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INTEREST GROUPS AND HEALTH REFORM: LESSONS FROM CALIFORNIA

by Thomas R. Oliver and Emery B. Dowell

Prologue: California has long been a battleground in the struggle to reform the traditional relationship between patients, payers, and providers. Many of the reform issues—particularly whether government should mandate employers to provide health insurance to their workers—that are now before Congress have been the subject of previous debates in California. In this paper Tom Oliver and Emery Dowell depict these struggles and how they were resolved or left untended. Oliver and Dowell underscore one of the realities about American democracy—that private interests play a critical role in shaping public policy. Oliver, who holds a doctorate in political science from the University of North Carolina, is an assistant professor in the Policy Sciences Graduate Program at the University of Maryland, Baltimore County. The Robert Wood Johnson Foundation recently bestowed on Oliver one of its Investigator Awards in Health Policy Research. Dowell is a retired vice-president for governmental affairs of Blue Cross of California. This paper draws upon his experience working among health care interest groups as an honest broker (or, as he put it in a telephone conversation, “a legendary nuisance”) in an effort to craft a compromise solution to California’s insurance access problem. Dowell helped to draft and promote the 1989 health insurance reform Legislation sponsored by Assembly Speaker Willie Brown, the legislature’s most powerful figure, and also consulted with the California Medical Association and the insurance industry. Dowell is a member of the California Managed Risk Medical Insurance Board, which designed the first state, wide, government-sponsored, regional health insurance purchasing pool for small groups (see Health Affairs, Spring 1994, page 350).
Abstract: We review the 1992 policy choices in California for expanding health insurance coverage, focusing on the rejection of an employer mandate by legislators and voters. We analyze how interest-group politics, gubernatorial politics, and national politics shaped those choices. Although public opinion and the shift of organized medicine showed considerable support for extending health insurance coverage, the opposition of liberal and conservative groups and a foundering economy prevented a significant change in public policy. The president’s health reform plan appears to address many of the unresolved concerns in California, but overcoming resistance to any kind of mandate will require skilled leadership and negotiation.

Many of the same arguments surrounding health reform now heard in Washington were debated in California in 1992. The political struggle there actually began in 1989, when Assembly Speaker Willie L. Brown Jr. (D-San Francisco) introduced legislation to adopt a Hawaiian-style employer mandate. The California experience provides important insights into the fragmentation of health care interest groups, the reasons underlying interest-group support or opposition, and the complex considerations and strategies that come into play when groups face a range of policy options on this issue. In contrast to several other states, California’s four-year push for reform ended with only a minor commitment to expand the scope and affordability of voluntary insurance coverage. Herein lie lessons for national health policymakers attempting to craft a coalition to enact universal health insurance.

Movement Toward Insurance Reform In California

In 1982 the California legislature enacted proposals to promote competition in health care and to contain rising expenditures through selective contracting with providers. Although the watershed legislation produced savings for the state, it also reduced access to providers for the poor and led private insurance companies to drop coverage or raise premiums for small, high-risk groups of employees. Over time the employment-based system of health insurance eroded, and by 1989 four million California workers and their dependents were uninsured. Economic recession added to the toll, leaving another three million unemployed persons without any coverage.

By 1992 a quarter of the state’s nonelderly population was uninsured, and a realignment in the politics of health in California had occurred. For the first time in more than fifty years, organized medicine endorsed broader access to health insurance and was prepared to fight openly for it in the political arena. The leadership of the California Medical Association (CMA) sought legislation to require all employers in the state to provide health insurance for workers and their families. The CMA also sponsored a ballot initiative with the same purpose in the 1992 general election.

As problems in health care received more attention in the state and in
the presidential campaign nationwide, some observers sensed that there would be a political breakthrough. In the 1992 session of the California legislature and the election campaign in November, several proposals received serious consideration. At year’s end, however, there was only incremental progress toward broader insurance coverage. Lawmakers enacted new rules to make insurance for small groups more available, affordable, and equitable. Other, more sweeping plans for reform—including Proposition 166, the CMA ballot initiative—were unsuccessful.

In the end, advocates for an employer mandate could not match the arguments and money put up by opponents of the CMA’s prescription for health care reform—some who said it went too far and others who said it did not go far enough. Although public opinion and the shift of organized medicine established serious support for extending health benefits, the opposition of other important interest groups and a foundering economy created insurmountable obstacles to a significant change in public policy.

California’s Policy Choices In 1992

We first summarize the proposals that California legislators and voters faced in 1992 as background for the political analysis that follows.

