



**Massachusetts' Health Care Law:
Model, Mirage, or Momentum?**

A Discussion Paper
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In a move that has attracted national attention and re-ignited the debate about universal health coverage, the Massachusetts legislature passed a comprehensive health reform package earlier this year designed to cover 90-95% of the state.

This package expands public programs, reforms the insurance market, requires employer contributions. It also includes a controversial “individual” mandate, which applied only if coverage is “affordable,” a yet-to-be defined term.

This report is an examination of the policy and politics of the Massachusetts law, from a California consumer perspective. It includes an discussion of the existing policy differences between the two states; and a discussion of the concepts and components of the measure that have already been considered in California, such as two bills vetoed last year by Governor Schwarzenegger: one that expands coverage to all children, and another that extends the age limit for dependent coverage. It also explores the heated debate about the proposal from across the political spectrum.

This is not an endorsement of the Massachusetts proposal, nor a condemnation. It is not the place of Californian consumer group to be the final arbiter of a proposal in Massachusetts. We leave that to our colleagues in Massachusetts who understand the policy and political context in which they operate in far more detail than a Californian can.

The report does conclude that the Massachusetts proposal would have to be significantly changed to work in California, and that there are preferred approaches pending in Sacramento. This report does point out the significant differences between California and Massachusetts, in size, policy context, existing policy, population, and other factors. However, this report does believe that California can learn from the experience in Massachusetts, both in the politics and creating the urgency for change, and in some of the policy components, many of which have been considered here.

The most important focus should be to capture the momentum from Massachusetts and the many other states that have passed or are seriously considering health reform, as we prepare for a major debate around comprehensive health care reform in California in the upcoming 2007-08 legislative session.

THE CONDITIONS FOR REFORM

The most noteworthy aspect of the Massachusetts law is not the details, but that it got passed at all.

The final proposal was the result of lengthy negotiations by a legislative conference committee considering multiple pending proposals: not just one by the Democratic House, another by the Democratic Senate, but also a third by Republican Governor Mitt Romney. While many have commented on the bipartisan nature of the deal, advocates in Massachusetts have, in particular, pointed to the needed leadership and engagement of these three policymaking bodies, and their ability to come to a deal.

External deadlines outside the legislative process created a window of opportunity.

- **BALLOT MEASURE THREAT:** A fourth proposal that was pending in a ballot measure for which signatures were already collected by a large coalition of health care and consumer advocates, called Affordable Coverage Today (ACT). This proposal went further than what was passed by the legislature, and the specifics are discussed below.
- **BROAD COALITION AND CAMPAIGN:** The ballot measure was both a direct force, and an indication of the strength of the movement for reform, which was staffed by Health Care For All, a longstanding consumer group with significant resources, history, and policy expertise. The forces for reform included leadership from the religious community, engagement from insurers and providers, and some business support.
- **FEDERAL FUNDS AT STAKE:** Additional urgency was provided by the expiration of the state's 1115 Medicaid waiver, and this plan was viewed as a way to preserve \$770 million in federal funds, funds that would be lost if they were not otherwise redirected. A primary goal of this legislation was to preserve these funds for key hospitals and provider in the state.

These two deadlines, working together, conspired to force the issue of coverage expansion. Advocates also give credit to legislative leadership and to Governor Romney, and his presidential ambitions that saw health care reform as a viable issue.

Governor Romney signed the bill, which received near unanimous votes in the legislature. While he used his line-item veto power for some elements of it, the legislature quickly overrode those vetoes, as part of the condition of the deal.

This background has some, limited relevance to California.

