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Ninety Years of Health Insurance Reform Efforts in California

By Michael Dimmitt, Ph.D.

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C A L I F O R N I A

R E S E A R C H B U R E A U

**Ninety Years of
Health Insurance Reform
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By Michael Dimmitt, Ph.D.

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EXECUTIVE SUMMARY

Health care reform has been on the national agenda since at least 1915 when the American Association of Labor Legislation (AALL) proposed a national health insurance system.¹ Efforts to expand health care coverage in California extend back to at least 1918.² Employment-based health benefits programs have existed for more than 100 years.³

Many Californians have had limited or no access to health care coverage throughout the state's history. California's policy for providing medical care to the medically indigent (those who are unable to pay for their health care), mandates that counties serve as the providers of last resort to low-income people without health insurance. The policy has been in effect since the early 1900s.

Over the last 90 years, several measures to extend health care coverage to the general population of Californians have been adopted by the legislature and signed by the governor.* First was the adoption of AB 350 (Brown, Keene),[†] and Senate Bill 1207 (Keene, Maddy), which created a voluntary health coverage program and tax credits to partially finance it. The bills were signed by Governor Deukmejian in 1989. Other bills extending health care coverage to the general population include:

- AB 1672 (Margolin) established reforms in the small employer group health coverage market and was signed by Governor Wilson in 1990.
- SB 480 (Solis) required the Secretary of the Health and Human Services Agency to submit a report to the Legislature on options to achieve universal health care; Governor Davis signed the bill in 1999.
- AB 1528 (Cohn) established a commission to recommend strategies for promoting high quality of care and containing health care costs and was signed by Governor Davis in 2003.
- Most recently, the Health Insurance Act of 2003, SB 2 (Burton, Speier) required that employers provide health care coverage to employees and their dependents (an "employer mandate"), was signed by Governor Davis in 2003. That statute was narrowly overturned by the voters in a statewide referendum in 2004 and was not implemented.⁴

This report will provide an overview of legislative and gubernatorial efforts to increase the number of Californians with health insurance. It will review the state's health care policy for the medically indigent for the period from 1918 until the present, and will describe legislative proposals to increase the number of insured. The review will also indicate whether the proposals were financed by regressive or progressive revenue taxes,

* Measures to increase coverage for subsets of the residents of the state, such as the Managed Risk Medical Insurance Program for the medically uninsurable, are not included in this report.

[†] Of the bills signed into statute the chapter numbers are: AB 350 was Chapter 929, Statutes of 1989; SB 1207 was Chapter 797, Statutes of 1989; AB 1672 was Chapter 1128, Statutes of 1992; SB 480 was Chapter 990, Statutes of 1999; AB 1528 was Chapter 672, Statutes of 2003 and SB 2 was Chapter 673, Statutes of 2003.

fees, or insurance premiums. Over that period, legislators introduced at least 44 measures to reduce the number of medically uninsured people in California. There also were four ballot measures that would have increased health care coverage.

The report will also briefly discuss three important issues that are central to increasing the number of insured in California. These are the effects of employer mandates on businesses and the economy, requirements of the federal Employee Retirement Income Security Act of 1974 (ERISA), and the affects of increasing health care costs on employee-based health care coverage. In brief:

- Recent studies indicate that employer mandates may have adverse effects on employment and income.
- ERISA has precluded states from establishing a mandate requiring large self-insured employers to provide health care coverage.⁵
- Between 1961 and 2002, health care costs increased almost without interruption.⁶ No effort to contain them has proven successful over the long term.⁷ Cost pressures include increasing demand, extensive deployment of new technologies, increases in the prevalence of chronic disease, and fee-for service delivery systems.⁸

NATIONAL EFFORTS TO EXTEND HEALTH CARE COVERAGE

In the 1870s, industries in rural areas such as railroads and mining began providing workers the services of a company doctor. Prior to World War II, very few people had health insurance and policies generally covered only hospital room, board, and ancillary services.

Employment-based health care coverage began to increase during World War II, as a result of labor shortages and the use of health benefits to circumvent wage controls. Health insurance was an attractive means to recruit and retain workers because unions supported it and workers' health benefits were not subject to income or Social Security payroll taxes.⁹ (See Appendix A for a compilation of important dates relative to employer-based insurance benefits.)

Employer-based health insurance grew rapidly after World War II and through the 1970s.¹⁰ In the early 1980s, it was relatively stable. Since the late 1980s, however, the proportion of people receiving employer-based insurance has declined by over six percent (1987 to 2004).¹¹ Gilmer and Kronick project the national number of uninsured will grow from 45 million in 2003 to 56 million in 2013.¹²

Achieving health care coverage reform at the national level has been problematical. In 1915, the American Association of Labor Legislation proposed creating a national health insurance system. Later, President Franklin Roosevelt's Committee on Economic Security produced a 1935 report, *Report on Health Insurance and Disability*,¹³ that was submitted to Congress but contained no specific policy recommendations. President Roosevelt in his *State of the Union* addresses in 1943, 1944, and 1945, referenced health care but never made a specific proposal.¹⁴

In 1947, President Truman addressed Congress on health care reform, and his proposal was introduced in Congress. In 1965, Medicare and Medicaid (Medi-Cal in California) were adopted by Congress and signed by President Johnson. Medicare provides health care coverage to persons aged 65 and over and the disabled. The Medi-Cal program provides health and long-term care coverage to over 6.6 million low-income children, their parents, and low-income elderly and disabled Californians.

President Richard Nixon proposed a health care reform in 1971; also in that year, Senator Ted Kennedy and Representative Wicks offered a healthcare reform proposal. In 1994, Senator Robert Dole made a proposal to expand health insurance coverage and President Bill Clinton proposed a restructuring of the health care coverage system.

Congress passed and President Clinton signed as part of the Balance Budget Act of 1997, the State Children's Health Insurance Program (Title XXI of the Social Security Act). The program provides health insurance for low-to-moderate income families who earn less than 250 percent of the Federal Poverty Level. The program provides health coverage for over 820,000 children in California who are not eligible for Medi-Cal.

Most recently, President George W. Bush proposed a health care program to increase the number of people with insurance coverage. Currently there are eight Democrats and ten Republicans running for President and each¹⁵ of them has a proposal to reform health care coverage. It is unprecedented to have a sitting president and all presidential candidates proposing changes to health care coverage.

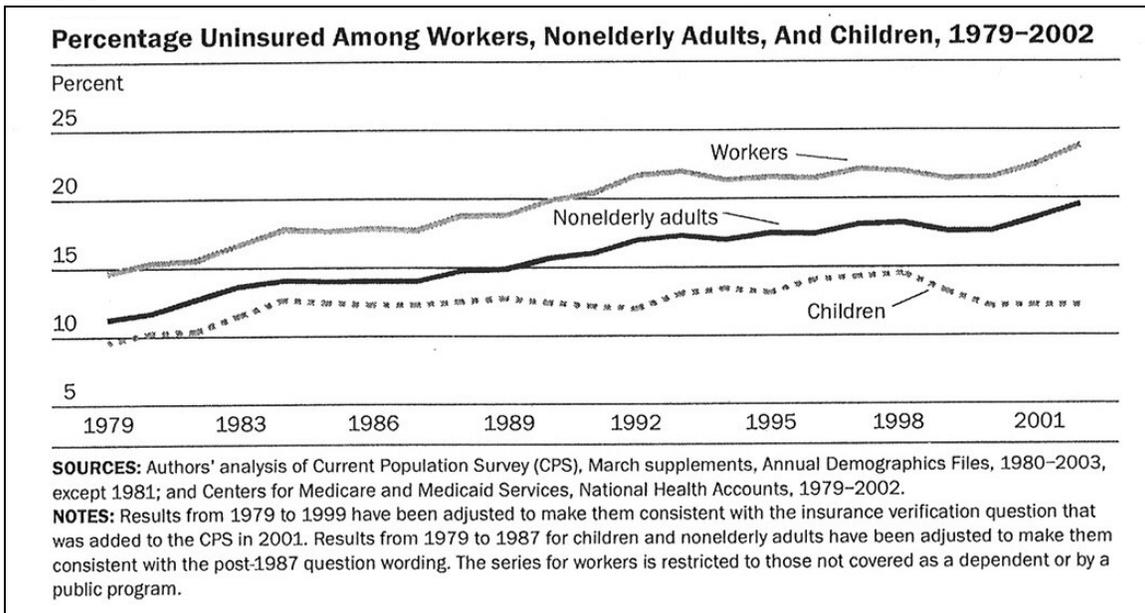
Federal programs provide health care coverage to over 7.4 million Californians. If the programs were not in place, the number of uninsured in the state would double.

Health Care Cost Containment, Federal Employment Retirement Income Security Act (ERISA), and Employer Mandates

When states address health care insurance coverage issues, among them are the nearly intractable issues of the federal Employment Retirement Security Act of 1974 (ERISA), the economic consequences of an employer mandate, and cost containment. As this history reports, expansion of health care coverage has proven to be very costly, in part due to the continuing rapid increase in health care costs.

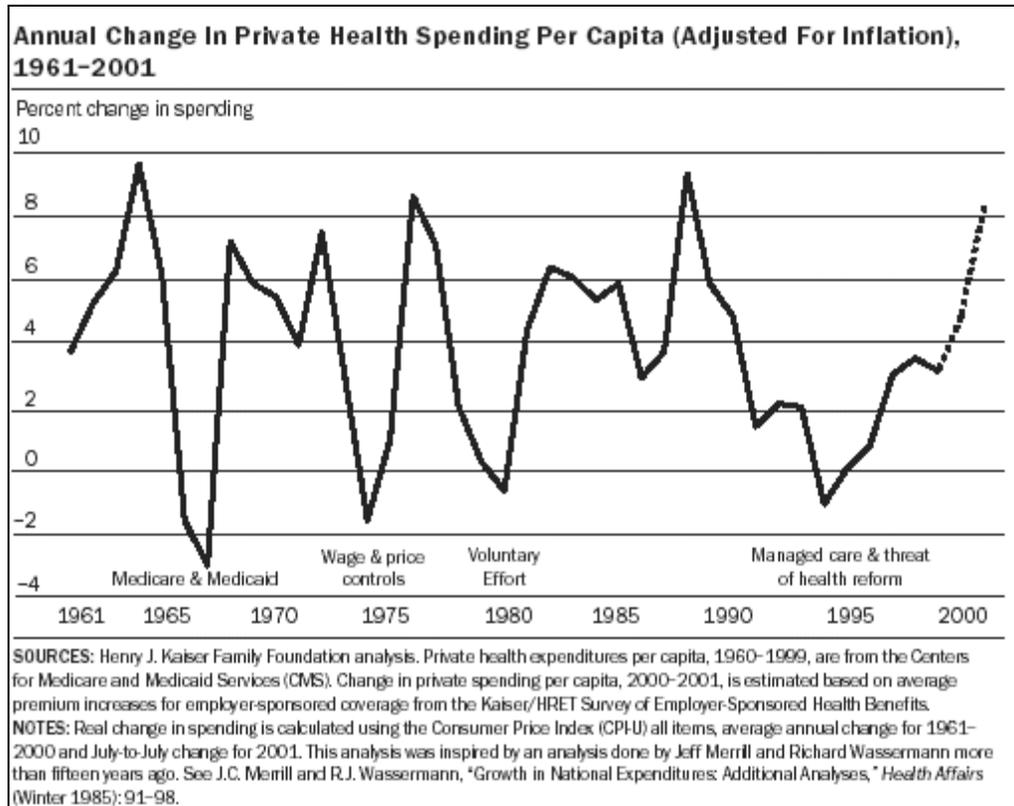
Gilmer and Kronick report that increases in the cost of health care from 1979 through 2002, are the primary reason for the decline in health insurance coverage during that time.¹⁶ They project that the number of uninsured, non-elderly Americans will grow from 45 million in 2003 to 56 million by 2013. Other research indicates that for every ten percent increase in health insurance premiums, 910,000 fewer adults are insured by employer-based plans.¹⁷

Chart 1



Cost pressures moderate, but they do not abate, while efforts to control costs, see Chart 2,¹⁸ have generally not been successful.¹⁹ The consequence is a decline in affordability and in the number of people covered by employer-based health insurance coverage.

Chart 2



ERISA

The interaction of federal and state law has adversely affected state efforts to expand health care coverage. In 1974, Congress enacted the Employee Retirement Income Security Act, or ERISA, which preempts state legislation. As a result, the U.S. Supreme Court has ruled that states are not able to regulate self-funded plans when insurance is not an element of the employee health plan.²⁰

Some of the health care reform bills that have been introduced in California since 1974 have proposed to postpone implementation until an exemption from the ERISA statute could be accomplished. In the absence of such an exemption, any state health care coverage program mandating employer participation that does not exempt self-insured plans is vulnerable to a lawsuit that could forestall implementation.

Hawaii established a mandate on employers to provide health care insurance, through the Prepaid Health Care Act (PPHCA) that was enacted in 1974, the same year as ERISA. After the Supreme Court upheld a lower court ruling that the PPHCA was preempted by ERISA, Congress granted an exemption to Hawaii's program in 1983. A consequence is

that all aspects of the Hawaii program are frozen, including the rules about which employers are covered and the amount contributed to coverage.²¹ Also, a New York statute affecting insurers was found not to be at odds with ERISA by the U.S. Supreme Court.²² Other states have enacted mandates and others are considering legislation to expand health care coverage.²³ Some analysts believe a law could be carefully crafted to stand up to an ERISA challenge.²⁴

ERISA is administered by the United States Department of Labor. The only body that can grant an ERISA waiver is Congress.[‡] The only waiver that has been granted is the one for Hawaii in 1983.