Small-group insurance underwriting reform (A.B. 1672). In August 1992 the California legislature enacted A.B. 1672. Authored by Assembly Members Burt Margolin (D-Los Angeles) and Beverly Hansen (R-Santa Rosa), this legislation changed insurance underwriting rules and encouraged greater price competition and more uniform benefits among insurers selling to groups of three to fifty persons. The final bill combined features of previous proposals, including one in April 1992 by Republican Governor Pete Wilson, The key provisions, which took effect 1 July 1993, (1) outlaw medical underwriting based on occupation, health status, or previous claims experience (allowing only adjustments for age, family size, and geographic area); (2) limit denial of coverage for preexisting conditions to one six-month period; (3) establish narrow “rate bands” so that an insurer must offer to any group a premium that is within 20 percent of its average premium for that plan; (4) set up small-employer pools (in up to nine regions) to purchase insurance plans approved by the state Managed Risk Medical Insurance Board (MRMIB); (5) create an insurer-managed small-group reinsurance pool to protect insurers with few beneficiaries; and (6) require insurers to guarantee issuance and renewal of all plans.

The strict underwriting and pricing limits are designed to provide affordable insurance to persons in high-risk occupations and to prevent exorbitant premium increases or termination of coverage due to serious illness. The new law does little, however, to extend insurance to those who for
other reasons have no coverage. A legislative analysis projected that A.B. 1672 would make employer-based insurance available to 100,000 more persons—less than 2 percent of Californians without insurance.4

Affordable basic health care through an employer mandate (S.B. 248 and Proposition 166). In January 1992 the CMA adopted a two-prong strategy to establish a legal obligation for employers to provide basic health benefits for workers and their families. The Affordable Basic Health Care Act of 1992, S.B. 248, was coauthored by Sen. Kenneth Maddy (R-Fresno) and Speaker Brown. Meanwhile, the CMA mounted a ballot initiative with the same purpose. By April it qualified the Affordable Basic Care Initiative of 1992 (Proposition 166) for the November election. The main provisions of S.B. 248 and Proposition 166 were: (1) mandate all employers to provide basic health care coverage (paying at least 75 percent of the premium) to eligible employees and their dependents; and (2) require that insurers charge the same premium to all employers within the same geographic region, except for groups of 100 or fewer persons, which they could charge up to 30 percent more.5 The proposal would have outlawed medical underwriting and exclusions or waiting periods for pre-existing conditions. Finally, the provisions created a Health Care Coverage Commission to set policies for cost containment, medical practices, and technology assessment. S.B. 248 authorized an annual percentage limit on increases in insurance premiums for basic coverage; if increases exceeded the limit, a panel would have been empowered to set premiums, hospital rates, and professional fees. Proposition 166 did not include cost containment provisions.6

CMA leadership estimated that an employer mandate would extend basic coverage to four million people, about 60 percent of the state's uninsured. S.B. 248 (Maddy-Brown) passed the Senate but stalled in the Assembly. As economic recession persisted and amplified a state budget crisis, no adequate base of support emerged, and the authors did not press for the bill's enactment. The CMA then worked to pass Proposition 166, but it lost by more than a two-to-one margin in the November election.

Universal health insurance under managed competition (S.B. 6 and A.B. 502). In February 1992 State Insurance Commissioner John Garamendi announced a plan to offer basic health benefits to all Californians. “California Health Care in the 21st Century” offered only a general blueprint for reform. It adapted the ideas of managed competition and added governmental regulation to achieve universal coverage and cost containment. The plan was introduced in the legislature as S.B. 6, authored by Sen. Art Torres (D-Los Angeles), and A.B. 502, authored by Assembly Member Margolin. It passed both houses in late August 1992 but was vetoed by Governor Wilson. Had the bill become law, it would have
created a commission to refine the proposal and report to the legislature in January 1994 with a package meeting the following guidelines: (1) The plan would need to provide all Californians with a single health insurance package, replacing health benefits currently in health, auto, and workers’ compensation policies. (2) It would allow individuals to select a health plan from a health insurance purchasing cooperative (HIPC) in their region. The HIPC would offer several approved health plans with guaranteed benefits similar to those of a health maintenance organization (HMO). Health plans could charge individuals additional premiums for greater choice of providers or various amenities. They would have to accept all applicants and could not exclude coverage for preexisting conditions. (3) The plans would collect payroll assessments for health insurance coverage from employers and workers based on ability to pay. These funds would go to the HIPC, which would pay health plans a set amount for each enrollee, adjusted for risk. The HIPC, governed by employers and consumers, would monitor quality of care in each plan and make that information public. The hallmark of this innovative plan was that it offered both stronger market competition and stronger regulation of insurers and providers.7

The incomplete details of the Garamendi plan made it primarily a political weapon for liberal Democrats; who sought a comprehensive alternative to pressure moderates in their own party and to wield against the incremental, voluntary strategies offered by Republicans (other than Maddy) in an election years.8

**Comprehensive government health insurance (S.B. 308).** The most liberal proposal of 1992 was S.B. 308, authored by Sen. Nick Petris (D-Oakland). The bill was sponsored by the Health Access coalition of consumer groups, labor unions, churches, senior citizens, academics, public health professionals, and the California Nurses Association. This group had worked since 1988 to mobilize public support for a Canadian-like, state-sponsored, tax-financed plan. The comprehensive benefits covered all medically necessary hospital care, professional services, prescription drugs, and institutional care for the disabled and elderly.