- Ballot measures are a standard policymaking tool in California, both as ways to force and influence legislative action, and as vehicles to pass policy changes in their own right. Recent examples include privacy and worker's compensation legislation. However, the expense of going to the ballot is significant: around a million dollars to collect the needed signatures, and well over \$10 million to run a credible campaign in such a large state with multiple, expensive media markets. Getting a "yes" vote on the ballot is an uphill climb: In the history of California initiatives, only a third pass, and even fewer succeed that have funded oppositions.
- Massachusetts has a different federal financing structure, and a very different structure of funding safety net hospitals, so the funds used in Massachusetts are largely not available in California, either to fund the coverage expansion, or to create a similar urgency. In 2005, California has already made a similar switch from using "intergovernmental transfers" (IGTs) to fund safety-net hospitals, to

another system of “certified public expenditures (CPEs).” As part of California’s hospital financing waiver, \$180 million a year for three years was designated for a “coverage expansion” project; but that relatively limited amount of money (which runs out) has specific restrictions, and is still greatly needed to benefit financially strapped safety-net hospitals. This is in part because Massachusetts funds hospitals from an uncompensated care pool supported by a tax on health insurance: California has no comparable mechanism or funding source.

California has also experience that legislative leadership can make a difference. Many credit John Burton, former Senate President pro tem, for being the driving force in passing SB2, to require large employers to provide health coverage, in 2003. Yet he was termed out in 2004, and some commentators have wondered if the same dynamic could be created in the post-term limits era.

Every state has its own mix of stakeholders and relationships. California also boasts a robust advocacy community, with not just a longstanding statewide consumer advocacy group with policy expertise in Health Access California, but a range of organizations that are diverse in constituency, policy stances, and tactics.

While Massachusetts is largely dominated by a handful of nonprofit health insurers, California has a mix of for-profit and nonprofit insurers. For example, the head of nonprofit Blue Cross, a supporter of reform, was the head of the Chamber of Commerce, which helped create a different conversation with the business community in Massachusetts. In California, Blue Cross is a subsidiary of the national for-profit insurer, Anthem Wellpoint, and the for-profit insurers that dominate the market have been at best nervously neutral about various reforms. The specific people, personalities, and relationships are unique to each state, but the right mix seems to be crucial in the passage of major reform.

BUILDING BLOCKS TO POLICY REFORM

The full text of the bill, summaries of its many components, a catalog of media coverage, and even a blog giving some political context, is available at the Affordable Coverage Today (ACT!) webpage of Health Care for All, a Massachusetts consumer advocacy group that was a key supporter of the measure:
<http://www.hcfama.org/act/>

The measure is made up of many different building blocks toward universal coverage, many of which have been considered individually or as part of proposals here in California. Supporters of the Massachusetts measure are clear that the bill leaves many details to be worked out in implementation, and that other reforms and efforts will be needed to ensure the program works, and to actually reach full universal coverage.

This is a rough sketch of most of the key components, with some California context:

COVERAGE EXPANSIONS: Of the various elements, the most familiar to California health policy advocates is the creation and expansion of public insurance programs, which account for 300,000 of the potentially 515,000 additional covered lives that are estimated to be covered by 2009.

- **CHILD COVERAGE EXPANSION:** The bill expands children's coverage through the MassHealth/Medicaid program to cover kids up to 300% of the federal poverty level (\$60,000 for a family of four). This is an increase from the current level of 200% FPL. It is similar to the current California efforts to cover all children, such as AB774 (Chan) that was vetoed by Governor Schwarzenegger last year, and the currently pending SB437 (Escutia) as well as an item in the pending 06-07 Conference Committee budget proposal.
- **SUBSIDIZED HEALTH INSURANCE:** The bill creates the Commonwealth Care Health Insurance Program, where adults (with or without children) under 300% of the federal poverty level can get subsidized private health insurance with no deductibles. Those under 100% of the poverty level (\$20,000 for a family of four) would not pay any premium, and those up to 300% would face a sliding scale of premium payments based on affordability. (California, in contrast, provides no coverage to adults without children under 18 at home, no matter how poor, unless that adult is pregnant or has extraordinary medical costs and few assets.)
- **MEDICAID ENROLLMENT:** The bill also reversed cuts made to Medicaid during the recent budget crisis in 2002, such as lifting enrollment caps on specific programs, and restoring vision and dental services. It would put some funding into outreach for eligible but unenrolled citizens, and also increases provider payments, on a pay-for-performance basis, including on an emphasis on reducing racial and ethnic disparities.