Economic Consequences of an Employer Mandate

Research finds that employer-mandated health insurance has both beneficial and adverse affects.²⁵ The biggest benefit is the increased number of individuals with health insurance or health care coverage and, therefore, improved access to health care services. Conversely, some jobs may be lost or changed from full to part-time, and wages may be reduced as a result of the increased costs to employers.

Research published by the Public Policy Institute of California on the potential impact of SB 2 (2003), which created an employer-mandate, found that it would have lowered wages and reduced employment in the state.²⁶ In a more recent University of California study, the authors conclude that the current leading state health reform proposals have been crafted in such a way that they would not generate adverse employment effects.²⁷ The issue is not resolved and requires careful consideration.

[‡] ERISA's Impact on State Health Policy: Maryland as a case study, National Conference of State Legislatures, January, 2007.

HEALTH CARE COVERAGE IN CALIFORNIA

A BRIEF HISTORY OF STATE POLICIES FOR THE MEDICALLY INDIGENT

The statutory mandate (Welfare and Institutions Code § 17000) for California counties to provide health care to the medically indigent was established in 1931, building on policies in effect since the early 1900s.²⁸ Historically, counties fulfilled their Section 17000 responsibilities by providing health care services in public hospitals and clinics. In 1925, there were 69 county hospitals and all but four counties had a hospital. In 1966, there were 66 county hospitals. However between 1966 and 1978, 25 county hospitals were closed, sold, or leased; another 21 hospitals were shuttered after 1978.²⁹ Consequently many counties now contract with private hospitals and the University of California hospitals for the provision of care to the medically indigent. However, nearly 75 percent of the care provided to the medically indigent is provided in the healthcare systems of counties with county hospitals.

Over time, the Legislature has attempted to provide fiscal relief to the counties in order to alleviate the fiscal distress resulting from being the health care provider of last resort.

A county option for indigent health care was included as part of the original Medi-Cal design in 1966. The Medi-Cal county option provided state General Funds to the counties for county medically indigent programs. Counties that opted into the program paid the state 100 percent of county medical costs, calculated for the 1964 to 1965 time frame. If a county's medical care costs exceeded its contribution to the state at that time, 100 percent of the excess costs would be reimbursed by the state.

In 1971, the legislature repealed the county option and adopted a state-only Medi-Cal program, funded by the state General Fund, to assist the counties in meeting their Section 17000 responsibilities. The program was outside of the federal Medicaid program as none of the beneficiaries were Medi-Cal eligible, so the state did not receive any federal funds for the program. Under the new policy the medically indigent were to be provided the same health benefits that were provided to beneficiaries of the regular Medi-Cal Program.

In the budget crisis of 1983, the Legislature ended the state-only Medi-Cal coverage for medically indigent adults and responsibility was shifted back to the counties. However the state provided some General Fund[§] support to the counties to partially reimburse them for the cost of that care. Each of the larger counties established its own eligibility and benefit levels for their medically indigent programs. The smaller counties, of less than 300,000 people, contracted back with the state for the administration of their medically indigent programs. The state-contracted County Medical Services Program, administered in 34 counties, mirrored the Medi-Cal Program.

[§] The state collects the statewide taxes and fees and deposits them in its general multipurpose revenue fund. That fund, the General Fund, provides the resources for the services the state provides to its citizens. The Legislature appropriates the General Fund for those purposes through the state's Annual Budget.

However health care costs continued to increase, stressing county budgets. Some fiscal relief was provided by the adoption of Proposition 99, the Tobacco Tax and Health Promotion Act, in the General Election of 1988. Proposition 99 increased the state tobacco tax by 25 cents on a pack of cigarettes and 42 cents on other tobacco products. Thirty five percent of the new revenues were reserved for indigent hospital payments. The tax generated nearly 600 million dollars in the 1989-90 fiscal year. However tobacco consumption is sensitive to price and has decreased significantly. A consequence has been reduced funding for the medically indigent (the Department of Finance projects \$337 million in 2007-08). However the revenues were shifted from the counties back to the state by the Legislature, decreasing funding for county indigent programs.

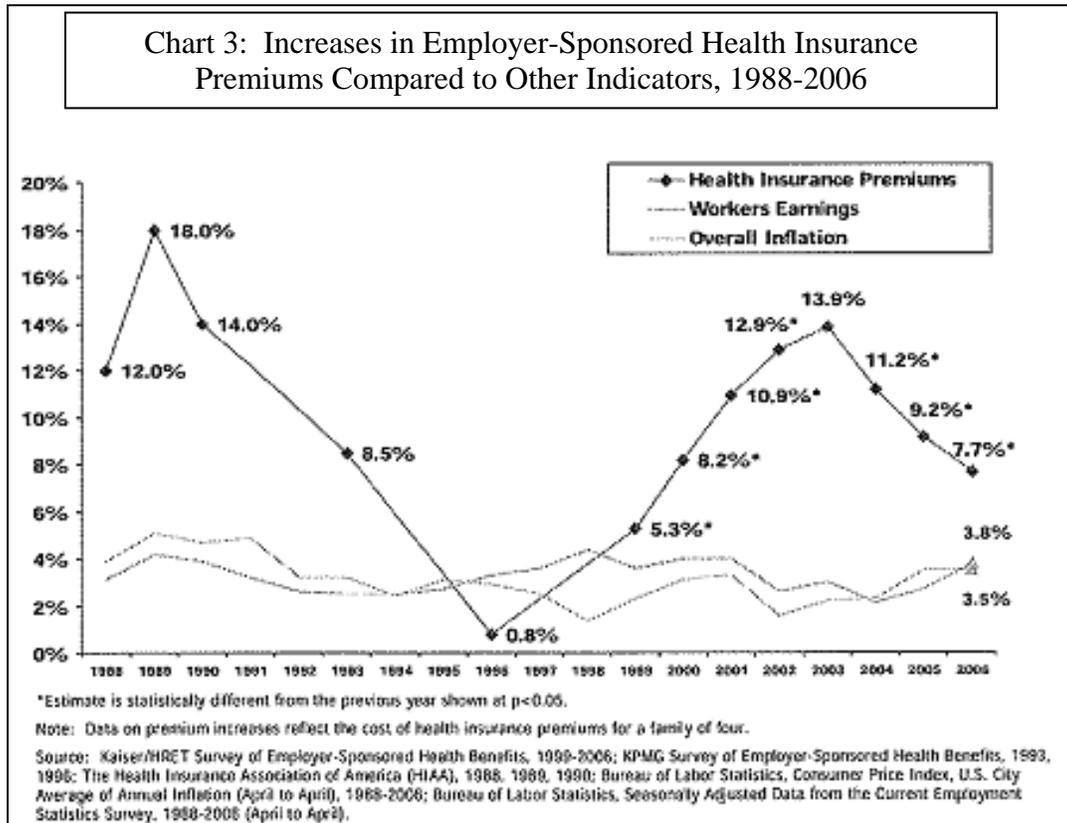
In 1991, the state established the Disproportionate Share Hospital Program (SB 855, Robbins, Chapter 279, Statutes of 1991), which provides supplemental Medi-Cal payments to hospitals that serve a disproportionate share of Medi-Cal and other low income patients. In addition, the SB 1255 Program (SB 1255, Robbins, Chapter 996, Statutes of 1989) provides supplemental payments to hospitals that are licensed to offer emergency medical services and contract with the California Medical Assistance Commission to serve Medi-Cal patients under the Selective Provider Contracting Program.³⁰

During the state's 1991 fiscal crisis, programmatic and fiscal responsibilities between the state and counties were restructured again. Under "realignment," the state increased the sales tax and motor vehicle license fees and directed the additional revenues to fund the county programs. With the increased revenues the counties assumed full programmatic and fiscal responsibility for health care programs, including mental health, substance abuse services, and indigent health care. Each of the large counties established its own income ceiling for eligibility and defined the scope of benefits to be provided. The 34 smallest counties continued to contract with the state to participate in the County Medical Services Program, which established income, eligibility, and benefit levels for the medically indigent in those counties. In 1994, that program was transferred from the state to the counties. Several counties then filed administrative claims and lawsuits to require the state to provide full funding for the mandate. San Diego County prevailed in the lawsuit in the lower court. However, the California Supreme Court reversed the lower court ruling, and the state was not required to reimburse the counties for indigent health care.

HEALTH INSURANCE COVERAGE IN CALIFORNIA

More than 20 percent of Californians, 6.6 million people, currently lack health care coverage over the course of the year according to research conducted for the California Healthcare Foundation.³¹ The number of Californians without any insurance at any point in a year has been estimated to be 4.9 million. As a consequence of the growth in premiums, the number of people covered by health insurance in California decreased from 64.6 percent to 54.7 percent between 1987 and 2005.³² Of those without health insurance, as estimated 75 percent are working people and their families.³³

Chart 3 provides an 18 year national history of the growth of health insurance premiums.³⁴



To some extent, the state’s Medi-Cal and Healthy Families Programs (discussed on page 3 under *National Efforts to Expand Health Care Coverage*) have offset the decline in employer-based health insurance coverage in California.³⁵ The trend is for private health insurance coverage to decrease and public health care costs to increase.

Expansion of health care coverage and the attendant reduction in the number of the medically uninsured has been the objective of governors and legislators for nearly 90 years. The following review discusses those proposals.

HEALTH CARE REFORM PROPOSALS IN CALIFORNIA: *THE FIRST THIRTY YEARS*

1918 - Legislative Ballot Proposition, SCA 26

Senate Constitutional Amendment (SCA) 26 to revise California’s health care system was placed on the ballot in 1918 by the legislature.³⁶ The proposition was developed by the Legislative Social Insurance Commission, a five member commission appointed by Governor Hiram Johnson in 1915 to study health insurance issues.³⁷ The proposal would have added a section to the California Constitution authorizing the Legislature to

establish a health insurance program and making a commitment to provide health care coverage to the people of California.

The program was to be for low income people who were unable to meet their medical expenses. The legislature was authorized to develop a system that was to be funded by voluntary or mandatory contributions from the beneficiaries of the program. The legislature also was to be able to require contributions by employers. In addition, the proposition authorized the legislature to provide support from the General Fund.³⁸

According to the proponents, the legislature needed the authority to remove technical impediments to health care reform in the state's Constitution. A similar Constitutional issue was addressed by the Workers' Compensation Act of 1917 (SB 818, Luce; Chapter 586, Statutes of 1917).

Article XIV Section 4 of the California Constitution, which begins:

“The Legislature is hereby expressly vested with plenary power, unlimited by any provision of this Constitution, to create, and enforce a complete system of workers' compensation, by appropriate legislation, and in that behalf to create and enforce a liability on the part of any or all persons to compensate any or all of their workers for injury or disability, and their dependents for death incurred or sustained by the said workers in the course of their employment, irrespective of the fault of any party.”³⁹

SCA 26 proposed adopting similar language authorizing state programs for health care coverage for low wage employees.⁴⁰

The opponents of SCA 26 argued that the proposition would have provided the legislature with redundant authority.⁴¹ They also noted that SCA 26 would not have treated similarly situated persons the same: some would receive health coverage and some would not. They were opposed to the non-specific financing mechanisms requiring contributions from employers, employees, and the General Fund of the state. Finally, they argued that the Amendment would “...wreck the whole idea of life, liberty, and the pursuit of happiness.”⁴²

The General Election was held in November 1918, and the final vote tally on SCA 26 was 73 percent opposed and 27 percent in favor.⁴³

1935 - SB 454 (Williams), Senate Committee on the Investigation of Sickness

The Senate Committee on the Investigation of Sickness was established in 1933. The members of the Committee were selected by Governor Frank Merriam. The committee was charged with investigating and reporting on the advisability of health insurance to reduce the high cost of sickness. The committee was charged to report to the legislature on its investigation and, if appropriate, to draft a bill to address the need for health care reform. No appropriation was provided, but the Committee was authorized to obtain funds from philanthropies, foundations, and anyone interested in such “practical work.”

The California Medical Association provided \$50,000 (\$700,000 in current dollars) for the work of the Committee.⁴⁴ As a result of the committee's meetings and research, the California Medical Association sponsored the introduction of SB 454 (Williams, 1935), the Health Services Insurance Act.^{**}

SB 454 proposed to create a new state entity, the Health Service Insurance Commission, to administer a prepaid health care coverage program. The proposal was a mandate on employers. If an employer did not provide health insurance coverage to its employees, it would have been required to make a payment to the state so that coverage could be purchased for its employees and their dependents. Employers that provided health care benefits to their employees and their dependents were exempt from paying the fee. The program was designed for working adults, both full-time and part-time, and did not provide for the unemployed or the medically indigent. Undocumented residents were eligible to participate in the program. SB 454, the first statewide health care coverage proposal, would have covered families with an annual income of less than \$3,000 (\$44,967 in current dollars).

The proposed benefits were extensive: all physician, dental, hospitalization, and drug costs would have been covered. The hospitalization benefit was for 111 days, with the first 21 days free to the patient and the rest requiring a co-payment. Funding for the proposal was to come from a five percent payroll tax assessed on employers, although a portion of the tax could be shifted to employees should an employer so decide.