The bill fell just short of the two-thirds majority needed to pass the Senate. There was no chance that it would be signed by Governor Wilson, however, because of the large tax increase and expansive governmental controls it would have required. It was seen largely as a vehicle to publicize plans for a ballot initiative that failed to materialize in 1992. Once Health Access abandoned its own initiative, it led the liberal opposition to Proposition 166 in the fall campaign. (In 1994 a new single-payer coalition led by grass-roots activists has emerged to promote a ballot initiative in California. If approved by the state’s voters, it would institute an even stronger government insurance program than the one proposed by Health Access in 1992.)
The Politics Of Health Insurance Reform In 1992

With momentum building for change in the health insurance system, why was so little actually achieved in 1992? We review here the political forces that were brought to bear on proposals for health insurance reform in California. We pay particular attention to the CMA proposal to require all employers to provide insurance, because it occupied the centrist position on the political spectrum and was the subject of both legislative and electoral battles. Our analysis shows how interest-group opposition and other conditions in the political environment combined to defeat both the CMA employer mandate and broader proposals to expand access to health services. Action on the issue was powerfully affected by the state of the economy, gubernatorial politics, and the national health reform debate.

Providers. Since 1989 organized medicine had supported expanding access to health services through mandatory employment-based insurance. The CMA endorsed Republican Governor George Deukmejian’s 1990 task force report and sponsored legislative proposals in 1990, 1991, and 1992. The CMA felt that its broad but moderate proposal to build on the existing private insurance system was attractive. Based on opinion polls, it appeared that the public supported almost any option to expand health insurance, and that four out of five Californians supported an employer mandate.9

The CMA was not internally prepared to advance this policy against strong opposition, however. The leadership was more enthusiastic than CMA members were. Physicians supported efforts to reduce uncompensated care but feared that such efforts would bring with them unacceptable cost controls. In addition, they ideologically resisted the idea of supporting certain government mandates, since others might be imposed on them.

It is common for interest-group members to lack accurate information about their leaders’ positions and actions. However, CMA leadership publicly promoted their views, and the issue of whether the CMA should proceed with a ballot initiative was debated in full view. Instead, the relatively liberal position of the CMA was based on larger political considerations. The CMA sponsorship of S.B. 248 and Proposition 166 was a middle-ground position taken by CMA leaders because they judged they could not block all proposed reforms and, privately, did not want to. The CMA could offer Governor Wilson and other moderate Republicans a plan for significant reform to help reverse their sagging political fortunes (an offer that was not accepted); they could gain credibility as reformers and be invited into negotiations if a Democrat unseated Wilson in 1994 and pursued broader reforms; and if they could attract liberals who wanted immediate action on behalf of the uninsured or larger businesses tired of paying for uncompensated care via cost shifting, they might even win.
Hospitals stayed mostly on the sidelines as others proposed and attacked plans for insurance reform. The hospital industry in California is politically fragmented. About 200 of the 500 acute care facilities in the state are investor owned. They and most private not-for-profit facilities now accept market-oriented policies that favor facilities able to attract patients through technological and organizational innovation. Catholic hospitals advocate the public utility model of rate regulation first proposed in California in 1971 and later adopted in Maryland and Massachusetts. Public hospitals, which in theory would gain the most from expanded coverage, covertly fear losing patients and public subsidies if more people are insured.

The California Association of Hospitals and Health Systems (CAHHS) supported Speaker Brown’s 1989 bill because it promised to reduce uncompensated care. In addition, near-community rating of insurance premiums would have reduced discrepancies in hospital benefits and other administrative headaches and financial pressures from selective contracting. Since 1989, however, hospitals’ support of the employer mandate has been equivocal because few are willing to agree to the cost controls likely to accompany a sizable expansion of insurance.

In 1992 the hospital association chose to support the Garamendi plan because it did not propose explicit controls on service providers. The CAHHS strongly opposed S.B. 248 after amendments were added to allow hospital rate regulation. Hospitals also disliked the provision in S.B. 248 and Proposition 166 that required basic insurance plans to cover only forty-five days of acute hospital care annually. Since the cost controls in S.B. 248 were not in Proposition 166, the CAHHS remained officially neutral in the election campaign. The internal divisions and unwillingness to negotiate concrete measures for cost containment kept hospital organizations from being major players in any of the insurance reform proposals.