INSURANCE MARKET REFORMS: Massachusetts already has significant insurance market regulations that California doesn't, including a form of "community rating" for some parts of the insurance market, which means that a patient cannot be turned down or charged more for non-group insurance because he or she has a "pre-existing medical condition," such as diabetes or asthma. The state also has existing regulations of deductibles and co-payments. Supporters hope that the reforms that are part of the new law, which seek to make health insurance more affordable and available, assist another 200,000 residents (of the 515,000 targeted uninsured) to get coverage.

- **NEW AUTHORITY:** The bill creates a new Commonwealth Health Insurance Connector, which would certify and offer new products. This is intended to allow the market to be easier understood by consumers, by making more easily comparable plans, and placing some oversight over the market. Importantly, all current mandated benefits are protected, including mental health. (However, the Connector does have some authority to create scaled-back plans specifically geared for young people.) It would also allow multiple employers to contribute to the health care of a worker (such as a seasonal and part-time workers).

- **INDIVIDUAL AND SMALL GROUP MARKET REFORM:** The bill merges the non- and small-group markets for health insurance products. While it would increase rates in the small group market by a small amount, supporters say this would stabilize the individual insurance market, and lower rates for individuals as much as by 24%.
- **DEPENDENT COVERAGE EXPANSION:** Young adults will be able to stay on the parents' insurance plans for two years past the loss of their dependent status or until age 25. This is similar to a bill last year AB1698 (Nunez), which was vetoed by Governor Schwarzenegger.
- **FEDERAL TAX HELP:** The bill also uses an interesting device to provide federal tax benefits to lower the cost of health coverage for those buying it as individuals. Every employer of more than 10 people is required to offer a cafeteria plan through Section 125 of the tax code, so that employees that purchase individual health coverage can use pre-tax dollars, providing a substantial savings.

FUNDING AND REQUIREMENTS: Massachusetts lawmakers were pushed into this effort by the potential loss of the Medicaid waiver, worth hundreds of millions of dollars, and that continues to be the backbone of funding. In addition, Massachusetts has an existing uncompensated care pool to fund care for the uninsured who use hospital emergency rooms, which is paid for by an existing fee on insurers and employers who buy coverage. (This allows Massachusetts to spend multiple times what California spends on care for the uninsured.) On top of these existing sources, and some modest money from the state's general fund, are the requirements on individuals and employers, which are the most controversial parts of the bill. One potential funding source, a tobacco tax in the proposed initiative, was not included in the final bill:

- **EMPLOYER CONTRIBUTIONS:** Employers of 10 or more that do not provide health coverage will pay \$295/year for each uninsured worker, which goes to pay for the subsidized insurance plans. (Gov. Romney is accepting this as an "assessment," rather than a "tax.") This is different than the employer responsibility in SB2 (Burton) which required employers to pay for coverage for their employees. (This California bill was passed in 2003, but narrowly repealed by referendum in 2004.) Instead, the assessment is a surcharge on employers that fail to provide coverage to support an existing Massachusetts program that provides care for the uninsured. As stated above, Massachusetts has an existing assessment on health insurance paid for by employers and individuals who purchase health insurance, to fund the "uncompensated care" to fund hospitals and clinics for care to the uninsured; This \$295 charge helps eliminate the inequity that now penalizes those employers that provide coverage, as opposed to those that don't. But it is important to note that the fee is not commensurate with covering workers or their families, and so is not an incentive to get employers to offer coverage directly. The Massachusetts bill also has a "free rider surcharge" if an employers' workers use uncompensated care often, which raised several other policy issues.