SB 454 charged the proposed program administrator, the Health Service Insurance Commission, with setting provider rates and contracting with providers. Reimbursement rates for health care providers could not be set so low as to adversely affect the participation of physicians and other providers. Depending on the sufficiency of resources, the Commission could also vote to expand the scope of services.

Although the California Medical Association supported the bill, the American Medical Association (AMA) was opposed. The AMA was opposed to all health insurance in principle and this bill in particular. Business interests also were opposed.⁴⁵

The bill was referred to the Senate Committee on Public Health and Quarantine, where it was amended. It was amended a second time but the amendments were rescinded on the floor and the bill died in committee.

1939 - AB 2172 (Rosenthal), On behalf of Governor Culbert Olson

Governor Culbert Olson was governor from 1939 to 1943, succeeding Governor Frank Merriam. He was the first Democrat to be elected governor in 40 years, and was politically aligned with the liberal New Deal policies of President Franklin Roosevelt, which he tried to promote in California.

^{**} See the full text at http://www.cmanet.org/upload/health_coverage_history.pdf.

In his April 13, 1939, message to the Legislature, Governor Olson proposed a reform of the state's health care coverage, stating:

It is no longer seriously debated that a fundamental change is needed in the method of meeting the costs of medical care and the risks and loss of sickness, especially for wage earners and others of small or moderate income.⁴⁶

The proposed compulsory program does not pretend to include all that an ideal and completely developed health insurance system eventually should contain. It is offered as a sound initial program which, in contrast to the beginning programs made elsewhere, furnishes the essential foundation and structure of an adequate health insurance plan.

AB 2172 (Rosenthal) contained the governor's health care coverage proposal. It would have integrated a new health insurance program into the Unemployment Insurance Program. To manage the integration, the State Treasurer would have been required to maintain six accounts:

1. the disability unemployment clearing account
2. the disability unemployment benefits account
3. the disability unemployment benefits administration account
4. the medical benefits clearing account
5. the medical benefits account
6. the medical benefits administration account

All working low income Californians earning \$3,000 or less annually (\$44,320 in current terms) would have been required to participate.⁴⁷ Individuals earning more than \$3,000 could voluntarily participate in the program's hospitalization benefit. Funding for the program was to come in equal parts from the state's General Fund, employers, and employees. The proposed tax rate for employers and employees was one percent on payroll/income.

Although the program was mandatory for low-income wage earners and their families, neither the unemployed nor those with high incomes were included. The self-employed could voluntarily participate.

A newly created Bureau of Medical Service was to administer the new program, which was to provide medical, drug and hospital benefits. The hospital benefit was to be up to twelve weeks per year for each injury or illness. The Bureau was authorized to contract with hospitals to provide physician specialist and consultant services. Physician services, including specialist care, were to be available on both an inpatient and outpatient basis. To control costs, reimbursement of physicians was by capitation, whereby physicians were paid a fixed amount per person per month to provide health care to eligible persons. A limited dental benefit was also included, subject to the availability of funding. If resources were sufficient, the Bureau also was to have the authority to increase licensed

nursing services and children's dental services. In all cases where services were not specifically identified in the legislation, reimbursement rates were to be established by the administrative authority.

Governor Olson's relationship with the Legislature was not good. Conservative Republicans controlled the Senate and conservative Democrats controlled the Assembly; and the Governor's proposals were not well received. The Legislature was opposed to the provision of the bill that required the participation of the state's General Fund. The bill was referred to the Assembly Committee on Unemployment. The bill was amended in Committee, considered in special order of the Assembly and was refused passage.⁴⁸

Governor Earl Warren – Leadership in Health Care Reform

Earl Warren, the state's Attorney General, defeated Governor Culbert Olson in 1942, and became Governor of California in 1943. During his three-term tenure as Governor, Earl Warren submitted at least four health care reform proposals to the legislature, but none were adopted. His first proposal would have established a universal health care system in California. The Governor's subsequent proposals were not as sweeping in scope.

In his 1947 inaugural address, Governor Warren outlined his rationale for reforming the state's health care system:

It is not sufficient, however, to have medical services, hospitals, clinics, and laboratories—no matter how expert or modern and no matter how conveniently located—unless the people have economic access to them, not as charity but as something for which they have willingly and individually paid.⁴⁹

1945 - AB 800 (Wollenberg), On behalf of Governor Warren

On January 8, 1945, Governor Warren addressed the Legislature and recommended that it adopt a compulsory universal prepaid health insurance program to provide health care to California's working people and their families.⁵⁰ His proposal, AB 800 (Wollenberg, 1945), was a single payer system and was based somewhat on Governor Olson's 1939 proposal.⁵¹ It would have provided health care coverage for all Californians. AB 800 shared characteristics with health care systems found in other countries in the 1940s, such as England and Germany, where the systems were funded by tax revenues and providers were paid by a state entity that administered the program.⁵²

The bill mandated participation by all employers subject to the Unemployment Insurance Program and their employees, with the exception of agricultural labor, domestic service in a private home, employees of the United States government, clergyman, railroad workers, non-office insurance sales workers, and religious organizations. Some excluded employers could voluntarily elect to participate under the same conditions as mandatory employers. The unemployed and recipients of public assistance and their dependents, among others, were not included. Services to those not covered by the mandate were to

be made available through contracts between the program and the state or any county or city.

The program was to be financed by a payroll tax on employers and employees. The proposed tax rate was three percent and it was to be assessed on the first \$5,000 of income (\$57,042 in current dollars). The tax was to be equally assessed on employers and employees, with each paying one and one-half percent based on wages and payroll taxable income.

The bill created a new state board, the California Health Service Authority, appointed by the Governor, to administer the program. The Authority was to establish rates and fees and to contract with providers. In addition the Authority was to adopt a procedure for the establishment and payment of claims. The benefits, particularly access to physicians, who were to be reimbursed on a fee-for-service basis, were comprehensive.^{††} In addition, the hospitalization benefit was 21 days for each episode of illness or injury. If the revenues were sufficient, the Authority had the power to increase services.

AB 800 faced major opposition from businesses and physicians. The adequacy of the funding was an important issue. The Los Angeles Chamber of Commerce, in its 1945 report on *Compulsory Health Insurance*, concluded the proposed funding would be inadequate and that either reimbursement of physicians would have to be reduced or services to beneficiaries limited.⁵³ The opposition was forceful and regulation of physician fees was strongly opposed. However, a detailed fiscal analysis of the bill conducted at the University of California, Berkeley, concluded that the proposed three percent payroll tax on the first \$4,000 of income would adequately fund the program (the bill actually proposed taxing the first \$5,000 of income), and that reimbursement of physicians was not in jeopardy nor were benefits at risk.⁵⁴

The bill was referred to the Assembly Public Health Committee. The bill was amended in Committee. In a special order the author made a motion to withdraw the bill from the Committee. The motion failed and the bill died.

1945 - AB 2201 (Wollenberg), On behalf of Governor Warren

After the defeat of AB 800, Governor Warren revised his prepaid health plan proposal. The new bill, AB 2201 (Wollenberg, 1945), established a new state agency, the California Hospital Services Authority, to administer the program. The Authority was to have the power to set rates, fees, or charges to reimburse providers for all of the services the program was to provide.

The employers and employees eligible for coverage by the program were those that were eligible for the Unemployment Insurance Program. The program was to be funded by a payroll tax of one percent; one-half on employers and one-half on employees. The tax base was to be on all wages and payroll. Tax proceeds collected from employers who were not providing health care coverage to their employees were to be remitted to the

^{††} Fee-for-Service reimbursement occurs when providers are reimbursed separately for each service.

state to pay for the purchase of health care coverage for the uncovered employees and their dependents. Employers could opt out of the program if they provided equivalent health care coverage to their employees and their dependents.

The benefits provided under the bill were more limited than under the governor's earlier proposal. For example, the hospitalization benefit was 30 days for each injury or illness. Physician services were to be reimbursed only for care provided in a hospital or outpatient services related to a hospital visit. Physician services unrelated to a hospital visit were not to be reimbursed. The Authority could increase the benefits if program revenues were sufficient.

The bill was referred to Assembly Public Health Committee, where it was amended. The author made a motion to withdraw the bill from the Committee but the motion was defeated and the bill died in committee.

As the 1945 session ended, a study committee on pre-paid health insurance was established in each house. The Assembly Committee, the Interim Committee on Health Care Needs, recommended against any further action on a health care coverage proposal until a survey conducted by the federal government on hospitals and hospital care was completed. (The federal survey led to the creation of the federal Hill-Burton⁵⁵ health facilities program in 1946. The program provided hospitals, nursing homes and other health facilities grants for the construction and modernization of facilities. In return, the facilities were to provide a reasonable volume of services to people unable to pay.)

1947 - AB 1500 (Wollenberg), On behalf of Governor Warren

The Senate Interim Committee on the Prepayment of Medical and Hospital Care recommended that the governor submit a new proposal, which became the governor's 1947 proposal to the legislature, AB 1500.⁵⁶

Once again, the bill proposed a prepaid health plan for employers covered by the Unemployment Insurance Program. A proposed California Health Services Authority would administer the program and have the ability to establish the rates, fees, or charges that were paid as reimbursements to beneficiaries and providers. The benefits covered by the proposal included hospital, laboratory, and medical care. Physician care was limited to that provided in hospitals and hospital coverage was limited to 100 days for any single illness.⁵⁷ If resources were sufficient, the benefits of the program could be expanded.

The program was to be financed by a payroll tax on all wages; one percent on employers and one percent on employees. However participation was limited to employed individuals who earned more than \$150 in a qualifying quarter and their dependents. As a result, there would still have been many people without health insurance coverage. The proposal was "pay-or-play;" employers had to either provide health care coverage to their employees or remit the required payroll taxes to the state. In that case, the state would provide health care coverage for the employees. Employers who opted to provide health care coverage to their employees and their dependents were required to demonstrate that the health care services were equal to those offered by the program.

The bill was referred to the Assembly Public Health Committee and amended. The bill died in the committee.

1949 - AB 863 (Collins), On behalf of Governor Warren

In early 1949, Governor Warren submitted his fourth health care reform proposal to the legislature, AB 863 (Collins, 1949). The proposal was a modified version of the single payer prepaid health plan that he had submitted in 1945.⁵⁸ However the plan was only to apply to employers who were covered by Unemployment Insurance. Employees of participating employers and their dependents were to receive health care benefits through the program.

The program was to be administered by a newly created California Health Service Authority. Funding was to come from a two percent payroll tax, one percent paid by all employers and one percent paid by all employees. The tax base was all wages received by employees and all payroll paid by employers. The Authority was to have the responsibility to set rates, fees, and charges for all services provided. Also, it was to develop procedures for the payment of claims. If revenues were sufficient, the benefits of the program could be expanded.

The benefits that were to be provided under this proposal were modest compared to those included in the first Warren Plan, AB 800. The covered benefits included inpatient, outpatient, and specialty physician services. Hospital services were to be limited to 21 days each year, although if a separate illness or injury occurred, an additional 21 day hospital stay was available. Also, the proposal provided for a drug and dental benefit.

The bill was referred to the Assembly Public Health Committee. The author made a motion to withdraw the bill from the committee; the motion failed and the bill died there.

In a *Los Angeles Times* article entitled, "Warren Says Lobbies Killed Health Plan," Governor Warren is quoted as saying in a statewide radio address that:

Any change that will improve a plan either before or after it is adopted will be welcomed. I would not object if the date on which the plan goes into effect is set far enough ahead to give the medical and hospital facilities of California time to make fully ready for it. My mind is open to the details.⁵⁹

In the *Los Angeles Times* article, the Governor is also quoted as saying that his health care coverage legislation was opposed and defeated by business, insurance, and medical interests in 1945, 1947, and 1949.^{‡‡} In an article in *Look* magazine, the Governor asserted his belief in the role of the states and argued that social problems could be best

^{‡‡} There may also have been a Warren health care proposal in 1950. The author could not obtain references, however, Kevin Starr, Ph.D., in his book, *Embattled Dreams: California in War and Peace 1940-1950*, states that "Warren came the closest to getting such a comprehensive health insurance program through the legislature in 1947, but it was defeated in 1945, 1947, 1949, and 1950."

addressed there.⁶⁰ In his third *Inaugural Address* on January 8, 1951,⁶¹ Governor Warren reiterated his support for a state-administered prepaid health care insurance system. But rather than submitting another proposal to the legislature, he urged the legislature to develop its own proposal.

HEALTH CARE INSURANCE COVERAGE AND LEGISLATIVE LEADERSHIP: *THE NEXT 50 YEARS*

Leadership in the effort to expand health care coverage shifted to the legislature after Governor Earl Warren submitted his last proposal in 1949. Legislative leaders who have authored legislation to expand health care insurance coverage in California include Senate President Pro Tempore John Burton and Senate Pro Tempore Don Perata, Assembly Speaker Bob Morreti, Assembly Speaker Willie Brown, and Assembly Speaker Fabian Nuñez, among others.

Between 1950 and 2007, 38 health care reform proposals were introduced in the legislature. Very few were signed into law. They include bills authored by Speaker Brown and Senator Keene in 1989, and signed into law by Governor Deukmejian. Assembly Member Margolin authored a bill that reformed the small group health insurance market that was signed by Governor Wilson in 1992. Finally an employer mandate, SB 2, authored by Senate Pro Tempore John Burton, was signed by Governor Davis in 2003.