Nurses took the most liberal positions of all health care providers. In 1989 the California Nurses Association also had supported Speaker Brown’s bill. Later they joined the Health Access coalition in advocating a single-payer system. When Health Access could not fund a ballot initiative in 1992, the nursing association debated whether to support the CMA proposals. In exchange for their support, nurses wanted representation alongside physicians, business, and insurers on the Health Care Coverage Commission proposed in S.B. 248 and Proposition 166, and they wanted legal expansion of their scope of practice and direct payment for their services. The CMA was unwilling to meet these demands, and in the end nursing organizations provided vocal opposition to the CMA. Nurses were not key on S.B. 248 since they had less influence in the legislature than other groups, but their great numbers and positive public perception made them influential rivals in the campaign opposing Proposition 166.
**Insurers.** Once the Health Access proposal died, the insurance industry was free to mobilize against more moderate reforms. Insurers did not have to work to kill the Garamendi plan—which mandated employee choice of health plans and community rating of premiums—because it was almost certain to be vetoed by Governor Wilson if it passed the legislature.

The positions of insurers on the employer mandate were more complicated. The main objectives of the CMA proposals were to expand the number of persons covered by private insurance and to restrict experience rating of premiums for small groups. California-based insurers generally were willing to accept underwriting reform to gain a larger market and had supported such reform in 1989 and 1990. As business resisted the employer mandate, however, support among insurers for strong underwriting reform deteriorated. Leading the dissent were companies based in eastern states, which, through the National Association of Insurance Commissioners (NAIC), had developed a model law for small-group insurance reform. Once this more lenient alternative surfaced, eastern insurers would not accept the CMA proposals since they provided for near-community rating.

Insurers’ positions changed again in 1991 when Kaiser proposed a pilot pool to allow small-business employees to choose from a number of plans. Other California insurers opposed the pool because putting choice directly in the hands of consumers would limit the role of independent agents and brokers who steer small businesses to insurers. The eastern companies, however, endorsed the small-group pool and in return won Kaiser’s support for less strict underwriting reforms closer to those in the NAIC model. This combination was in the original version of A.B. 1672, but Blue Cross, Blue Shield, Pacific Mutual, and Lincoln National continued to lobby for stronger underwriting reform and no pool. This split was resolved in 1992 when Governor Wilson proposed the stricter position on both issues—tight controls on underwriting and a small-employer pool. The legislature approved an amended version of A.B. 1672 (Margolin-Hansen) in August.

Once the legislative battle over small-group insurance was settled, attention turned to Proposition 166. In theory, insurers stood to gain business in California from the employer mandate and benefits that were more comprehensive than what many plans currently sold. With A.B. 1672 already enacted, Proposition 166 was also somewhat attractive since it had fewer restrictions on underwriting and setting premiums. Thus, there were some benefits and few immediate costs to insurers that would justify mounting an expensive and hostile campaign against physicians. Insurers based outside the state and Blue Cross decided that Proposition 166 had to be killed, however. They were making profits by selling small groups plans with limited benefits and high coinsurance and copayments, so they objected to the minimum benefit package required by the initiative and the advantage
it would give to comprehensive managed care plans. More importantly, Proposition 166 had become a bellwether for national health care reform. Insurers did not want to give momentum to more progressive proposals in other states or to Bill Clinton, who was regularly criticizing the insurance industry throughout his presidential campaign. Nearly all of the $7 million contributed to the campaign against Proposition 166 came from eastern insurers and Blue Cross, which then kept low profiles and let small-business and consumer advocates criticize the CMA plan.

**Employers.** The business community remained the most intractable obstacle to broad health insurance reform in 1992. Publicly, the trade associations representing business were uniformly opposed to the CMA and the more comprehensive reforms offered by Health Access and Insurance Commissioner Garamendi. Beneath the surface, groups and individual companies actually held disparate positions. Interests split in several ways: between firms offering insurance and those that do not, large and small firms, in-state and interstate firms, union and nonunion firms, and manufacturing and service firms. Most business groups did not devote much staff time or money to contest the proposals, but they consciously avoided negotiating a solution to what the public perceived as a crisis.

The California Chamber of Commerce was the nominal representative of all business in the debate. The organization could not take a focused position because employers of all sorts are members-including insurance companies, hospitals, and physicians. Before 1992 the chamber took a simplistic stance against the employer mandate, claiming that it would damage business and jobs. Then the Garamendi proposal for a tax-financed and more heavily regulated health insurance system forced business to review its position on the less radical CMA proposal. The chamber officially maintained its objection to the employer mandate, however, and relied on Governor Wilson to veto legislation it deemed unacceptable.