- **INDIVIDUAL MANDATE:** All residents in Massachusetts would be required to obtain health coverage. However, the requirement is limited, in that there must be “affordable” coverage available, although that term is presently undefined. If no coverage is deemed “affordable,” there is no penalty. While those under 300% of the federal poverty level are eligible for subsidized insurance or public insurance programs, those over 300% of the poverty level are at risk for the penalty, which range from the loss of the personal tax exemption (around \$150) to half the cost of coverage (perhaps around \$1,000). This is the most controversial part of the measure, as discussed below; California has seen such proposals soundly defeated in recent years, as also discussed below.

THE RORSCHACH TEST

Because of all the different components, many have called the Massachusetts plan a “Rorschach test,” since so many different analysts, by focusing on different elements, have widely different opinions about what the proposal is, much less what to think of it.

The plan did get bipartisan, near-unanimous support from elected leaders in Massachusetts, and from a broad coalition including many consumer and health advocates. Senator Ted Kennedy was seen as helping behind the scenes, as was the Heritage Foundation. However, the opposition to the proposal has been just a wide-ranging, from the left and right.

Among conservative supporters of the proposal, for example, Governor Romney made the case that “this is a plan that gets everybody insured with private health insurance that doesn’t require new taxes, doesn’t require state government or the federal government to take over healthcare like HillaryCare and instead says we can have a private, market-based system ... [that] works.” In another article, he said, “the old single-payer canard is gone.”

A conservative critic based in California, Sally Pipes, president of the Pacific Research Institute, called Romney’s plan an attempt to pour “political capital into creating a new state healthcare bureaucracy, further regulating health insurance, forcing individuals to spend their money on a government designed product, and increasing spending by \$200 million.” In an article, she predicted her nightmare vision, “Individual mandates lead to groaning about price. At the same time, the true costs to the state will explode. This will build pressure for price controls. Having already erected a government apparatus to impose price controls, regulation and rationing, the state will again come to the rescue of those it stranded by imposing single-payer health care for all.”

Different critics and supporters have charged that it will lead to the bolstering or the deterioration of our employer-based health coverage system, and toward either a single-payer health system that covers everybody or to a marketplace where people have to purchase their coverage as individuals.

SPINNING THE YOYO: YOU'RE ON YOUR OWN

This is not merely an idle philosophical argument. To the extent that no one reform will solve all our health care problems, an important question is what direction any policy proposal take us.

Health Access California believes that health care works best when people are brought together to share the risk and cost of care. This works now with our current the system, for those 19 million that get health coverage with their co-workers through their employers, or the 10 million that get coverage through public insurance programs like Medicaid and Medicare. This is the basis of many efforts at universal coverage.

In contrast, only 1-2 million purchase coverage as individuals, largely because it is unavailable or unaffordable. Consumer advocates fear that as public programs and employer-based coverage unravel, that the push for tax credits, vouchers, high deductible health plans, health savings accounts, and other solutions that lead to a health system where “you’re on your own” (YOYO), leaving most people uninsured or underinsured, facing the consequences of living sicker, dying younger, and being one emergency away from financial ruin.

Massachusetts is seen by some as furthering the cause of the “you’re on your own” philosophy by placing the burden on individuals to buy coverage, but by others as a vehicle to pool people into public insurance programs, and into plans that are regulated to provide coverage to broad pools of people.

A FRAMEWORK FOR FUTURE FIGHTS

So why do so many have so many different interpretations of the Massachusetts law? Part of the reason for this is that so much is undefined. Most major reforms leave some details up to for implementation and regulatory processes; certainly California’s experiment with SB2 suggests that there was a host of issues left for implementation.

