stalled California reform and in Massachusetts, individuals who qualified for premium subsidies could only use those subsidies towards policies purchased through the state pool. In theory, insurance companies should be willing to negotiate lower premiums and stronger benefit packages with the purchasing pool in exchange for access to this subsidized market.

A unique provision of the Massachusetts reform, however, softened the negotiating power afforded by this subsidized market. The Massachusetts reform allowed all members of the non-group market to purchase insurance through the Connector, but created separate insurance products for the subsidized market, prohibiting individuals without subsidies from purchasing these plans. By isolating the subsidized plans from the unsubsidized market, the Connector concentrated all its negotiating leverage in the subsidized market. Massachusetts' experience in the past year confirms this point: while the Connector has been fairly successful in negotiating lower premiums for the subsidized plans, it has been less successful at lowering premiums in the unsubsidized plans.

The California legislation, on the other hand, would have extended its negotiating leverage to the entire purchasing pool by allowing individuals who qualified for subsidies to use them towards *any* product offered through the purchasing pool. By spreading the negotiating leverage of the subsidized market throughout all products, ABx1-1 would have armed its purchasing pool with stronger across-the-board negotiating power to lower premiums and secure more robust benefit packages. It's important to note, however, that unlike Massachusetts, not all members of the non-group market in California would have been permitted to enroll in Cal-CHIPP. Eligibility for Cal-CHIPP was restricted primarily to those (or dependents of those) whose employers paid the full assessment to the state or to those (or dependents of those) who were paying the full cost of their health care coverage through an employee tax savings program and whose employer designated Cal-CHIPP in the cafeteria plan.

**More generous subsidy standards, but with some loopholes**
ABx1-1 would have offered protection against high premiums to a larger range of families than the Massachusetts reform. While Massachusetts only offers subsidies to individuals earning up to 300% FPL, California would have subsidized the premiums up to 400% FPL. Despite its broader income protections, the California mandate would have left some low-income and middle-class families in a difficult situation.

- **Some individuals under 250% FPL would have been left without any health insurance.** Individuals in this income range would have been exempt from the California mandate if they did not qualify for public insurance, and if premiums would have cost them over 5% of their income. The relatively few individuals who would have qualified for this exemption – primarily undocumented immigrants and single adults who were offered unaffordable insurance through

their employers – would still be without insurance, but not in a worse situation than they are now. Meanwhile, the relatively few single adults and undocumented immigrants under 250% FPL who could have obtained insurance for less than 5% of their income would have been required to purchase that insurance without any premium subsidies. These individuals would have had the option of applying for an individual hardship waiver, but there's no guarantee the waiver process would have been accessible or effective. Research shows that many individuals under 300% FPL, especially those living in high-cost housing markets, struggle to afford their basic needs (food, clothes and shelter) and are likely to have negative cash flow; forcing these individuals to pay anything towards insurance may result in financial hardship[11].

- **Individuals between 250% and 400% FPL would not have qualified for subsidies if they were offered ESI.** Individuals in this income range who did not have access to ESI could have qualified for subsidies for insurance obtained through Cal-CHIPP. The subsidies would have assured that no individual between 250% and 300% FPL would have to spend more than 5.5% of their income on premiums; the amount of the subsidy would have decreased on a sliding scale between 300% and 400% FPL. But individuals who were offered ESI – no matter how expensive it may have been – would not have qualified for these subsidies. The California mandate placed no limit on how much individuals between 250% and 400% FPL who were offered ESI would have to pay for insurance, posing a potential threat to the financial security of these families. In addition, ERISA prevented California legislators from specifying which kind of coverage employers had to offer to comply with the mandate, leaving employees vulnerable to sub-standard coverage.
- **Most individuals above 400% FPL would not have been offered many affordability protections**. Although ABx1-1 would have set aside some money for subsidies for early-retirees, most of the subsidies under ABx1-1 were devoted to individuals between 250 and 400% FPL. Most individuals above 400% FPL would not have received any assistance in purchasing health care; if health coverage had been too expensive, their only recourse would have been to apply for a hardship waiver to be exempt from the mandate.