The largest employers, represented by the California Manufacturers Association, resented increases in their insurance premiums to cover uncompensated care for uninsured workers. In private, they did not resist spreading costs through an employer mandate. But other considerations kept them from supporting S.B. 248 or Proposition 166. Big business would abandon small employers for two things: direct cost controls on health care providers, and reform of the state’s workers’ compensation program. The rate-setting provisions that the CMA added to S.B. 248 in April 1992 interested the manufacturers, but it was too late to add the same language to Proposition 166. Reform of workers’ compensation, their highest priority, never materialized during the legislative session. (It came a year later.) Also, employers with interstate operations were unsupportive of state-by-state solutions and preferred to let momentum build for national reform.
One of the stalwart opponents was the California Restaurant Association, made up of businesses that generally provide insurance only to management, if at all. Workers are largely part time and include many undocumented immigrants. Acquiring and administering insurance would be complicated and time-consuming. If forced to provide insurance, restaurants would prefer that it be financed and administered by government.

The National Federation of Independent Business (NFIB) also vehemently opposed the CMA proposals because of the immediate costs for small business. The NFIB was able to stir up grass-roots resistance but had relatively little political influence in Sacramento. It relied on insurance companies to fund and manage its opposition activities.

Although business interest groups have at times been influential in state health politics, they do not maintain qualified staffs to help design or negotiate the details of policy. During the 1992 debates over health insurance reform, most employer groups refused to enter any sophisticated discussions. Their resistance did not necessarily spell defeat for S.B. 248 and Proposition 166, but it made victory much less likely. It meant that consumer groups and the voting public had to be persuaded if physicians were to rally support for their version of reform.

Consumers. When Willie Brown proposed an employer mandate in 1989 to cover four million uninsured workers and their dependents, it attracted enthusiastic support from liberals and consumer groups. Yet by 1992 consumer support for similar proposals by the CMA was uneven and declining. Virtually all groups asserted that the CMA proposals were too narrow: They did not provide adequate benefits, they did not cover all seven million uninsured Californians, and they lacked sufficient controls to guarantee affordability. For the CMA, the most salient reason for pushing an employer mandate was that it could be passed without additional taxes. What led consumer advocates away from legislation they had supported in 1989? First, a visible and articulate consumer organization emerged in the form of Health Access. Liberal health professionals joined labor unions, seniors, and other activists who sought to become consequential players in state politics. Health Access negotiated with the CMA and employers until 1991, when the CMA retracted its proposal for new taxes to provide insurance for the unemployed (after CMA polls indicated strong opposition). Second, liberal opposition to the CMA hardened after November 1991, when Harris Wofford won a U.S. Senate seat in a special election in Pennsylvania with universal health insurance as his primary campaign proposal. This increased the confidence of consumer advocates and produced greater commitment to waiting and working for a national solution. Third, labor unions were wary that an expansion of private health insurance, which their members already had, might come at the expense of
existing benefits or workers’ compensation reforms,

Fourteen organizations on the Health Access steering committee at one
time had endorsed an employer mandate, but now the liberal coalition
preferred to spoil the CMA’s partial solution rather than compromising its
principles or hard-won benefits. In contrast to other studies of purposive
interest groups, the opposition of Health Access appeared to reflect the
interests of a coalition membership that was, if anything, more committed
and extreme in its views than the leadership. 14

Despite opposition by consumer groups, opinion polls showed strong
support for the CMA position. In early September, 87 percent of Califor-
nians surveyed by Gallup agreed that reform of the health care system was
needed. Fully 80 percent thought employers should be required to provide
insurance for their workers. 15 With these mixed signals—yes from the
general public, no from most organized groups—the issue of health insur-
ance reform moved into the mainstream of party and electoral politics.

Gubernatorial politics. As the political battle over health insurance
reform shaped up in 1992, economic indicators warned politicians not to
take action that would increase the costs of labor and weaken business
confidence during a recession. Conversely, public opinion warned them
that they could not ignore the issue. Indeed, the economic downturn fed
popular insecurity about whether employers would continue to provide
insurance and whether escalating costs would put it out of reach of many.

The stakes shifted significantly when Insurance Commissioner
Garamendi announced his plan in February 1992. He cut short the work of
his advisory committee before it reached agreement on significant design
issues and before it voted to endorse the plan. Critics suggested that
Garamendi was leaving out crucial details and proposing a formal study
commission for strategic reasons. They viewed it as his way to attract
publicity, create support for broad principles, and lay the groundwork for a
gubernatorial campaign against Wilson in 1994. 16 Meanwhile, the political
situation for Wilson and fellow moderate Republicans worsened as state-
wide unemployment approached 10 percent, partisan deadlock left the
state government operating without a budget, the popularity of President
George Bush declined, and intraparty challenges came from the conserva-
tive wing. 17

The Garamendi proposal affected the thinking, if not the positions, of
many interest groups. Groups opposed to the CMA proposals but friendly to
Governor Wilson had to decide how to help him—or help themselves in
the increasingly likely event a Democrat became the next governor. If
business and the CMA cut a deal, they might preempt Garamendi and
liberals on health care reform. These calculations temporarily reduced
business opposition to the CMA and increased the chance of a negotiated
settlement on S.B. 248 or an easier campaign for Proposition 166.¹⁸

National politics. The national political climate also affected the considerations of many players, especially after the California legislature adjourned in September 1992 and the Proposition 166 campaign began in earnest. Many factors appeared to favor the CMA initiative. A Gallup poll in June 1992 for the Employee Benefit Research Institute (EBRI) reported that 26 percent of Americans would vote for president on the health care issue alone. In California Bill Clinton was far ahead of George Bush, and Dianne Feinstein and Barbara Boxer were on their way to winning seats in the U.S. Senate. These factors were expected to help Proposition 166, since Clinton had endorsed an employer mandate like Hawaii’s and the Senate races were likely to increase voter turnout among women, who disproportionately supported an employer mandate in preelection polls.