But the Massachusetts proposal is less of a plan and more like a framework for a plan, leaving an inordinate number of policy fights for the future. Which employers are assessed the \$295? What constitutes a “covered” employee? Is it somebody without any coverage? A worker who has bare-bones coverage with a high deductible? Somebody who is offered coverage, but the employer pays only 50% of the premium? On whether the individual mandate applies, the Connector is just beginning to explore the question of what is “affordable,” which includes the same questions about the cost and comprehensiveness of coverage, the level of subsidies that can be provided, and ultimately what people, in what income ranges, are impacted.

These questions are explicit; the biggest future fight is implicit. The math on the Massachusetts plan is expected to work for the first three years, but after that it is a question. Many analysts believe that the plan is underfunded as it is.

If and when the funding becomes inadequate, then policymakers will face hard choices: do they reduce coverage, either to certain groups of people, or water down the coverage with higher deductibles and other out-of-pocket costs and skimpier coverage? Do we look toward insurers and providers for greater savings? Or do we find other funds, such as by increasing the employer assessment, or raising revenues like a tobacco tax—both things that Massachusetts advocates proposed in their ballot measure?

But it is better to have an explicit choice about cutting coverage than to face what California faces where consumers have no voice in the changes being visited upon them, as employers raise deductibles and copays while insurers make high profits. Some of these changes—such as the movement to higher-deductible, or so-called “consumer driven” plans—are already taking place by employers and insurers, without the accountability of a policy process.

Of course, those who supported the proposal did so with the understanding of the political context they would find themselves in, including who might be the next Governor. Governor Romney is term-limited, and so while he has an initial say in this work, he may not have as much impact on the eventual implementation of the law.

WHAT THE PROPOSAL IS, AND ISN'T

Some of the critiques of the Massachusetts proposal, especially from traditional supporters of universal health care, is to point out various elements missing from the proposal.

First and foremost, even supporters of the Massachusetts measure are clear that the proposal is not universal, despite some of the characterization in media coverage. Their best estimates would achieve 90-95% coverage of the state, and other analysts don't believe that it will achieve those benchmarks. But that is less a critique of the bill than a fair description of what it is: a framework for a major expansion of health coverage, rather than a universal plan.

The Massachusetts plan is also criticized because it leaves some residents without coverage; that it doesn't control costs; that it is either underfunded, by not raising enough money through the employer assessment, or by not wringing savings from insurers or providers.

Boston physicians Steffie Woolhandler and David Himmelstein, co-founders of Physicians for a National Health Program, and veteran advocates of a universal single-payer system, stated: “The legislation will do nothing to contain the skyrocketing costs of care in Massachusetts Indeed, it gives new infusions of cash to hospitals and private insurers... The program is simply not sustainable over the long- or even medium-term.”

Many supporters of the Massachusetts measure also support a universal, single-payer health care system, and would admit that the package isn't all that they wanted—it was a compromise that didn't include all that was in the pending ballot measure, such as a much larger employer assessment and a tobacco tax to help fund the program. But they state that given all the issues in the health care system, it isn't fair to criticize a plan for what it isn't, but critics should focus on what it does do.

John McDonough, director of the Massachusetts group Health Care for All, states in his online blog: “We are confident the new law will result in new coverage for hundreds of thousands of uninsured in Massachusetts, with the best help going to those at the bottom of the economic ladder, as it should be. We would love it if we had been able to raise a lot more money to push the subsidies higher...Wish we could have gone further. Still, this is a damn good improvement.”

He also states: “Fundamentally, this law is about expanding access to affordable coverage, not about reducing costs. Everybody has favorite ideas how to lower costs, and most of them lack sufficient political support to be achieved.” Other supporters indicate how this proposal can serve as a foundation toward additional reforms, including bigger program expansions, employer assessments, and cost controls, as well as the ultimate reform of publicly-financed universal health care.

THE INDIVIDUAL MANDATE: MIRACLE DRUG OR POISON PILL?

Despite the multiple components of the measure, what has gotten the most attention in the media is the “individual investment” or “personal responsibility” section, which is being attacked from both the right and the left. The right-wing chorus includes attacks from the libertarian Cato Institute and the Wall Street Journal, which challenge this as “big government,” both in the programs created, and the intrusion on individuals.