What follows is a chronological summary of each of the bills that we have identified as significant since the Warren proposals. The bill number, year of introduction and the author are identified, and a link to a scanned copy of the legislation is provided on the California State Library's website (see www.library.ca.gov under "California Research Bureau reports"). We discuss the central elements of each bill, including program eligibility, the extent of the proposed coverage and types of benefits, program financing, the role of the employer, the administrative structure and its authority, the role of Medi-Cal, and the disposition of the bill.

1953 - AB 3138 (Collins)

AB 3138 proposed to require employers to participate in a prepaid health care insurance service system. The mandate would have applied to all employers subject to Unemployment Insurance and to public agencies. Their employees and their dependents were to be eligible for the benefits provided for in the program. Employers not mandated to be in the program could apply to participate and have their employees and their dependents also receive health care through the program.

The program was to be financed by a two percent tax on payroll; one percent paid by employers and one percent by employees. A Health Services Fund would have received the funds. The basic services of the program were to include comprehensive physician services, 21 days of hospitalization for each illness or injury with a life-time benefit of one year for each illness or injury, and drug and dental services. If the revenues collected were more than sufficient, the benefits could be expanded.

A California Health Services Authority would be created to administer the program. The primary responsibility of the Authority was to set rates, fees, or charges for providers. It was charged with maintaining rates high enough so that providers would be willing to participate in the program.

The bill was referred to the Assembly Governmental Efficiency and Economy Committee and died there.

1961 - AB 605 (Phillip Burton)

AB 605 proposed establishing a prepaid health service system. It would have mandated that employers subject to the Unemployed Insurance Program, and public employers, provide health care coverage for their employees and their dependents. Non-employed residents could contractually participate after a 60-day waiting period. If employers were providing health care coverage similar to that offered by the program, they could opt out.

The program was to be administered by a new state agency, the California Health Services Authority. The Authority had the responsibility to set the rates, fees, and charges that were to be claimed and paid. In addition, the administrator was to develop a procedure for the payment of claims. A comprehensive set of benefits included full physician services, hospitalization services limited to 21 days for each illness or injury (with a lifetime maximum of one year for any illness or injury), and dental services. If the revenues were sufficient the benefits could be expanded. The program was to be financed by a three percent employer tax on all wages.

The bill was referred to Assembly Finance and Insurance Committee and died there.

1963 - AB 2644 (Song)

AB 2644 was similar to the two previous proposals. The bill mandated the participation of all employers covered by the Unemployment Insurance Code and all public employers. Employers were to pay three percent of total payroll to a new Health Services Fund to purchase health care benefits for all eligible employees and their dependents.

A newly established California Health Services Authority would administer the program. It was charged with setting rates, fees, and charges for providers. The only constraint on the Authority was that rates had to be set high enough to assure the participation of providers in the program. If revenues were sufficient, additional benefits could be provided. The Authority was also to adopt procedures for the payment of claims.

The proposal contained a comprehensive set of benefits including a full scope of physician services, hospitalization benefits of 21 days per calendar year for each illness or injury (with a lifetime limit for each illness or injury of one year) and a limited dental benefit.

The bill was referred to the Assembly Finance and Insurance Committee and then referred to the Rules Committee where it died.

1971 - AB 2860 (Burton and Brown)

AB 2860, the Health Insurance Act, proposed establishing a “single payer” (state financed and administered) program to provide universal health care coverage to all bona fide residents of the state with comprehensive, but unspecified, benefits. Non-residents would need to seek care through the county-provided programs. The program was to be financed by a personal income tax and a payroll tax.

- The personal income tax was progressive. For the first \$5,000 of income, the tax rate was 0.2 percent. The maximum tax rate was three percent on incomes over \$30,000. There were seven steps from lowest tax rate and income level to the highest tax rate and income level.
- The employer payroll tax was one-half percent on payrolls less than \$100,000, two percent for payroll between \$100,000 and \$500,000, and two and a half percent on payroll in excess of \$500,000.

The program was to be administered by a new entity called the Health Insurance Commission, which was advised by an Advisory Health Insurance Policy Council on all questions of insurance policy and administration. The Commission was also charged with submitting a statewide health insurance plan to the federal government in order to obtain a waiver to include Medicare and Medi-Cal in the program. (The same year, Senator Kennedy and Representative Wicks introduced in Congress a health care reform proposal similar to the Canadian system.)

The new health insurance system would have offered two health plans. Plan I would allow a person to enroll with a medical group and receive health care from the group and its associated hospitals. The plan would receive capitation payments (a fixed predetermined contractual payment from a purchaser of health care) for the members enrolled in the program. If the state’s application for a federal waiver to incorporate Medi-Cal and Medicare was approved, and a person were a Medicare or Medi-Cal beneficiary, the benefits of those programs would have to be exhausted before the enrollee could receive benefits under Plan I.

Under Plan II, an enrollee would pay for the medical care received and then would be reimbursed for medical expenses. The enrollee was required to make a co-insurance payment of 20 percent and pay the first \$50 of the cost of medical care in each calendar year, and the first \$150 per family. Provider fee schedules were to be established by the program. As in Plan I, if an enrollee was a Medicare or Medi-Cal beneficiary, the benefits of those programs had to be exhausted before state program benefits were available.

The bill was referred to the Assembly Health Committee, amended and then died there.

1972 - AB 1199 (Speaker Moretti)

Speaker Moretti introduced AB 1199 in 1972, a proposal to create a statewide comprehensive health security system. It was a spot bill that stated the intent of the Legislature to enact health care legislation to establish a system of coverage for all citizens of the state in which low income enrollees would pay less for a service than would higher income persons.

The bill noted that adequate hospital care was not available to all who needed it and proposed establishing a program that provided for adequate medical and hospitalization coverage as state policy.

The bill was referred to the Assembly Health Committee and died there.

1972 - SB 770 (Moscone)

SB 770, the Consumer Health Protection Act of 1972, would have established a single payer universal health care coverage program for all legal residents of California. Migrant agricultural workers and their families would be eligible if they could demonstrate that they were employed or actively seeking agricultural employment. Low income citizens that lived in the state and were over 18 years of age and not receiving adequate financial support for health care would also be eligible for the program.

The benefits of the program were to be extensive. There were to be no deductibles, co-payments, waiting periods, or cutoffs. Funding was to come from property, payroll, and income taxes. A Health Care Trust Fund was to receive the tax revenue.

A new state entity, the State Health Commission, was to be created to act as the agent for the state and establish policy and regulations, including setting rates for provider reimbursement. In setting the rates, the Commission was to take into account geographical differences in costs for the various areas of the state. The Commission was also to be responsible for the re-organization of the state's health care planning process, as required by the federal *Hill-Burton Act*, and for seeking a federal waiver to include Medi-Cal in the program.

The program was to contract only with Health Maintenance Organizations (HMOs) for the delivery of health care services. The HMOs were required to provide full fiscal disclosure, meet the federal conditions of participation, offer services in languages other than English, reimburse providers at their prevailing and customary fees, and provide services either directly or through subcontractors.

The bill was referred to the Senate Health and Welfare Committee, amended and died there.

1978 - AB 1207 (Hart)

AB 1207 proposed to establish a statewide voluntary insurance agency, the California Voluntary Medical and Hospital Services Insurance Plan Agency. The Agency was to be responsible for the operation of the California Voluntary Medical and Hospital Insurance Plan. The proposal explicitly rejected mandatory participation in the state plan, asserting that it would create the expectation of receiving unlimited health care services.

The plan was to have the authority to set reimbursement rates for all providers to control the cost of the medical care. Two Agency subdivisions were to be established: Section I was responsible for relations with hospitals and their reimbursements; Section II was responsible for relations with physicians and laboratories and their reimbursements. Providers had to be approved by the program in order to participate. The administering agency was to have no role in regulating the quality or availability of medical care.

The benefits under the plan included reimbursement for all medically necessary care including hospitalization, dental, laboratory, and podiatric services.

The program was to be funded through premiums paid by every subscriber. The premium was set at \$18 per month or \$216 for the year. Low income subscribers would be charged a lower premium of no less than \$3 per month, which would require a premium subsidy. Additional program funding would come from General Fund appropriations. A prerequisite for the program to become operational was the state obtaining a waiver from the federal government to include Medicare and Medi-Cal and associated funds into the program.

The bill was referred to the Assembly Finance, Insurance, and Commerce Committee and died there.

1980 - AB 3068 (Bannai)

AB 3068 proposed the establishment of the California Comprehensive Health Insurance Association to administer a comprehensive health insurance program. The intent was to provide access to health care through reforms in the health insurance market. Health insurers and prepaid health plans were required to participate and offer qualified comprehensive health insurance policies. If they did not participate, they would be barred from participating in the state's broader insurance market. Qualified carriers could elect to offer health coverage through the Association, on their own, or through reinsurance from the Association. Regulatory powers were provided to the Insurance Commissioner to enforce these provisions.

All employers were required to offer to their employees a comprehensive health care insurance policy that provided specific benefits. If either a business had 25 or more employees, and 50 percent applied for coverage, or less than 25 employees and ten employees applied for coverage, the business was required to offer the policy. Covered employees did not include those who worked less than 20 hours per week and 26 weeks per year.

The program was to be financed from funds contributed by employers, employees, or some combination thereof. At a minimum, the employer's contribution had to equal the employees' contributions. In addition, the program required deductibles, co-payments, and maximum out-of-pocket costs including a \$200 deductible per person per year. Maximum out-of-pocket payments for eligible expenses could not exceed \$200 or ten percent of the insured's adjusted gross income, whichever was greater.

All qualified health care plans were required to pay reasonable and customary charges for health care services. The benefits were extensive. There was to be no limit on hospitalization and physician services. In addition, benefits included drugs, reimbursement for skilled nursing facilities and home health agencies, and a modest mental health benefit.

The bill was referred to the Assembly Finance, Insurance and Commerce Committee and died there.

1982 - AB 1262 (Torres)

AB 1262 would have required every insurance carrier, insurer, nonprofit hospital service plan, health care service plan, and fraternal beneficiary association, to make a qualified individual comprehensive health care plan available to every resident of the state as a condition of doing business in the state. Also it required every carrier offering group health insurance to make a group comprehensive plan available to every employer of three or more employees and their dependents. Group comprehensive health care plans could be sold to employers with between three and 25 employees through participation in the California Comprehensive Health Insurance Association, the administrative entity for the program.

The benefits in the individual and group plans were the same and included catastrophic coverage with a maximum lifetime benefit of \$1 million per person, physician services for all medically necessary care, hospital services for necessary care, mental health diagnosis and treatment, prescription drugs, skilled nursing services, home health services, radiation therapy, and dental services. In addition, the plans could require deductibles. Deductibles for outpatient services could not exceed the deductible for inpatient services. Deductibles could be adjusted with increases in the consumer price index. In addition, co-payments of 20 percent of charges were to be permitted. However, co-payments and deductibles could not exceed \$1,000 for an individual and \$2,000 for a family. The insurance program was to be fully financed by premiums.

The bill created the California Comprehensive Health Insurance Association. All insurers doing business in the state were required to be members of the Association and could not charge higher premiums than those authorized by the Association. The Association was authorized to establish appropriate rates, separate pools, accounts, or other plans for its insurance products. It was vested with other responsibilities to oversee the operation of the health carriers. The Insurance Commissioner and the Director of the Department of Corporations were vested with oversight authority over the Association.

The bill was referred to and passed by the Assembly Finance, Insurance, and Commerce Committee. It was then referred to the Ways and Means Committee and died there.

1988 - AB 2647 (Campbell)

AB 2647 was to put before the voters a statewide measure that would require the governor to request the President and Congress to enact a national health program. The proposal was premised on the continued upward trend in health care costs and the consequent decline in the affordability of health care coverage. The requested program elements included providing accessibility for all, sound financing, an allowance for innovation in the delivery system, provision of pilot projects, and a reliance on professional judgment and sensitivity to consumer input.

The bill was referred to the Assembly Finance and Insurance Committee, amended and died there.

1989 - AB 350 (Speaker Brown, Keene) and SB 1207 (Keene, Maddy)

AB 350 proposed a voluntary program for employers to provide health care coverage to their employees, the *Tucker Health Care Coverage Act*. The companion bill to implement the program, AB 1207, proposed an employer tax credit. If the credit was not adopted, the program contained in AB 350 could not be implemented. Both bills were signed into law by Governor Deukmejian in September 1989.

Under the voluntary program, employers had the option of selecting coverage from any carrier and could establish their own plan if there was not a similar insurance carrier product. Employers who opted to provide coverage under the program were required to pay at least 75 percent of the cost of the coverage for their employees unless they were not the principal employer of the employee, the employee was a dependent under another plan, or the dependent of the employee was a minor or permanently disabled child. Requiring employees with low incomes to pay the same premium amount as employees with high incomes would have been regressive. The relatively high premiums made it difficult for low income employees to secure health care coverage. Employers could form associations to purchase health care insurance coverage at group rates rather than an individual rate. The organizing employers were responsible for the associations; the state did not have any authority over them.

The benefits of this voluntary program included hospital inpatient services of 20 days per year, and unlimited hospital outpatient services. Mental health benefits were provided, exclusive of substance abuse. The total lifetime benefit in the program was \$1 million per person. Employers could require employees to share in the cost of the coverage through deductibles and co-payments as long as the maximum annual costs for employees did not exceed 50 percent of the premium.