Still, factors on the periphery of Proposition 166 worked against the CMA. The proposal attracted outside attention simply because California accounts for 12 percent of the U.S. population and a greater share of the economy. The state also had symbolic importance since, as in Washington, Democrats controlled the legislature and the executive was a moderate Republican. If major health reform could pass in California, pressure for reform elsewhere would increase, even if President Bush won reelection. The high stakes intensified when Clinton sent Sen. Jay Rockefeller (D-WV) to Los Angeles in October 1992 to talk with the CMA and to show interest in Proposition 166 as a moderate path to reform and to send a strong message to Washington. The initiative was becoming a de facto referendum for national legislation and a new political game for organized interests. Groups that wanted to stall reform and groups that favored stronger reform now viewed the “No on 166” campaign as a high priority.

The Anatomy Of Defeat

In the fall of 1992 the CMA moved its four-year effort to make health insurance a benefit of employment out of the stalemate of legislative affairs and into electoral politics. This change was initially a breath of fresh air to the physicians’ side. General opinion polls had previously shown overwhelming public support for requiring employers to provide health care coverage, and the initial polls on Proposition 166 were supportive as well. The California Field Poll of registered voters in September 1992 reported that 55 percent were in favor, 32 percent opposed, and 13 percent undecided. By early October, Proposition 166 still had a substantial plurality, but voter uncertainty was rising. The Field Poll conducted 3–10 October 1992 showed voters favoring Proposition 166 by 46 percent to 26 percent, with 28 percent undecided.¹⁹ As the campaign entered its final phase, the Los
Angeles Times poll from 20–23 October reported Proposition 166 still leading 49 percent to 35 percent, with 16 percent undecided. The tide turned swiftly after the opposition began its television campaign in mid-October. The last Field Poll at the end of October indicated that opponents outnumbered supporters 27 percent to 17 percent among initial respondents and 46 percent to 36 percent after hearing a summary of the proposal. Finally, voters on 3 November rejected the CMA initiative by 6.7 million to 3.1 million. The results of Proposition 166 reflect political factors present throughout 1992 as well as peculiar factors that come into play when public policy is decided by a ballot initiative.

**Economic constraints.** The most obvious reason why efforts to achieve health insurance reform produced only incremental change was the dire economic situation in California. Government officials were careful to avoid actions that might appear to further undermine the economy, even at the risk of alienating an influential group such as the CMA. In contrast to other states in which employer mandates have been enacted, the budget deficit meant that state subsidies to soften the effects on small business were not an option.

Broad economic and budgetary concerns also distracted key politicians who might have brought business into serious negotiations on the issue. The CMA thought it was well positioned with the legislature’s most skillful and influential members, Brown and Maddy, as coauthors of S.B. 248. But the party leaders were absorbed by negotiations with the governor to eliminate an unprecedented $10.7 billion budget deficit; they could not give any attention to crafting compromises to bring at least part of the business community on board. Virtually every other state at the forefront of health care reform benefited from key political leaders—usually the governor—committed to and focused on the issue.

Voters, too, worried about the effects of an employer mandate on the economy. Most of the political advertising warned that small businesses would close and more people would be out of work if Proposition 166 passed. An election-night survey indicated that 50 percent of those who voted against the initiative felt that it would put many small employers out of business, and 14 percent of opponents believed that it would cause job losses or cutbacks in wages. Their vote was based not on health insurance, but on economic uncertainty.

**Lack of a moderate-conservative coalition.** Although liberals and insurers created problems for the CMA, the key to the political equation was business. If physicians had persuaded the Chamber of Commerce and the California Manufacturers Association that their brand of moderate reform made economic sense and would give a political boost to Governor Wilson, other interest groups could not have stopped medicine and busi-
ness from putting a version of the Maddy-Brown bill (S.B. 248) on the governor’s desk. The centrist coalition never materialized, however. Business leaders preferred to wait for the economy to improve and, still believing that President Bush would be reelected, felt no need to rush into a bargain. Some large employers favored an expansion of insurance but withheld support for other reasons: They were preoccupied with workers’ compensation reform and gave it priority over the health insurance issue; they wanted national instead of state-by-state solutions; and they especially wanted reliable cost controls on the health care industry and never considered the CMA offers satisfactory. They believed that physicians were trying to assign responsibility to business without accepting enough themselves.