Research shows that an effective individual mandate should enforce a sliding-scale upper-limit cap on out-of-pocket expenses for families up to 600% FPL[12]. This cap would not only protect families from unaffordable premiums, it would also assure that people with lower incomes aren't forced to pay disproportionately high shares of their income for health insurance. Without this cap on out-of-pocket expenses, the individual mandate risks imposing a regressive tax on working families.

**Automatic enrollment**

[11] The Community Catalyst study on defining appropriate affordability standards, *Affordable Health Care For All: What Does* Affordable *Really Mean?*, by Christine Barber and Michael Miller is available at http://www.communitycatalyst.org/doc_store/publications/affordable_health_care_for_all_apr07.pdf.
[12] Ibid

ABx1-1 took a very different approach to enforcing the individual mandate than the Massachusetts reform. Under the Massachusetts mandate, uninsured individuals are only fined up to half the cost of a premium, so the healthiest individuals may choose to pay the fine rather than purchase insurance[13]. By automatically enrolling uninsured individuals in the cheapest plan, the California mandate would have assured that healthiest people entered the risk pool, bringing down premium costs for the rest of the pool.

This automatic enrollment approach, however, carried the risk of imposing a much higher burden on low-income families than the Massachusetts' approach. If the waiver process was not sufficiently efficient or accessible, people with specific circumstances that prevented them from being able to afford coverage could have been held responsible for the entire cost of health insurance. On the other hand, unlike in California, the individuals who pay the fine in Massachusetts are still left without coverage.

**Lack of benefit standards**

ABx1-1 specified that the minimum acceptable level of insurance under the mandate must include doctor, hospital and preventive services; this would have set an absolute minimum standard, ruling out hospital-only plans. However, the legislation would have assigned the more specific decisions on the minimum acceptable level of health insurance to a state board. Under ABx1-1, the board could have defined the minimum scope of services, the maximum deductible and co-payments, and coverage or services outside the deductible. In addition, the legislation set some minimum standards for the population receiving subsidies; the subsidies for the 250-400% FPL population would have been calculated according to the cost of a "tier 3" plan which was minimally defined as exempting physician visits and prescriptions from the plan's deductible. By passing the individual mandate without pre-specified benefit standards for the population that does not qualify for subsidies, and only minimal specified standards for the subsidized population, California would have risked forcing families to buy high-deductible plans they couldn't afford to use or insurance that didn't cover necessary medical services.

## IMPORTANT POLITICAL LESSONS FROM ABx1-1

**Political leadership that is committed to reform is crucial**

Assembly Speaker Fabian Nunez (D) and Governor Arnold Schwarzenegger (R) played key roles in developing momentum for health reform legislation in California. During the years leading up to ABx1-1, the Democratic-controlled legislature passed a series of major health reform proposals, all of which Schwarzenegger blocked by veto or opposing a ballot measure. In January 2007, the Governor gave into the mounting pressure to reform the health care system by declaring 2007 "the year of the reform" and announcing a detailed plan to expand health coverage to most of the state's 5.1 million uninsured. His decision to make health reform a gubernatorial priority marked a turning point in the larger effort to pass comprehensive legislation.

[13] However, initial research shows a high compliance with the individual mandate in Massachusetts, and little evidence of healthier individuals opting out of the insurance market at higher rates than sick individuals.

Meanwhile, Speaker Nunez and Senate President Pro Tem Don Perata (D) had already drafted reforms of their own, which were eventually merged in one bill. The Democratic Legislature's plan differed on several key provisions from the Governor's plan, and the reform efforts would have ended if Speaker Nunez and Governor Schwarzenegger had not devoted much of the fall to negotiating a compromise bill. When their negotiations culminated in ABx1-1, Speaker Nunez used his considerable influence to quickly rush the bill through a vote of approval in the Assembly in late December.