The SB 1207 tax credit was deferred for a few years and then repealed, so it never took effect. The credit was \$25 per month per covered individual for employers that provided

health care coverage to their employees. Alternatively, the credit could be 25 percent per month of the amount paid by the employer. To qualify for the credit, an employer had to pay at least 75 percent of the premium for an employee and 50 percent of the premium for dependents. The credit was in lieu of any state business tax deduction. Employers eligible for the credit could have no more than 25 employees. The credit was applicable to plans that were regulated by either the Commissioner of the Department of Insurance or by the Department of Corporations.

AB 350 required the governor to designate a state agency to research and report on the factors relevant to a solution of the problems posed by the state's large and growing uninsured population. The governor designated the Secretary of the Business, Transportation, and Housing Agency and the Secretary of the Health and Welfare Agency to conduct the study. The report was to estimate the number of uninsured in the state, assess what other fiscal incentives might encourage employers to provide health care coverage to their employees, recommend improvements in insurance underwriting, and analyze why many employers do not provide health care coverage. Also, the report was to assess the potential cost savings that might accrue by integrating Workers' Compensation medical benefits with employer-based health care coverage. Finally the report was to assess the viability of an employer mandate to provide health care coverage for all Californians.

AB 350 was adopted and signed into law, Chapter 829, Statutes of 1989. SB 1207 was also adopted and is Chapter 797, Statutes of 1989.

The report required by the legislation was released in 1990, but its recommendations were not adopted.⁶² It became the basis for several other bills discussed in this report including a later version of AB 350 and AB 328 (1989), and AB 3032 and AB 1521 (1990).⁶³

1989 - AB 328 (Margolin)

AB 328 was designed to assist all California residents with no other available health insurance or coverage. The bill would have established the California Health Plan Commission, with authority over insurance and health care plans, in order to achieve price stability in the health care insurance market. Small businesses, the self-employed and business partnerships with less than 50 employees would have been eligible to purchase basic health insurance for their employees through the Commission. The Commission was also to provide basic health coverage to persons receiving Unemployment Insurance by exercising continuation options like COBRA benefits or by purchasing or providing basic minimum health coverage.

The program was to be financed by a payroll tax, Proposition 99 funds, a General Fund appropriation equal to the amount spent on the Medically Indigent Services Program in 1988-89, and unemployment health insurance tax and health insurance premiums.

The Commission was to contract for delivery of health care at negotiated rates and, whenever possible, to contract with plans such as HMOs, prepaid health plans,

independent practice associations, county organized health systems, other qualified health systems under the *Knox-Keene Act*, and health insurance plans certified by the Department of Insurance or Department of Corporations.

The Department of Health Services was charged with seeking federal approval to include the Medi-Cal medically needy in the program, along with the associated funding and benefits. Basic benefits, exclusive of Medi-Cal, were to include inpatient and outpatient services as well as children's dental care. The premium for the basic plan was to be determined by the Commission and was to be no higher than comparable premiums for state employees.

The bill required the implementation of new health insurance regulatory measures. Notably, the Insurance Commissioner had to approve any rate increase in health insurance rates proposed by any insurance entity doing business in the state. A rate request in excess of increases in the consumer price index was presumed to be excessive and required justification. The Insurance Commissioner was to have all the necessary powers to implement the plan. For HMOs, the Director of the Department of Corporations was required to approve any rate increase, and rate increases in excess of the consumer price index had to be justified. The Director of the Department also had the authority to disapprove any exclusion or reduction which had the effect of denying reasonable access to the minimum basic benefits.

All employers subject to the Unemployment Insurance Program would have been required to participate in the program and remit an eight percent of payroll tax for in-state employees who were not covered by a health benefits plan. A two percent tax on gross wages of employees without health care coverage was to be assessed. A tax rate of two percent was to be levied on taxable income of every person who was neither an employee nor employer and not covered by a health benefit plan. The self-employed were to be taxed on income and payroll. The maximum tax collected was to be no greater than 25 percent of the average insurance premium. The cost of the premium for the minimum health coverage package was to be no higher than the premiums for state employees for comparable coverage. Employers who provided health care coverage to their employees were to receive a credit against the payroll tax when they filed a tax return. Employees not covered by a health plan were to pay a two percent tax on wages and to pay a premium for their healthcare. For individuals with incomes less than 300 percent of the Federal Poverty Level, the premium was to be charged on a sliding fee schedule.

The bill passed the Assembly and was sent to the Senate, where it was placed on the Appropriations Committee Suspense File and died.

1990 - AB 1521 (Margolin), Proposed Conference Committee Report

AB 1521, or the Health Insurance Act of 1990, proposed to ensure basic health care coverage for all persons in the state. Employers were required to provide health care insurance coverage to their employees and their dependents or pay a premium to the California Health Plan Fund, which was created by the bill. The bill established a mandate where individuals not otherwise covered were required to purchase basic health

coverage or pay an assessment into the California Health Plan Fund to secure health care coverage.

The health care coverage program was to be funded by premiums paid by participating employers and individuals without coverage. Additional funding was to come from Proposition 99 (tobacco tax) and a General Fund appropriation. The Department of Health Services was directed to seek federal approval to include the Medi-Cal program in the plan, along with the state and federal funds devoted to the program. A new administrative agency, the California Health Plan Commission, was created with regulatory authority independent from the Department of Corporations and Insurance.

Participating employers were required to pay 75 percent of the cost of employee health care insurance premiums and 50 percent of the cost for employee dependents, or alternatively to pay a fee so the coverage could be purchased. Employees were to pay 25 percent of the premium cost for themselves and 50 percent of the cost for their dependents. Requiring employees with low incomes to pay the same premium amount as employees with high incomes would have been regressive. The relatively high premiums made it difficult for low income employees to secure health care coverage. For large employers (more than 50 full-time equivalent employees), health care insurance coverage was to be funded entirely by premiums. Premiums and surcharges (a percentage addition to the premium) were to fund health care coverage for employees of small businesses and individuals. The premiums and surcharges were to be established by the Commission and implemented upon enactment of subsequent legislation. The Commission was to develop a mechanism to assure affordability for low-income workers.

The basic minimum health care coverage was to include comprehensive inpatient and outpatient benefits and a modest mental health benefit. Health benefits plans could impose cost-containment measures such as requiring the use of generic drugs, with a 25 percent co-pay for generic drugs and a 50 percent co-pay for non-generic prescriptions. Other health benefits including long-term care, dental, vision and speech, and occupational and physical therapy, were to be excluded from the program.

The bill addressed several issues associated with health carriers including the difficulties small businesses encounter in purchasing basic health coverage, guaranteed issue and renewal, the requirement that insurance carriers must sell and renew policies to employers, the stability of premiums over time, and limits on the factors that could be considered when developing premiums for the small group market. Employers were authorized to form associations in order to collectively negotiate better rates with health insurance carriers.

The program was authorized to selectively contract with health care plans and providers for lower rates whenever possible. In addition, the California Medical Assistance Commission (CMAC) was required to establish a plan to assist public hospitals to become qualified contractors in the health care delivery system. CMAC was also to set limits on the rate of increase in hospital charges and professional fees. Hospitals would have been required to reduce their rates by eliminating cost shifting from non-paying to

paying patients. A Cost Containment Committee was to limit provider rate increases in the private health insurance market.

If any of the provisions of the bill were found by the courts to be in violation of the federal Employment Retirement Income Security Act (ERISA), the bill was to become inoperative. Nonetheless, many large employers had self-funded benefit plans that did not fall under ERISA and could have been affected by the bill.

The bill passed the Assembly in June 1989, and was passed by the Senate and returned to the Assembly in June 1990. At that point, the Assembly refused to concur in the Senate Amendments and a conference committee was appointed. The Senate appointees were Senators Petris, Senate Pro Tempore Roberti and Minority Leader Senator Maddy. On the Assembly side the conferees were Assembly Speaker Brown, Assembly Member Bronzan and Minority Leader Assembly Member Johnson. The conference committee passed the bill on a 2-1, 2-1 vote of the houses. The bill was returned to each house for its consideration. Governor Deukmejian, however, opposed the bill and neither house brought it up for a vote, so the bill died.⁶⁴ Nonetheless, many of the small group insurance provisions of the bill were included in AB 1672, which was signed by Governor Wilson in 1992.

1990 - SB 2868 and SB 308 of 1992 (Petris)

SB 2868 and SB 308 proposed the establishment of a single payer health care system to achieve universal health care coverage in California. The bills were very similar. Any resident of the state would have been eligible. Benefits were to include comprehensive medical, hospital, dental, and mental health care and also long-term care services at home or in health care facilities. The funding was to come primarily from General Fund appropriations.

The California Health Care Commission was proposed to administer the program, including expanding health care benefits beyond those that were originally proposed if revenues were sufficient. Eligible residents of the state had the option of enrolling in an open plan or a prepaid health plan. The open plan gave the beneficiary the option of receiving services from a private or public provider or hospital. The prepaid plans offered panels of physicians and hospitals from which an enrollee was able to choose.

The Legislative Analyst Office was to determine the amount of statewide health care expenditures and report their findings to the California Health Care Commission. A statewide health care budget was to be developed, including a capital expenditure budget, based on the relative needs of specified geographic areas in the state. The Commission was to establish reimbursement rates for providers, which were to be reviewed annually for sufficiency, and to seek federal waivers to allow all federal payments for health care services in the state to be made directly to the program.

Co-payments could be required in the open program for covered medical benefits but could not exceed ten percent of the cost of services. The yearly maximum co-payment was not to exceed \$250 for an individual and \$500 for a family. Low income families

(those with family income less than 250 percent of the Federal Poverty Level), were exempt from making co-payments. If a person was a member of a pre-paid health plan, he/she could be required to make a co-payment of five percent of the cost of a service if the family income was more than 250 percent of the Federal Poverty Level. An annual limit for co-payments was to be \$100 per individual and \$250 per year for families.

Physicians were to be reimbursed by the California Health Care Program consistent with Medicare's resource-based relative value fee schedule.^{§§} Hospitals were to be reimbursed based on a hospital-specific global budget developed yearly by the Commission, limiting the amount that each hospital could spend. A hospital was to stay within its budget; it could not be exceeded. The budget provided the incentive for a hospital to keep the costs of care down, since if it exceeded the budget, it would not have resources to provide care or pay employees at the end of the year.

SB 308 passed both houses but the Senate did not concur with the Assembly amendments and the bill died. SB 2868 was voted out of the Senate in June 1990. It was referred to the Assembly Committee on Finance and Insurance and was passed out to Assembly Ways and Means, where it died on the Inactive File.

In addition Senator Petris introduced another single payer bill in 1992, SB 36. The bill was amended in the Senate Health Human Services Committee and re-referred to the Senate Revenue and Taxation Committee. It was then referred to the Senate Appropriations Committee, where it died.

1990 - AB 3032 (Speaker Brown)

AB 3032 proposed the creation of an employer-mandated health care program, to become operational only if an exemption to ERISA were to be granted by the federal government⁶⁵ Also, if federal legislation was adopted prior to the operative date of this program that was equal or superior to the state's program, the state's program would not be implemented.

Employers were required to provide health care coverage through any carrier in the state and to pay 75 percent of the cost of health care insurance coverage for an employee and 50 percent of the cost for an employee's dependents. Employees were to pay the difference. Employers were authorized to form associations for the purpose of providing the group health care coverage required by the Act, with the goal of obtaining more advantageous large groups. Employers who did not provide health care coverage to their employees were required to pay all health care costs for eligible employees for the time during which the employer did not provide coverage.

The program provided basic health care coverage including hospitalization of at least 30 days each year and all medications that were medically necessary during a hospital stay.

^{§§} The Resource Based Relative Scale (RBRVS) is a statistical methodology developed for Medicare to reimburse physicians.

All physician services on either an inpatient and outpatient basis, emergency care, and hospice and mental health benefits were covered. The bill relieved physicians of medical malpractice liability when care was delivered in the hospital emergency room.

The Cal-Care Program was established to provide coverage to employees and their families with incomes less than 200 percent of the Federal Poverty Level. Other individuals eligible for the Cal-Care program included employees of 501c (3) corporations (non-profits), part-time and seasonal employees and the self-employed. The Department of Health Services was to submit a waiver proposal to the federal government to merge the Medi-Cal program into Cal-Care. Additional benefits available under the Cal-Care Program included all medically necessary hospitalization, long term care, durable medical equipment, and mental health services.

The bill established the California Health Plan Fund to receive all revenues. Eligible employers and employees who opted to purchase health care coverage through the Cal-Care Program were to pay a premium and a premium surcharge. In the case of the self-employed, the surcharge was a percentage of payroll or taxable income. Premiums for eligible employers and employees were to be fixed in statute but adjusted annually by the Department of Health Services, and they were to cover the cost of providing health care to the eligible employees and their dependents. Subsidies were to be provided to low profit employers and low income employees.

The Fund was to receive 50 percent of the Unallocated Account funds raised by Proposition 99 tobacco taxes, insurance premiums, premium surcharges, and appropriations from the General Fund equal to the appropriation for the Medical Services Program in the 1988-89 Fiscal Year.

The bill required the California Medical Assistance Commission to contract with hospitals for services under the Medi-Cal program and to negotiate hospital contracts for prepaid health plans. To further control health care costs, the bill authorized the Commission to utilize selected cost control measures, including the assessing a gross receipts fee on all providers that benefited from an excessive medical cost inflation rate. Those fees would reimburse payers or contribute to the low income subsidies offered by the program. The bill statutorily raised the reimbursement rate for many providers.