Of those forces that otherwise support reform, the most prominent critique was from AFL-CIO chief John Sweeney, who stated, “Forcing uninsured workers to purchase health care coverage or face higher taxes and fines is the cornerstone of Mr. Gingrich's health care reform proposals. And it is unconscionable that Massachusetts has adopted this misguided individual mandate.”

“The bill protects workers with the lowest incomes, but punishes middle-income families. A typical family in which the husband and wife each earn a little more than \$30,000 and who have two children would be forced to purchase health care, but would not be qualified for any help even if their employer does not offer any coverage or they can't afford their share of the premium. We believe that workers have to participate in the solution to the problem, but this plan puts the entire burden on workers while letting employers off the hook.”

Supporters argue that the individual requirements were part of a package that includes requirements on employers, that 2/3 of the uninsured that are under 300% would get significant financial assistance, and that the mandate would not apply unless there was

an “affordable,” meaningful plan available. Some have argued and/or predicted that for both political and policy reasons, they don’t see the individual mandate applying for anybody other than wealthy individuals, who overwhelmingly have coverage.

The media focus on the individual mandate rather than other aspects of the proposal places the emphasis on a problem that really doesn’t exist. It’s not that people don’t want health coverage: people overwhelmingly take up coverage when offered, but either are not eligible through an employer or for a public insurance program, or otherwise find it unaffordable or unavailable, due to “pre-existing conditions.” Even young, healthy people—which are not the majority of the uninsured—take up health coverage as much as others. Younger people have higher rates of uninsurance largely because they tend to be newer employees in low-income jobs, and more likely not to be offered coverage by employers, and without children and thus less likely to qualify for public insurance programs.

Consumer advocates have often opposed such individual requirements that are not in the context of a social insurance program (such as Medicare, or a single-payer system) that ensures access and affordability. And there is disagreement about whether the Massachusetts bill provides such a context.

Most consumer advocates do not oppose the concept of “individual responsibility” such as the contributions required for Medicare, or a single-payer system. Richard Kirsch, a veteran of health care wars as head of Citizen Action of New York, made the case as such: “...there is an enormous difference between an individual mandate to purchase private insurance and an individual’s obligation to pay a progressive tax. The individual mandate requires people to navigate a complicated, private insurance system to purchase coverage, with cost and availability based on where you work, whether you work, how much you earn, and other factors such as your age. The mandate punishes you for failing to successfully navigate the system or your inability to afford the coverage offered.”

Individual mandates, especially those outside of a social insurance system, often end up being punitive, with many issues about how to enforce it. Some end up structured to end up criminalizing the act of getting needed care, for those who remain uninsured. Beyond the principle, to make such a mandate workable requires many other policy changes to ensure affordability and availability of coverage, and usually carry a hefty price tag.

CALIFORNIA INDIVIDUAL MANDATES DEFEATED MULTIPLE TIMES: An “individual mandate” proposal that was vastly different than the Massachusetts bill, AB1670(Nation/Richman), was considered last year in the California legislature. The proposal, which shifted the entire burden of the cost of health care on to the individual, and mandated high-deductible, bare-bones “skeleton” policies, was opposed by Health Access California and numerous other health care and consumer organizations, and ultimately only got two votes on the Assembly Health Committee.

Two new “individual mandate” bills were considered this year. AB2450 (Richman) fared even worse, only getting one vote from the bill’s author. Assemblyman Nation also tried again, but with a more comprehensive approach in AB1952, that included shared responsibility for the employer and public program expansions. After extensive amendments, including the adoption of community rating, the requirement that individual coverage be affordable, and other consumer protections, Assembly Health Committee Chair Wilma Chan asked that it be voted out of her committee on a courtesy vote, with the caveat that she and others still had concerns about the individual mandate and other provisions. AB1952 died on suspense in Assembly Appropriations Committee earlier this year largely because of the billions of dollars of subsidies required to make an individual mandate affordable for low and moderate income individuals.