Although the legislation stalled when the Senate Health Committee rejected the bill in late January, it's clear that California reform would never have made it off the ground without the political leadership of these two key players. In Massachusetts, Maine and Vermont where major legislation has passed, the reform movements were also catalyzed by prominent political leaders.

**Concessions to key stakeholder groups are necessary to build a strong base**
During the negotiation process, Schwarzenegger and Nunez each made concessions in order to keep key stakeholder groups at the table. While Schwarzenegger's original proposal would require everyone to have a basic level of insurance, the Democrats, the unions and most consumer groups had significant concerns about the potential impact of an individual mandate, fearing it would increase the financial hardship on the low- and moderate-income populations. The insurance companies, on the other hand, refused to accept some of the insurance market reforms included in the bills without the guaranteed increase in their customer base that an individual mandate would afford.

The eventual compromise – an individual mandate coupled with public program expansions and substantial premium subsidies – was designed to keep unions and consumer advocates as well as the insurance companies at the table. It was only partially successful. Three of the state's major insurance companies, Healthnet, Blue Shield and Kaiser Permanente, accepted this compromise and threw their support behind ABx1-1, yet Blue Cross continued to oppose the legislation. Likewise, many unions – the Service Employees International Union, the American Federation of State, County and Municipal Employees, and the carpenter union – were mollified by the subsidies and the public program expansions, as was the state's most influential health care consumer advocacy organization, Health Access. The Teamsters union and the United Food and Commercial Workers union, on the other hand, opposed the compromise bill. The California Nurse's Association also continued to oppose ABx1-1 on the grounds that it did not overturn the current privately-run insurance system in favor for a government-run "single-payer" system.

Another strategic compromise involved the employer mandate. The employer's fee under the Speaker and the Senate President's plan would have been higher – 7.5 percent of payroll, compared with 4 percent of payroll under Schwarzenegger's plan. The compromise eventually reached, an assessment of 1-6.5% of payroll depending on the size of the company, managed to satisfy both Governor Schwarzenegger and Democrats while maintaining the support of a few business leaders, notably the Chairman of

Safeway, the Small Business Majority (a nonprofit organization representing small business group interests in California), and the President of the San Diego Chamber of Commerce.

The Governor and the Speaker also made some compromises in an attempt to gain the support of the provider community. The Governor's plan originally included a 2% physicians' fee, which was strongly opposed by the California Medical Association (CMA). Although the Schwarzenegger conceded and removed the fee from ABx1-1, CMA remained neutral on the bill, while opposing numerous elements of it, including reporting cost and quality data on physicians. The compromise legislation also included substantial Medi-Cal fee increases in a successful campaign to secure the support of the hospital industry, who nevertheless remained fairly inactive in the campaign.

California's recent attempt at passing comprehensive health reform illustrates the delicate balancing act in making reform as robust as possible while maintaining sufficient support from powerful interest groups. Because it was the product of a Governor who insisted on an extremely tough individual mandate and a legislature that insisted on substantial employer assessments, ABx1-1 was – in many respects – a more robust bill than the Massachusetts reform. However, the bill's "robustness" may have led to stronger opposition both from employer groups on the right and from consumer groups on the left. In the end, the California reform gained support from some unions, some insurance companies as well as hospitals, and a small minority of the business industry; it left every major stakeholder group divided in its response to the legislation (with the exception of the tobacco industry, who was united in its opposition to the bill due to the tobacco tax increase included in the accompanying ballot measure). This coalition of strange bedfellows proved insufficient to push the legislation through the Senate, but the California experience highlights the concessions necessary to avoid opposition from key stakeholder groups who could take down the legislation if united.