An objective of the bill was to hold the rate of inflation in medical services to a rate no higher than that of the Consumer Price Index. All health coverage and insurance carriers were to provide a minimum health benefit basic package. In addition, carriers doing business in the small group market (employers with less than 25 employees) were to be subjected to additional regulations. The bill also proposed to prevent unfair and deceptive business and trade practices among health and health coverage carriers.

The bill was amended in the Assembly Finance and Insurance Committee and died there.

1992 - AB 2001 (Speaker Brown and Senate Minority Leader Maddy)

AB 2001, the Affordable Basic Health Care Act of 1992, proposed to maximize employer-sponsored health care coverage, strengthen the public safety net, ensure that all parties assumed responsibility for containing health care costs, and eliminate fraud in the Worker's Compensation system. Implementation was dependent upon obtaining an exemption from ERISA, the federal Employee Retirement Income Security Act of 1974 that preempts state laws that "relate to any employee benefit plan."⁶⁶

The proposal mandated that all employers provide health care coverage to their employees. Employers providing basic health care coverage would qualify for state tax credits. An employer would pay 75 percent of the lowest premium cost for basic health care coverage; an employee's share could be no greater than 25 percent. However, if an employee's share exceeded two percent of wages, the difference in the cost was to be absorbed by the employer. Limited co-payments and deductibles were permitted. The required employer coverage could be delayed for employers with less than 25 employees with a determination of economic hardship.

The benefits in the program were broad based. They were to include a 45 day hospitalization benefit, extensive physician medical and surgical benefit, and a mental health benefit for 15 days of inpatient care and 20 outpatient visits. A long-term care benefit and prescription drug benefits were also provided. The program was to have a lifetime limit on health care expenses of at least \$500,000 (\$920,000 in current dollars).

The proposal would have imposed operating constraints on all health care insurers, requiring them to offer basic health care coverage policies to employers with less than 100 employees in their service areas. All policies issued by health insurers were to have a guaranteed renewable feature whereby all policies previously contracted had to be renewed by the carrier irrespective of other underwriting conditions. In addition, health care insurance carriers that offered basic health care coverage were to make catastrophic coverage available to retired employees not eligible for Medicare, based on sound actuarial principles.

A Health Care Coverage Commission was proposed to administer the program, and charged with the responsibility of developing a program for all Californians not covered by private health insurance, Medicare, or Medi-Cal. Insurance pooling mechanisms were to be created to provide basic health care coverage for part-time employees and their dependents. The Commission was additionally charged with determining if individuals eligible for Medi-Cal could be incorporated into the program. The Commission was required to make regional purchasing pools available to employers with 25 or fewer employees, to be administered by a contractor.

The program was to have a Medical Policy Panel, Cost Containment Panel, and a Technology Panel. The Medical Policy Panel was to recommend how the Commission should deal with health care procedures, services, drugs or devices that were experimental, investigational, outmoded, not efficacious, or not cost-effective. The Cost Containment Panel was to have the authority to limit insurance carrier's premiums,

hospital rates, and professional fees. Hospitals were required to reduce their rates to reflect the elimination of cost shifting, bad debt, and charity care. Insurance carriers were to reduce their premiums to reflect the reduction in hospital rates. Carriers could market insurance products that covered both health care benefits and Workers' Compensation benefits.

The bill passed the Assembly and was referred to the Committee on Insurance Claims and Corporations in the Senate, it was amended and died.

1992 - SB 6 (Torres) and AB 502 (Margolin)

SB 6 and AB 502 contained Insurance Commissioner Garamendi's proposal for universal health care, "California Health Care in the 21st Century." They did not include many details on how universal health care coverage was to be achieved. In general, increased coverage was to result from more regulation, expansion of cost containment measures, and enhanced competition among health plans to attract beneficiaries.

The bills established a Commission to refine the proposal and report back to the legislature in 1994. The Commission was charged with following two guidelines: (1) develop a health insurance product that incorporates the benefits of health, auto, and workers' compensation into one insurance product, and; (2) allow individuals to select health plans from a health insurance co-operative.

The benefits offered by each plan were to be the same, although plans could charge higher premiums when they offered a broader selection of providers. Health plans could not turn down any applicant because of a pre-existing condition. Finally, the financing for the program would come from payroll assessments on workers based on their ability to pay and from employers.

AB 502 passed the Assembly and Senate. The bill was returned to the Assembly for concurrence in the Senate amendments but the Assembly did not take up the amendments and the bill died with concurrence pending. SB 6 passed the Assembly and Senate. The Senate concurred in the Assembly amendments and the bill was sent to Governor Wilson who vetoed the bill.

1992 - AB 1672 (Margolin)

Small businesses confront a number of difficulties in purchasing and providing insurance for their employees. AB 1672, Chapter 1128 Statutes 1992 addressed many of those challenges.⁶⁷ It created an optional small group health insurance purchasing pool, the Health Insurance Plan of California (HIPC). This significant reform enabled "pooling," which provided many small employers the opportunity to purchase health care coverage for their employees at less costly group rates. Initially employers with between five and 50 employees qualified. The pool size expanded to employers with between two and 50 employees over a three year period.⁶⁸

The HIPC was administered by the Managed Risk Medical Insurance Board at the outset. The statute required the purchasing pool be spun off to the private sector after three years. However it took six years for a private entity to take it over. The Pacific Business Group on Health (PBGH), a not-for-profit coalition of 50 large employers in San Francisco, was the successful bidder in 1998. PBGH renamed the program PacAdvantage. At the time it closed on December 31, 2006, PacAdvantage covered 6,200 small employers and 116,000 employees and dependents. Another pool, a for-profit plan, California Care, had 160,000 enrollees and over 10,000 employers and is still operational.⁶⁹ PacAdvantage failed because health care insurance carriers were losing money and a restructured plan could not be developed.⁷⁰

In addition to the HIPC, other reforms were included in AB 1672. They were limitations on pre-existing conditions and waiting periods, and guaranteed issue and renewability of insurance for small employers. Finally, the reforms included provisions for rate stability. The program's statutory authority is still in place.

California's law defines the small group insurance market as those employers who employ between two and 50 employees. Research from the Kauffman-RAND Center for the Study of Small Business and Regulation, utilizing national data, concludes the small group insurance reforms adopted in the 1990s have had little or no effect on the propensity of small firms to offer health insurance. The study also concludes, the laws encourage firms with close to the 50 employee threshold to increase the number of their employees to over 50 so they can avoid the reforms.⁷¹

1992 - Proposition 166

Nearly 50 years after Governor Warren made his last health care reform proposal, Proposition 166, an employer mandate sponsored by the California Medical Association,⁷² qualified for the ballot. SB 248 (Senator Maddy, Speaker Brown)⁷³ was the legislative counterpart to the Proposition. The differences between the Proposition and the bill were in their cost containment provisions. The bill provided for a Cost Containment Commission to set policies on cost containment, medical practices and technology assessment. Also the bill established an annual limit on insurance rate increases. If an insurance premium increase exceeded the statutory limit, the Commission could set premiums, hospital rates and professional fees.

The title of the proposition was *The Basic Affordable Health Care Initiative Statute*.⁷⁴ It contained the following key elements:

- Required employers to provide basic health care coverage for employees working specified hours and for their dependents, as permitted by federal law;
- Provided for a phase-in period;
- Specified that employee contributions were not to exceed two percent of wages and eliminated duplicate coverage;
- Detailed types of health care benefits, including prescription services;

- Subjected health insurance carriers and health care plans to the enforcement powers of the Insurance Commissioner or Commissioner of Corporations, respectively, and prohibited exclusion based upon prior disease, disorder or condition;
- Established the Health Care Coverage Commission with panels for Medical Policy, Cost Containment, and Technology, with an appropriation;
- Provided for employer tax credits.

A unique feature of the Proposition was that it authorized insurance carriers and health care plans to market products that combined health insurance and Workers' Compensation services. According to the Legislative Analyst's Office, the program would have required an exemption from the federal Employee Retirement Income Security Act of 1974 (ERISA).

The vote on Proposition 166 was 69 percent (7,310,636) against to 31 percent in favor (3,255,301).⁷⁵ The Proposition was supported by the California Medical Association and a "working mother." The opposition was led by the California Nurses Association, the National Federation of Independent Business/California, and the National Tax Limitation Committee.

1994 - AB 16 (Margolin), Proposed Conference Committee Report

AB 16 proposed the creation of the California Health Plan Commission, and charged it with establishing a universal health care coverage program for all California residents. The Commission was to administer health care insurance coverage reforms and establish a statewide budget for health services. At that time, the administration of President Clinton was developing a national health insurance plan, so the program was to become operative upon the enactment of federal legislation that required or authorized a state to adopt a comprehensive health care plan. Benefits were to be made available through competing health plans. In addition, health care coverage, Workers' Compensation, and automobile insurance would be incorporated into the program. The Commission was to administer the reforms and not to be subject to the licensure or regulation requirements of the Departments of Insurance or Corporations.

The bill passed the Assembly in June and the Senate in September 1994. The Assembly did not concur in the Senate Amendments and a Conference Committee was convened. The members of the Conference Committee were Speaker Brown and Assembly Members Margolin and Woodruff. The Senate conferees were Senators Torres, Petris, and Minority Leader Maddy. The bill died in the Conference Committee.

1994 - Proposition 186

In 1994, another initiative, Proposition 186, qualified for the ballot. The *California Health Security Act* proposed to establish universal access to health care for California residents by creating a single payer health care system.⁷⁶ Key provisions included:

- Established a health care services system with defined medical, prescription drug, long-term, mental health, dental, emergency, and other benefits;
- Replaced existing health insurance programs;
- Funded by a tax upon employers and individuals, with some exemptions, and by a cigarette/tobacco products surtax along with existing federal, state, and county health care funds, if authorized;
- Created a Health Security Fund from which health benefit providers and authorized costs were to be reimbursed;
- Proposed that an elected Health Commissioner administer the fund and program;
- Authorized cost controls and limited annual expenditures based on prior year expenditures, unless adjusted;
- Created an advisory Policy Board and Consumer Council.

The vote on Proposition 186 was 73 percent (6,110,899) against to 27 percent (2,212,691).⁷⁷ The opposition included the California's Taxpayer's Association, the Organization of Nurse Executives/California, and the National Federation of Independent Business/California. The support was led by the California State Legislative Council of the American Association of Retired Persons, the California Nurses Association, the California Small Business Council, the Consumers Union, the League of Women Voters of California, and the California Physicians Alliance.

1998 - SB 2123 (Lee)

SB 2123 would have required the Legislative Analyst's Office to study options for financing a state health care system. The study was to consider financing options for universal health care coverage, including the current employer-based system and a single payer system.

The bill was assigned to the Senate Rules Committee and died there.

1999 - SB 480 (Solis)

SB 480 (Chapter 990, Statutes of 1999) required the Secretary of the Health and Human Services Agency to submit a report to the Legislature on options for establishing universal health care coverage. The report was to discuss mechanisms by which universal coverage could be achieved and financing options. Research was to be conducted by the University of California to examine data sources that might be available to support the study. The bill also required the report to identify all necessary waivers to implement the program. A report was to be submitted to the Legislature by December 1, 2001.

The Agency received a federal grant to conduct the study. The Secretary contracted with a contractor to develop and analyze six alternative proposals. The Secretary selected the Healthy Californians Program Proposal.

The California Research Bureau organized the research project and contracted with contractors and managed the public meetings.

2002 - SB 1414 (Speier)

As noted above, SB 480 (Chapter 990, Statutes of 1999) required the Secretary of the Health and Human Services Agency to report back to the Legislature on options for achieving universal health care coverage. The Secretary contracted with a contractor to develop and analyze six proposals and selected the Healthy Californians Program alternative (HCP). Senator Speier's bill, SB 1414, would have enacted the HCP proposal. The proposal specified that all citizens and legal immigrants in California would receive health care coverage.

The coverage would have been accomplished in two stages. In the first stage, coverage would be expanded to include all non-custodial adults earning up to 150 percent of the Federal Poverty Level. The second stage would institute a pay-or-play approach and require employers to provide private coverage or pay a premium as a percentage of payroll to the state in order to purchase coverage.

The Managed Risk Medical Insurance Board (MRMIB) would administer the program. The Department of Health Services (DHS) and MRMIB were required to integrate the Medi-Cal, Healthy Families, and the Access for Infants and Health Programs into one program through securing of appropriate federal waivers. The bill required the DHS and MRMIB to use a simplified application and continue existing eligibility levels.

Employers were to pay a premium payroll tax as a percentage of each employee's wages to the HCP. They could instead opt to provide health benefits and receive a credit for the full amount of the tax. The premium payroll tax was to be progressive with tax rates increasing with levels of income. The tax rate was to be reduced for small employers with low wage workers.

The bill was sent to the Senate Rules Committee for assignment and then to the Committees on Insurance and Rules. The bill was amended and passed out of the Rules Committee and referred to the Committee on Health and Human Services. It was amended and passed out of that Committee and sent to the Senate Appropriations Committee, where it died.

2003 - AB 1527 (Frommer)

AB 1527 declared the Legislature's intent to (1) increase the number of Californians with affordable health care coverage, and (2) to establish a pay-or-play system under which employers with 51 or more employees would be required to provide health care coverage (including prescription drugs) to employees and their dependents or to pay a fee to obtain coverage. A purchasing pool, operated by the MRMIB, would provide health care coverage for the employees and dependents of employers that did not provide coverage.

Finally, the bill provided assistance to small employers for the cost of covering their employees, and to employees who could not afford their share of premium costs.