THE CALIFORNIA DIFFERENCE

As California advocates evaluate the Massachusetts proposal, it is important to note the differences between the policy environment in the two states.

- **EXISTING POLICIES:** As stated above, Massachusetts starts with a different policy foundation, including an existing pool of funds for uninsured care at hospitals and clinics, and a broader range of regulation on insurers, such as community rating. These existing policy building blocks are essential for the plan to be workable: If California were to try to transport the Massachusetts proposal, it would also need to do significantly more. For example, you can’t impose an individual mandate, even on the wealthy, without requiring “guaranteed issue” so insurers take patients with “pre-existing conditions.”
- **SCOPE:** The scope of the problem is almost twice as great in California, where nearly 1 in 5 residents are uninsured, as opposed to in Massachusetts, which is closer to 1 in 10. This is not due to the eligibility of public programs, but to the fact that California has a far lower percentage of population that get employer-based coverage. Finally, the scale is different, as Massachusetts is smaller than Los Angeles County, and California’s nearly 7 million uninsured is comparable to the entire population of Massachusetts. Massachusetts has to close a gap in health coverage. California has to close a chasm.
- **COST:** The most telling difference is the potential cost of such a proposal. The California Health Care Foundation commissioned the Institute for Health Policy Solutions suggests that “the adoption of a Massachusetts-style coverage construct in California would cost the state” an estimated range of \$6.8 to \$9.4 billion. This large amount is not just because of our much larger number of uninsured, but also the fact that California’s uninsured are more likely to be lower-income workers, who would need more subsidies. Also, California spends only a fraction of what Massachusetts devotes to care for the uninsured, meaning there are fewer funds to redirect to coverage programs. The CHCF study indicates: “Massachusetts is redirecting almost \$1 billion from its uncompensated

pool and other related spending toward the low-income subsidies established in the legislation. That amount equates to between \$1300 and \$1800 per uninsured per year. California's \$2 billion in DSH funds for uncompensated care, on the other hand, would provide only \$300 per uninsured California per year if re-allocated."

MOMENTUM FOR REFORM FROM THE STATES

Despite these differences, and the real concerns against certain provisions, there are lessons to learn from the Massachusetts proposal, both the policy, and the politics that led to its passage.

Most importantly, the discussion is re-igniting national interest in universal health care and possibility of moving ahead with major health reform. It is less important to argue about the (often undefined) details of the Massachusetts proposal, than to take note of the momentum that it is providing to the state-based movement toward health reform.

California helped start this conversation with the passage of SB2 in 2003, which was hailed, along with the Dirigo Plan in **Maine**, as the start of this recent spate of state-based efforts to expand coverage to the uninsured. Just this past year, **Illinois** won universal coverage for children.

Maryland passed a minimum health care contribution for very large employers. **New York** City and neighboring Suffolk County also passed requirements on employers in certain industries, setting a minimum standard for on-the-job coverage.

After Massachusetts, **Vermont** soon followed afterwards, where Gov. Jim Douglas signed a bill in May 2006 that went further than Massachusetts. A new subsidized health-care plan called Catamount Health will be offered on a sliding scale basis by insurance companies and paid for in part with tobacco tax increase, federal matching funds, and a \$365 fee on employers who do not offer health insurance to their workers. It will provide coverage similar to that offered to state employees, providing coverage to nearly 25,000 people who are uninsured but do not qualify for existing programs. The proposal has various other provisions as well.

Many other states have active, serious proposals on health reform, including Connecticut, New Jersey, Wisconsin, and Washington. It is likely that one or two more states might take at least modest steps toward expanded coverage and health care reform.