**A unified voice from the progressive movement improves chance of success**
Although ABx1-1 passed through the Democrat-controlled Assembly along strict party lines, the legislation halted in the Senate Health Committee where the Democratic Chairwoman voiced her opposition to the legislation[14]. Senator Kuehl, the Senate's strongest proponent of a single-payer government-run program, argued that the legislation failed the low-income population. Other Democratic Senators and the California Nurses Association agreed with her, preferring no reform to one that preserves the privately-run health care system. This ideological division in the Democratic party and in the broader progressive movement contributed to the legislation's defeat.

Ardent single-payer proponents are also influential in health care politics in Massachusetts and in other states that have successfully passed major health reform. In these states, however, most single-payer supporters backed the more moderate reform efforts. They ultimately viewed these reforms as a step in the right direction, rejecting the

[14] The Chairwoman's analysis of ABx1-1 is available here: http://dist23.casen.govoffice.com/index.asp?Type=B_PR&SEC={88ED6A03-02D2-492F-8C37-9434DFB58E29}&DE={13629583-8EB6-4FF0-9C04-E20D38C6E25E}.

"all or nothing" approach adopted by some of the more liberal Democrats and consumer advocates in California. California's experience emphasizes the importance of uniting the progressive movement behind the reform efforts.

**Budget deficits can undermine support for reform**

California's sizeable projected budget deficit secured the Senate Health Committee's rejection of ABx1-1. Although Senate President Don Perata was a co-sponsor of the bill, he eventually withdrew his support after the Governor revealed a budget deficit of $14.5 million (equivalent to the cost of the reform) in mid-December. When Schwarzenegger proposed cutting Medicaid in an effort to balance the budget, Perata delayed the Senate vote on ABx1-1, ordering a report from the non-partisan Legislative Analyst's Office (LAO) on the net financial effect of the legislation, the deficits, and the proposed Medicaid cuts. This LAO report proved to be the final blow for ABx1-1, projecting that by the 5th year the reform would cost $300 million more than it was raising. When the LAO report was released Perata refused to use his considerable influence to push the bill through the Senate Health Committee, although he had already been withdrawing support. Perata, along with most of the Democrats who voted against the legislation, identified the combination of California's projected $14.5 billion dollar deficit and the legislation's weak financial footing as an insurmountable hurdle for the bill.

Some observers speculate that Perata and other Democrats used the LAO report as an acceptable public excuse not to support a piece of legislation they already opposed for other reasons. California's experience highlights the danger that budget deficits pose on the prospects for comprehensive state health care reform. It's unknown whether ABx1-1 could have overcome these challenges had it included more cost-containment provisions or identified a sufficient revenue base, but it's clear that states considering health reform will have to take any budget deficit into account when designing their legislation.

## CONCLUSION

California's most recent attempt at health care reform aimed to expand medical coverage to the majority of the state's uninsured through a variety of different health policy reforms. ABx1-1 included Medicaid/SCHIP expansions, individual and employer mandates, premium subsidies for low-income adults, a California-wide purchasing pool, and private market reforms. Although its affordability standard had some worrisome loopholes and it lacked a detailed minimum coverage floor, the legislation had many strong features. It would have provided generous premium subsidies to the low-income population, created a strong incentive for employers to offer coverage to their employees, and armed its state-wide purchasing pool with powerful negotiating leverage.

Although ideological objections and economic concerns ultimately lead to the Senate committee's rejection of ABx1-1, California's experience highlights several political strategy lessons that might be useful to consumer advocates in other states. First, political leaders that are committed to reform are powerful forces in moving a policy agenda forward. Second, at least some accommodation of the concerns of key stakeholder groups is necessary to prevent a strong and unified pushback from major interest groups. Third,

ideological divisions within the progressive movement can harm efforts to expand health care coverage. And finally, a significant budget deficit can derail major health reform therefore advocates must take their state's financial situation into account when designing legislation. Even though the federal government can deficit-spend (unlike the states), these lessons are also very relevant to the national reform efforts.