The bill passed out of the Assembly and the Senate in an amended version. The Assembly refused to concur in the Senate amendments and a Conference Committee was appointed. The members Frommer, Cohn, and Pacheco were Assembly conferees. The Senate conferees were President Pro Tempore Burton and Senators Speier and Aaenstad. The bill was held at the Senate desk and died in the Senate.

2003 - AB 1528 (Cohn)

AB 1528 (Chapter 672 Statutes 2003), required the governor to convene a new commission, the California Health Care and Quality Cost Containment Commission, to research and recommend strategies for promoting high quality health care and containing health care costs. The commission was to be composed of 27 members knowledgeable about health care and health care spending.

The bill passed out of the Assembly and Senate. The Assembly refused to concur in Senate amendments and a Conference Committee was appointed. The Assembly conferees were Assembly Members Frommer, Cohn, and Pacheco. The Senate conferees were Burton, Aaenstad, and Speier. The bill conference committee report was adopted and signed into law.

2003 - SB 2 (Senate President Pro Tempore Burton, Senator Speier)

SB 2, Chapter 673 of the Statutes of 2003, imposed a mandate on large and medium sized employers to provide health care coverage to all employees and their dependents.⁷⁸ The employer was to pay at least 80 percent of the premium costs and the employee no more than 20 percent. Employees earning less than 200 percent of the Federal Poverty Level were to pay five percent of wages. Part-time workers were not included. The health care insurance coverage was to include a comprehensive set of benefits including hospitalization, physician services, dental, vision, and mental health.

The mandate applied to all large and medium sized employers. The employers were to pay a fee to the state so health care coverage could be purchased for employees and their dependents. If employers were providing coverage for their employees they were eligible for a credit for the amount of the fee. Those employers that did not provide coverage did not receive a credit for the fee. The fees were remitted to the State Health Purchasing Fund which was administered by the Managed Risk Medical Insurance Board (MRMIB).

The bill would have permitted insurance carriers to sell a combined insurance product that included health insurance and Workers' Compensation. Many other insurance reforms were contained in the bill. Had it been implemented, the program would have been phased in over four years.

A State Health Purchasing Fund was established in the MRMIB to purchase health care coverage for employees not provided coverage by their employers and their dependents.

The Board was to administer the program in such a way as to ensure that sufficient revenues were collected to fund it. In addition, MRMIB and the Department of Health Services were to develop health care insurance premium assistance programs for clients of the Healthy Families and Medi-Cal programs. Eligible individuals would receive additional health care insurance to cover any gaps in service between the employer-based plans and benefits provided under the Healthy Families and Medi-Cal programs. Federal approval was required to implement this aspect of the proposal.

An analysis of SB 2 conducted for the California Healthcare Foundation concluded that the employer mandate might be vulnerable to an ERISA challenge over the structure of the fee and the credit.⁷⁹

Although SB 2 was passed by the legislature and signed by Governor Davis, the business community quickly qualified a referendum, Proposition 72, in 2004. The title and summary of Proposition 72 were as follows.⁸⁰

Health Care Coverage Requirements Referendum

A “Yes” vote approves and a “No” vote rejects legislation that:

- Provides for individual and dependent health care coverage for employees, as specified, working for large and medium employers;
- Requires that employers pay at least 80 percent of coverage cost; maximum 20 percent employee contribution;
- Requires employers to pay for health coverage or pay fee to medical insurance board that purchases primarily private health coverage;
- Applies to employers with 200 or more employees beginning January 1, 2006;
- Applies to employers with 50 to 199 employees beginning January 1, 2007. If a tax credit were enacted, firms with 20 to 49 employees would be eligible for participation.

The Referendum narrowly defeated SB 2. The statewide vote was 51 percent (5,889,936) No to 49 percent (5,709,500) Yes.⁸¹ As a result, the legislation to reform health care insurance adopted by the legislature and signed by the governor was not implemented.

Proposition 72 was supported by the Consumer Federation of California, the California Nurses Association, the California Medical Association, and the American Medical Association. Those opposed included the California Chamber of Commerce, the Association of California School Administrators, and the San Diego Medical Society.

The impact on the state’s businesses was an important issue during the campaign for Proposition 72. Research published by the Public Policy Institute of California in 2006, concluded that SB 2 would have lowered wages and reduced the level of employment in California. According to the research, employers with increased costs would have shifted the costs back to their employees by reducing wages. The analysis also found that 70,000

workers would have lost their jobs; in the case of low income employees, the impact could have been greater. The study suggested a number of options to mitigate the impact of the mandate including restricting coverage to the employee (not dependents), establishing a high deductible for emergency room care, and scaling back the employer's share of premiums.⁸²

2005 - AB 1670 (Nation)

This bill proposed to mandate all residents of the state to obtain health care coverage, either through a health care service plan regulated by the Department of Managed Health Care (DMHC) or a health insurance policy regulated by the Department of Insurance. The plans or policies were to have a maximum annual deductible of \$5,000 per person and to provide first dollar coverage for all medically indicated preventive care.

The Secretary of the Health and Human Services Agency was required to work with the counties to establish quasi-public purchasing pools to provide health care coverage for all individuals without coverage. The purchasing pools were to negotiate with insurance companies and health care service plans to provide a range of insurance products, including catastrophic coverage. The MRMIB and the DMHC were required to determine the essential benefits.

Insurance companies and health care service plans that participated in the pools were to guarantee the issuance of coverage and charge rates on a modified community rating basis. Individuals and employers were permitted to purchase health care coverage through the purchasing pools to take advantage of the flexible benefit options and pricing.

The MRMIB and the DMHC were to establish a voluntary non-entitlement program to allocate available state and federal funds to subsidize qualified employers who offered essential benefits health care coverage for employees who earned less than 200 percent of the Federal Poverty Level. A qualified employer had less than 50 employees, 60 percent of whom earned less than 200 percent of the minimum wage. The premiums were regressive as they made no distinction for all low income employees vis-à-vis high income individuals.

The bill was referred to the Assembly Revenue and Taxation and Health Committees. The bill was amended in the Revenue and Taxation Committee and failed passage.

2006 - SB 840 (Kuehl)

SB 840 proposed the establishment of a single payer health care system in California, shifting from the existing pluralistic financing system to one financed and administered solely by government. Financing would have come from state tax revenues and existing federal, state, and local healthcare programs. Proposed new revenues were to include employer and employee payroll taxes, a self-employed business income tax, a tax on non-wage and salary income, and a tax surcharge on incomes over \$200,000.

The bill provided for extensive health care benefits for all of the residents of California, including all medical care that was determined to be medically necessary by a physician. Eligibility for the program was not to be determined on the basis of employment or income.

The bill proposed the creation of the California Health Insurance System. The program was to be administered by a newly created California Health Insurance Agency. The Agency was to have the authority to establish the system's budget, set reimbursement rates for providers, and establish expenditure limits. The Agency was also charged with securing all the federal waivers necessary to implement the program. The program was to be operational when sufficient funding for operations had been certified.

The Legislature adopted the bill in 2006, but Governor Schwarzenegger vetoed it.

2006 - AB 1952 (Nation)

AB 1952 would have required employers to provide health care coverage to their employees and their dependents. If employers did not provide health care coverage, they would be required to pay a fee of not more than seven percent of total payroll to the Essential Health Benefits Fund for the purchase of health care coverage. Employees were also to make premium payments. The premiums were regressive as they made no distinction for low income employees vis-à-vis high income individuals. Individuals over the age of 18 who were not covered by employer-based health care insurance were required to purchase health care coverage. Benefits included comprehensive physician and hospital care.

The Managed Risk Medical Insurance Board (MRMIB) was to administer the California Essential Health Benefits Program and to certify that the coverage available in the individual market was affordable. If the Board did not so certify, the program was to be inoperative. MRMIB was also to establish maximum out-of-pocket costs for the individuals and families who received health care insurance coverage from the program, taking into account the purchasing ability of moderate and low income persons. Additionally, MRMIB was to administer selected insurance market reforms.

The bill was referred to the Assembly Health Committee, amended and it died there.

2006 - AB 2450 (Richman)

AB 2450 required all residents of the state obtain and retain health care insurance coverage. The coverage was to be obtained through a person's employer or a government-approved plan. The minimum required insurance was that which was available under a plan regulated by either the Department of Managed Health Care or the Department of Insurance. The plan was to have basic health care coverage including hospitalization and physician services and an annual deductible no greater than \$5,000 per person. For all preventive care, the plan would provide coverage without charging co-payments. The Department of Health Services was to submit a waiver to the federal government seeking the authority to include Medi-Cal and Healthy Families in the plan.

If a California resident did not obtain health care insurance, the Franchise Tax Board was authorized to take control of any tax refund and transmit it to the entity administering the state-approved plan. Regional quasi-public purchasing exchanges were to be established in each county or groups of counties to negotiate with carriers so that an array of insurance products could be offered, including catastrophic care. The carriers were required to adopt a number of reforms such as guaranteed issue and modified community rating. Guaranteed issue assured that no one would be turned down when he/she sought health care coverage from a carrier. Employers and individuals could also purchase health care coverage through a consortium of health carriers to take advantage of their market strength.

The Managed Risk Medical Insurance Board and the Department of Managed Health Care were to administer a voluntary non-entitlement program, financed by an annual tax on health care service plans (yielding the same amount as current taxes and in lieu of all other taxes). The funds were to be deposited in the Universal Health Care Fund and appropriated in the annual budget process. The funds were to be used to subsidize qualifying employers with 50 or fewer employees, 60 percent of whom earned less than 200 percent of the Federal Poverty Level, and who offered those employees health care insurance coverage. The premiums were regressive as they made no distinction for all low income employees vis-à-vis high income individuals.

The bill was referred to the Assembly Health Committee and died there.

HEALTH CARE REFORM PROPOSALS: *THE PRESENT DAY*

In January 2007, Governor Schwarzenegger proposed an employer-based program to expand health care coverage. Assembly Speaker Nunez and Senator Pro Tempore Perata also introduced proposals to reform health care coverage and increase the number of insured in California. The Pro Tempore's and Speaker's bills were subsequently merged into one bill, AB 8.

The Governor's Proposal

Governor Schwarzenegger's proposal requires employers to provide health care coverage to their employees or pay a fee so coverage can be purchased for them. The mandate applies to employers with ten or more employees. Employers that chose not to provide health care coverage to their employees must contribute on a sliding scale up to four percent of payroll for employees' health coverage. Employers with less than ten employees are exempt from the mandate. However, the proposal requires that all Californians have health care coverage. The employees of exempt providers would secure mandated coverage through a purchasing pool administered by the Managed Risk Medical Insurance Board. Financing of the program would come from employers (on a sliding scale of 0%-4% of total payroll), employees, state and federal funds, county funding, hospital fees, and additional revenues from leasing the state lottery. The

proposal would express the Legislature's intent to partially finance the plan through employer contributors.

The minimum benefit level is to be established by the Secretary of Health and Human Services through the regulatory process. The benefit level only can be changed by an act of the legislature. The minimum benefit level must cover medical, hospitals, preventive and prescription drugs, and must be set at a level where premiums are affordable.

All employers are required to establish a Section 125 Plan, whereby both employers and employees can shelter health insurance contributions from taxes. Changes in the state tax code to conform to the federal tax code will need to be made. A consequence of establishing the tax shelter will be a reduction in state tax revenues.

The Governor's Plan requires hospitals to pay fees equivalent to four percent of gross revenues. The hospital industry has agreed to contribute the gross revenue to overhaul the state's health care system. The proposal is contingent upon the passage of a measure on the November 2008 ballot to finance the program.⁸³ The proposal also increases Medi-Cal reimbursements for physicians and hospitals. A federal waiver request would need to be submitted to relieve the state from selected Medicaid statutes and allow the state to implement financing and care delivery changes.

The proposal would expand the Healthy Families and Medi-Cal Programs. The income eligibility limit for Healthy Families would increase to include all children in families with income up to 300 percent of the Federal Poverty Level irrespective of immigration status. The Medi-Cal maximum income limit for eligibility would increase to 100 percent of the federal level. Medi-Cal, via benchmark plan to a new pool, would expand to include parents and caregivers at or below 250 percent of the Federal Poverty Level. The expansion would also include young adults ages 19 and 20 earning less than 250 percent of the Federal Poverty Level.

Counties would continue to be the providers of last resort for the medically indigent. They will share the costs of providing coverage to those they currently serve.

A purchasing pool would be created for individuals and families that do not receive health care coverage from their employers. The Managed Risk Medical Insurance Board would administer the purchasing pool for both subsidized and non-subsidized components of the program. The pool would require a sliding scale contribution from individuals based on their income in order to receive health care coverage. The contribution would be three percent of gross income for the lowest income participants and six percent of gross income for the highest income participants.

The proposal makes several changes to insurance underwriting. The first, guaranteed issue requires health plans to provide coverage to all Californians. Second, health plans would be able to vary the rates they charge based only on a person's age and the location of their residence in the state. Health plans and hospitals are required to spend at least 85 percent of the premiums on health care with a maximum of 15 percent devoted to

administrative costs and profits. Additionally, the program would establish a pilot project to combine workers' compensation and health coverage benefits into one package.

The Proposal of the Speaker and Pro Tempore

The proposal by Assembly Speaker Nuñez and Senate Pro Tempore Perata would mandate employers provide health care coverage for their employees. Employers that do not provide health care coverage would be required to pay into a state trust fund to purchase coverage administered by the Managed Risk Medical Insurance Board. The medically indigent would continue to be the responsibility of county governments.