The CMA might still have formed a winning coalition had there been greater pressure from the left. If Health Access had put an initiative on the ballot, the debate would have shifted in favor of a middle-of-the-road solution. A liberal alternative would have instilled greater unity among physicians and increased contributions to the campaign for Proposition 166. Insurers trying to line up opposition would have lost credible allies on the left and would have been forced to divide their attention and resources, instead of having the luxury of attacking only the CMA proposal.

Political ideology and strange bedfellows. Liberals and conservatives combined forces to defeat Proposition 166. The main arguments were that an employer mandate was not sufficient to solve the problems of access to care and rising expenditures, and that imposing a mandate would hurt the economy. The arguments somewhat contradicted each other but were effective because they were aimed at different groups.

Although business is an ideological ally of physicians on most political issues, the results of Proposition 166 suggest that, ironically, the CMA could have done better by adopting a more liberal position. Had the CMA retained the tax provisions in its 1991 proposal and then added the S.B. 248 cost controls, a bloc of liberals might have joined mainstream voters to approve a plan for nearly universal coverage.

While two-thirds of the opponents cited economic concerns as their primary reason for voting against Proposition 166, the rest claimed that they voted against the initiative because more comprehensive reform was needed (17 percent), it did not cover all uninsured Californians (6 percent), or it would not control health care costs (10 percent). Thus, the core group of liberals who opposed Proposition 166 because it was considered inadequate might have decided the outcome. Had they joined those who voted for the CMA plan, a moderate-liberal coalition may have had a slim majority. It is difficult to project how many supporters of Proposition 166 would have rejected it if it had included tax increases to cover unemployed workers and their families. What is striking is that the initiative
revealed how large a segment of the population is ready for serious reform, considering that the CMA did not mount a competitive campaign to draw more support from moderates and conservatives.

**The role of money.** Interest groups spent almost $9 million in the Proposition 166 campaign. Opponents spent $6.8 million, and proponents, nearly $2 million. The monetary resources made an immense difference in interest group tactics to influence voters late in the campaign. The Consumer Health Insurance Coalition (CHIC) of insurance companies and trade associations dominated the opposition spending with just over $6 million. Within that group, the Health Insurance Association of America contributed $2.4 million; Blue Cross of California, $509,000; Travelers Insurance Company, $251,000; and the American Council of Life Insurance, $241,000. Business, principally small employers, formed a separate entity called Health Coalition '92 and raised $813,000. The opposition groups pooled their funds and campaign management. They saturated the television airwaves just before the election, targeting areas of economic distress in the state and making job loss the dominant theme.

The CMA, lacking intense support from within its ranks and major coalition partners, was in a weak fund-raising position. It used $500,000 to gather signatures and qualify the initiative in January and February and only $1.5 million in October on a statewide mailing promoting Proposition 166 and “prohealth” candidates and limited radio and newspaper advertising. The CMA could not afford a television campaign. When it became apparent that S.B. 248 had no chance of legislative passage, the CMA attempted to bring the American Medical Association (AMA) into the election campaign either through direct donations or loans. But the AMA chose not to provide substantial assistance to the CMA campaign, even though its own Health Access America plan for national health care reform included an employer mandate similar to Proposition 166.

The CMA strategy for health insurance reform in 1992 failed to attract allies and financial support for a competitive election campaign. Once hopes for a compromise legislative solution disappeared, physicians alone would not provide the $5–7 million necessary to win a contested statewide initiative in California. The CMA was outspent seven to two by the insurance industry during the fall campaign.

**All eyes on Washington.** Nearly every state legislature has discussed health care reform, and several states have enacted fundamental changes and begun implementation. Yet few have found the right combination of policy and politics to move decisively toward universal health insurance coverage, and not a single state has actually achieved that goal.

The battles in California confirm the psychological and political difficulties of substantially reforming the health insurance system at the state level.
A combination of factors—uncertainty about the effectiveness of the proposed solutions, economic fears, and interest-group pressure—created a climate in which California policymakers and voters could easily decide to wait for a plan from Washington. The visibility of the issue and commitments from all of the presidential candidates to act on health reform reduced the perceived costs of inaction in the state and for many groups made deferring to a national solution more attractive.

**Implications For National Health Reform**

Now the challenge of overcoming economic uncertainty and opposition from special interests falls to President Clinton and Congress. The president’s plan and all others that realistically hope to achieve universal health insurance use compulsory means to expand coverage, whether they impose an indirect tax via an employer mandate or direct taxes on workers, employers, or providers. Any funding mechanism will be strongly resisted because, in the short term, paying to bring the currently uninsured into the system increases the financial burden for others already in the system. Specifying the sources of funding causes the societal consensus for expanding access to dissolve into the politics of self-interest. 34

Because of political advances in several states and even the unsuccessful legislative and election campaigns in California, there is a new starting point for negotiation. Physicians and insurers—the central special interests in health care politics—have had difficulty defending the status quo. In the new political environment, each group has taken positions it had never agreed to in Washington. The early and vigorous promotion of reform by President Clinton led to further concessions.