The hope is that if enough states breakthrough with reforms, this will force health care reform onto the national agenda, including for the 2008 presidential election. That campaign is expected to include Governor Romney, running for the Republican nomination.

CALIFORNIA PROPOSALS

California has multiple proposals pending, to continue to provide leadership in this regard:

- Of particular note is SB840 (Kuehl), the California Health Insurance Reliability Act, which would establish a universal, publicly financed, single-payer health care system in California, similar to the Medicare program. It is currently pending in the Assembly.
- There are new attempts to set a standard for on-the-job health care benefits, most prominently at the local level in San Francisco. These negotiations, being led by Supervisor Tom Ammiano, and Mayor Gavin Newsom, are expected to bear fruit this summer.
- Many advocates are ramping up efforts to cover all children in California, with an urgency to pass something this year, through bills including SB437(Escutia/Chan), the budget proposal, and a ballot box initiative pending for November.

The momentum continues to build for the goal of quality, affordable health care for all. Health advocates can use the attention to this Massachusetts measure and other reforms in other states to ensure that these and other proposals move forward, that candidates feel obliged to talk about health reform in this upcoming election season, and to make it clear that comprehensive health reform is not just urgent, and necessary, but achievable.

The Health Access Foundation is a statewide health care consumer advocacy organization, working for the goal of quality, affordable, health coverage of all Californians. This report was written as a briefing for the Access to Care Expansion Strategy Group, and was supported in part by a grant from The California Endowment. For more information, contact:

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APPENDIX I : COMPARISON CHART OF MASSACHUSETTS AND CALIFORNIA

Policy Foundation

Massachusetts	California
“Community rating:” patients in individual market cannot be turned down or charged more for non-group insurance because of pre-existing medical conditions (i.e. diabetes, asthma)	No such protections exist
Uncompensated care pool, funded by a tax on health insurance, goes to fund care for the uninsured at hospitals and community clinics.	No such funding exists. California overall spend about one-fourth to one-sixth of what Massachusetts spends per uninsured person.

Health Policy Proposals

Policy	Massachusetts’ new law	Similar California Proposals and outcomes
Employer contribution	Employer contributions: Massachusetts requires employers with more than 10 employees to provide health coverage, or pay \$295 a year for each uninsured worker, which would go toward subsidized insurance plans.	In 2004, former Senate President Pro Tem John Burton’s SB2/Prop. 72, which required employers with more than 50 employees to pay for health insurance was defeated on the ballot. Governor Schwarzenegger actively campaigned against the measure.
Children’s coverage expansion	Expands children’s coverage through MassHealth/Medicaid program to cover children up to 300 percent of FPL, from current 200 percent FPL.	In 2005, similar legislation, AB772 was vetoed by Schwarzenegger. The expansion is pending in the 2006-07 budget and SB437.

<p>Subsidized health insurance for adults</p>	<p>Creates the Commonwealth Care Health Insurance Program, where adults (with or without children) under 300 percent FPL can receive subsidized health insurance with no deductibles.</p>	<p>California authorized the expansion of the Healthy Families program to include parents of children in the program, but it was never funded. Uninsured adults are covered only if they are pregnant, or if they have children under 18 at home, incomes under 100%FPL, and few assets. Otherwise uninsured adults, even the poorest, have no ability to get public health coverage.</p>
<p>Dependent coverage expansion</p>	<p>Young adults will be able to stay on their parents' insurance plans for two years past the loss of dependent status, or until age 25.</p>	<p>In 2005, Gov. Schwarzenegger vetoed a similar bill, AB1698 (Nunez), which would have extended dependent coverage until age 26.</p>
<p>Individual mandate</p>	<p>All residents living above 300% FPL would be required to obtain health coverage as long as coverage is "affordable", a yet-to-be defined term.</p>	<p>AB2450 (Richman) would have required all residents – at all income levels – to have "bare bones" health coverage, at whatever cost. The bill received only Richman's vote in his second year of attempting to pass this legislation.</p>