Momentum for reform can easily dissipate, however. A climate of broad-based concern and openness to compromise existed in California in 1989 and 1990, yet over time, positions hardened and bipartisan cooperation deteriorated. This now appears to be happening in Washington. The Health Insurance Association of America, which intervened in 1990 to spoil the insurance reform offered by California carriers to Speaker Brown and Governor Deukmejian, is leading interest-group resistance. The insurers who spent $6 million to defeat Proposition 166 in California have run a national television campaign estimated to cost $20 million to raise public doubts about the Clinton plan. Despite entreaties from the administration, major business groups have retracted their mostly favorable congressional testimony in the fall of 1993 and now oppose the president. 35 In December 1993 AMA delegates retracted the group’s earlier endorsement of an employer mandate. 36 Many of these groups have directed their support to the proposal offered by Rep. Jim Cooper (D-TN), whose bill has much in
common with the administration bill but does not include the employer mandate or explicit cost containment measures that the administration believes are needed to fund universal coverage.

Nonetheless, the president’s proposal reflects lessons from the successes and failures of states’ reform efforts. Despite public opposition, business remains divided, since large employers are entitled to operate their own systems of coverage, escape the downside of cost shifting, and reduce their outlays for retiree benefits. The automobile manufacturers and other industries continue to support the president. Subsidies of various kinds are incorporated to quiet objections from small business and, in addition, most administrative responsibilities under the president’s plan would be handled by health alliances rather than by employers themselves. Insurers also are divided; large companies with experience in managed care may support much of the president’s plan, leaving smaller indemnity insurers no allies and little chance to oppose substantial changes in their marketing and underwriting practices. Consumers will probably lend the president support to protect universal coverage and a relatively comprehensive standard benefit package—organized labor has committed at least $10 million to promote the Clinton plan—but if financial considerations push policy makers either to delay universal coverage or to scale back benefits, popular opinion and backing from consumer groups will quickly diminish. Finally, most health care providers have recognized the desirability of expanding both private and public insurance coverage but will staunchly oppose governmental spending limits. Despite reservations about various details, ten physician groups have countered the AMA’s resistance by announcing their support for the president’s bill. The careful balancing of new benefits and new obligations in the Clinton plan indicates a heightened sensitivity to interest-group politics and a desire to produce a legislative package that, whatever its technical merits, will meet the tests of political logic.

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NOTES

3. The Health Insurance Plan of California, the state purchasing cooperative established to negotiate and regulate small-group insurance policies, has received considerable attention as a potential model for health alliances.

5. S.B.248 required coverage for all employees who worked at least twenty-five hours per week; Proposition 166 mandated coverage for employees who worked at least 17.5 hours per week or seventy hours per month for more than two months a year. New employers were exempt from the mandated coverage for the first twenty-seven months. The mandate was to be phased in beginning with employers with twenty-five or more workers in 1994 and ending with all employers in 1997.

6. The provisions in S.B. 248 marked the first time that the CMA had ever proposed statutory controls on health care costs.


12. This contributed to business's rejection of the cost controls inserted as amendments to S.B. 248 in April 1992.

13. For the same reasons, consumer advocates virtually ignored the legislation on insurance underwriting reform. They believed that without an employer mandate or provisions for universal coverage there would be little worthwhile impact.


15. Gallup, *Sixth Annual California Health Care Poll*.


18. In August 1992 former state Secretary of Health and Welfare Clifford Allenby, now executive vice-president of the California Building Industry Association, submitted an opinion article to the *Los Angeles Times* urging business to accept S.B. 248. The article implied that a shift in position would benefit Governor Wilson. The Times, which had endorsed the Garamendi plan and published an editorial critical of Proposition 166, chose not to print Allenby's article.


24. The roles of top state officials are discussed in Goldberger, “The Politics of Universal Access,” and in various articles in *Health Affairs* (Summer 1993).


28. This was the strategy adopted in 1993 by physicians and hospitals in the state of Washington. Crittenden, “Managed Competition and Premium Caps in Washington State,” 82.


30. Campaign spending figures are from reports to the California Secretary of State.

31. There was a tacit agreement that insurers would provide the necessary money in exchange for vocal business opposition.

32. J.S. Todd et al., “Health Access America-Strengthening the U.S. Health Care System,” *Journal of the American Medical Association* (15 May 1991): 2503-2506. Late in the campaign, the AMA offered a $500,000 loan, but the CMA judged it insufficient and turned it down.