Employers would pay at least 7½ percent of Social Security base wages for employee health care. The program also would be funded by employee contributions, state funds and funds from Medi-Cal and Healthy Families. The state would seek a federal waiver to incorporate those programs into the proposal. The bill also requires all employers to establish a Section 125 plan so both employers and employees are able to shelter health insurance contributions from taxes, thereby reducing federal and state tax collections.

Employees of employers that do not provide health care coverage must enroll in the newly established California Cooperative Health Purchasing Program (Cal-CHIPP), administered by the Managed Risk Medical Insurance Board (MRMIB). The Board is responsible for negotiating and purchasing health insurance for eligible employees, which is an extension of its current responsibilities. Premiums for enrollees earning less than 300 percent of the Federal Poverty Level are not to exceed five percent of family income. Cost sharing is required, assessed on a sliding scale of income. MRMIB is to determine if deductibles and co-payments will deter enrollees in seeking health care.

Cal-CHIPP will offer at least three benefit packages from which an eligible person may choose. Health care plans also are required to offer those plans in the private market.

The program expands eligibility in the Healthy Families and Medi-Cal Programs. Irrespective of immigration status, children's eligibility in Healthy Families would expand to include children in families with income up to 300 percent of the Federal Poverty Level. Medi-Cal would include parents who have children between five and 18 years old and have family income less than 133 percent of the Federal Poverty Level.

Other insurance market reforms would also be implemented. Health plans would limit their administrative costs and profits to 15 percent of the premium dollar and offer coverage to all who request it (discrimination is not permitted). Also, when establishing rates, health plans could only use age and geography in setting rates. For individuals with critical health problems, a high risk pool would be established to provide health care coverage. Finally, the small group insurance market reforms enacted in 1992 and amended in 1993, would be extended to employers that have between 50 and 100 employees.

Both houses of the Legislature adopted the bill, which was vetoed by the governor.

SB 236 Runner - Senate Republicans

The Senate Republican proposal is a 20+ bill package introduced in the special session. The bills would enact a program similar to the Cal Care program introduced early in the year. The goal of the early version of Cal Care would be to improve access to health services for residents of the state. It would:

- allow hospitals to offer “preventive health services only” through primary care or community-based clinics.
- allow nurse practitioners to establish and run primary care clinics.
- provide a tax credit to providers for the cost of providing care to the uninsured.
- conform state statutes to federal statutes for purposes of tax deductions.
- conform to federal law relative to health savings accounts.
- establish a new system to address seismic safety priorities.

The proposal would divert funds from county hospitals to clinics to increase access to primary care; raise Medi-Cal rates over eight years to equal the reimbursement rates of Medicare; redirect Medi-Cal reimbursement for Disproportionate Share Hospitals to the establishment of new clinics; require hospitals to make pricing information more readily available to consumers, and; urge the federal government to pay for the mandated health costs for undocumented immigrants.

Assembly Republican Caucus, 17 bills

The Assembly Republicans introduced a number of proposals to expand health care coverage in 2007. The bills do not contain new mandates, tax increases, or public programs. The rubrics for their proposals are Maximizing Choice, Reducing Costs, and Increasing Access.

The Maximizing Choice proposals include making Health Savings Accounts more accessible to employees and small businesses. Another proposal would permit CalPERS to offer health savings accounts and catastrophic care options to state workers. Health Savings Accounts would be offered to Medi-Cal beneficiaries on a voluntary basis. In addition, individuals would be permitted to choose the benefits to be included in their health insurance coverage. Out-of-state health insurers would be authorized to offer health plans in California, with the goal of introducing more competition and lowering prices in the health insurance market. Finally, the proposals include additional tax benefits to employers that offer catastrophic health insurance plans to their employees.

Several proposals seek to reduce costs. For example, the proposed California Health Insurance Exchange would allow individuals to purchase their own health insurance coverage rather than relying on an employer-sponsored plan. Another aspect of the proposal would permit employers to purchase a combined workers’ compensation/health insurance product for their employees. Finally, proposals would expand state tax deductions for health care expenditures.

Increasing access to health care is the third goal of these proposals. Access to Neighborhood Health Clinics would be increased through repealing statutes that prohibit the establishment of walk-in clinics. Reimbursement of physicians in the Medi-Cal program would be enhanced in order to increase the number of doctors serving Medi-Cal patients. Individuals unable to secure health care coverage due to a pre-existing condition would be assured access to a health plan. Foundations created through conversions of health plans would be required to spend 90 percent of their investment income on medical services. Finally, seismic safety upgrades of hospitals would be performed on a worst-first basis.

CONCLUSION

Expansion of health care insurance coverage in California has been an unmet challenge for the last 88 years. Whatever reforms the governor and the legislature pursue, balancing powerful competing economic issues is a demanding and difficult process. The conundrums of ERISA, employer mandates, financing and health care cost containment may prove to be intractable. However, at no other point in the history of the health care coverage debate has the governor and legislative leadership individually concluded health care coverage needs to be reformed. The action is historic and the time for reform in California may be at hand.

APPENDIX A

NATIONAL HEALTH INSURANCE BENEFITS HISTORY, 1789-2000⁸⁴

- 1789—Congress establishes the U.S. Marine Hospital Service. The service was funded by compulsory contributions from seamen's wages.
- 1847—The Massachusetts Health Insurance Company of Boston becomes the first insurer to issue sickness insurance.
- 1849—New York passes the first general insurance law.
- 1853—The French mutual aid society, La Societe Francaise de Bienfaisance Mutuelle, establishes prepaid hospital care plan in San Francisco.
- 1863—The Travelers Insurance Company of Hartford, CT, offers accident insurance for railway mishaps (followed by other forms of accident insurance). Travelers was the first to issue insurance resembling today's policies.
- 1870s—Railroad, mining, and other industries begin to provide company doctors funded by deductions from workers' wages.
- 1877—The Granite Cutters Union establishes first national sick benefit program.
- 1910—Montgomery Ward & Co. enters into one of the earliest group insurance contracts.
- 1910s—Physician service and industrial health plans are established in the Northwest and remote areas.
- 1912—The National Convention of Insurance Commissioners (now the National Association of Insurance Commissioners) develops the first model for state law, the Standard Provisions Law, for regulating health insurance.
- 1913—The International Ladies Garment Workers Union (ILGWU) begins the first union medical services.
- 1915-1920s—Efforts to establish compulsory health insurance programs fail in 16 states.
- 1929—A group of schoolteachers arranges for Baylor Hospital in Dallas, Texas, to provide room, board, and specified services at a predetermined monthly cost. This plan is considered the forerunner of Blue Cross plans.
- 1937—The Blue Cross Commission is established.
- 1939—The Revenue Act of 1939 (Section 104) establishes employee tax exclusion for compensation of injuries, sickness, or both received through workers' compensation, accident, or health insurance.
- 1943—The War Labor Board rules the national wage freeze does not apply to fringe benefits.
- 1945—The Kaiser Foundation Health Plan opens to non-Kaiser Company groups.
- 1948—The McCarran-Ferguson Act gives states broad power to regulate insurance.
- 1949—The Supreme Court upholds a National Labor Relations Board ruling that employee benefits are subject to collective bargaining.
- 1954—The Revenue Act of 1954 (Section 106) excludes from taxation employer contributions to accident and health plans benefiting employees, and

clarifies that such contributions had always been deductible as business expenses.

- 1965—Medicare and Medicaid legislation passed as Title XVIII and Title XIX of the Social Security Act.
- 1968—The Firestone Tire & Rubber Co. begins to self-fund health benefits.
- 1973—The federal Health Maintenance Organization (HMO) Act of 1973 establishes benefit, administrative, financial, and contractual requirements for entities seeking designation as federally qualified HMOs and requires most employers who offer an HMO to offer a federally-qualified HMO.
- 1974—The Employee Retirement Income Security Act of 1974 (ERISA) establishes uniform standards that employee benefit plans must follow to obtain and maintain their tax-favored status. ERISA supersedes or preempts all state laws otherwise applicable to pension and welfare plans covered by ERISA, but recognizes the states' role in regulating insurance.
- 1978—The Pregnancy Discrimination Act amends Title VII of the Civil Rights Act of 1964 and requires that employers treat disabilities and medical conditions associated with pregnancy and childbirth the same as other disabilities or medical conditions.
- 1984—The Deficit Reduction Act of 1984 changes the tax treatment and contribution limits of voluntary employee beneficiary associations (VEBAs), and imposes new nondiscrimination rules for VEBAs similar to those for tax-qualified pension and profit-sharing plans. The Act makes Medicare the secondary payer for the health expenses of workers ages 65-69 who are covered by an employer plan.
- 1986—The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers with 20 or more employees to offer continued health coverage to terminated employees and dependents for a specified period (18 or 36 months).
- 1996—The Health Insurance Portability and Accountability Act of 1996 sets national nondiscrimination and "portability" standards for individual health insurance coverage, HMOs, and group health plans, and establishes the tax-favored treatment of long-term care insurance. The Act requires regulations establishing standard electronic formats and ensuring the privacy of personal health information. It also institutes a pilot medical savings account (MSA) program, limited to 750,000 individuals by the year 2000. (See Consolidated Appropriations Act of 2001, enacted in 2000, for extension of MSA pilot program.
- 1996—The Mental Health Parity Act requires group plans that offer mental health benefits to provide the same level of coverage for those benefits that they provide for medical and surgical benefits. The Act does not apply to groups of fewer than 50 or include substance abuse or chemical dependency treatment. The provisions expired on September 30, 2001, and have not been extended.
- 1996—The Newborns' and Mothers' Health Protection Act requires health care plans that cover maternity benefits to provide a minimum 48-hour (for normal vaginal birth) or 96-hour (for caesarean delivery) inpatient stay for a

mother and her newborn following delivery. The Act also mandates timely post-delivery care when the mother and newborn are discharged prior to the expiration of these minimum lengths of stay.

- 1997—The Balanced Budget Act of 1997 creates the Medicare+Choice program, modifies Medicaid to increase state administrative flexibility, and establishes new guarantee opportunities for Medicare supplemental policies along with an expansion of private plan options. Notably, the Act creates the State Children’s Health Insurance Program (SCHIP) and provides \$24 billion in federal funds over five years to support it.
- 1998—The Omnibus Consolidated and Emergency Supplemental Appropriations Act requires health care plans to provide coverage for reconstructive surgery after mastectomies.
- 1999—The Financial Services Modernization Act of 1999, restricts financial institutions’ disclosure of “non-public personal information,” including (1) certain information about consumers to nonaffiliated third parties, and (2) certain information the institutions receive from nonaffiliated third parties. Financial institutions are required to disclose to consumers their policies and practices with respect to information sharing among both affiliated and nonaffiliated entities. In certain circumstances, consumers must be notified prior to the disclosure of personal information and given the opportunity to prevent it.
- 2000—The Electronic Signatures in Global and National Commerce Act of 2000, gives electronic signatures and records the same weight as written signatures and records, which should lead to easier administration of electronic benefit, compensation, and human resources systems.
- 2000—The Consolidated Appropriations Act 2001, extends the pilot MSA program by two years to December 31, 2002, and renames the program Archer MSAs.

Table 1
California Legislative Health Care Reform, 1918 to 2007

Year	Author	Bill Number	General Description	Effect of Proposal on Number of Uninsured Indigent	Tax Rate/Tax Base
1918	Governor Johnson	Senate Constitutional Amended 26	Constitutional Amendment authorizing Legislature to enact health insurance.	Minimal; proposal, is undefined.	No fiscal details.
1935	Williams	SB 454	Pay-or-Play.	Employer-based program expansion; everyone not covered.	Combined 5% on employers & employees; <\$3,000 in family income.
1939	Rosenthal	AB 2172	Mandatory for individuals making less than \$3,000 annually; others not affected.	Employer-based program expansion; everyone not covered.	1% on employers, 1% on employees, 1% on state; <\$3,000 family income.
1945	Wollenberg	AB 800	Single Payer; all employers covered by Unemployment Insurance (UI).	Employer-based program; everyone not covered.	1½% on employers and on employees; first \$5,000 of family income.
1945	Wollenberg	AB 2201	Pay-or-Play; all employers covered by UI.	Employer-based program expansion; everyone not covered.	½% employers; ½% employees on all payroll and wages.
1947	Wollenberg	AB 1500	Pay-or-Play; all employers covered by UI.	Employer-based program expansion; everyone not covered.	1% on employers and 1% on employees/all wages.
1949	Collins	AB 863	Single payer; all employers covered by UI.	Some employers and employees not included.	1% on employers and 1% on employees/all wages.

Table 1
California Legislative Health Care Reform, 1918 to 2007

Year	Author	Bill Number	General Description	Effect of Proposal on Number of Uninsured Indigent	Tax Rate/Tax Base
1953	Collins	SB 3138	Single payer; all employers covered by UI.	Some employers and employees not included.	1% on employers and 1% on employees on payroll and wages.
1961	Burton	AB 605	Single payer; all employers covered by UI.	Some employers and employees not included.	3% on employers/all payroll.
1963	Song	AB 2644	Single payer; all employers covered by UI.	Some employers and employees not covered under the program.	3% on employers/all payroll.
1971	Burton, Brown	AB 2860	Single payer.	Universal coverage for bona fide residents.	Progressive personal and payroll taxes.
1972	Speaker Moretti	AB 1199	Comprehensive statewide health care coverage, spot bill.	Universal coverage.	Taxes on ability to pay.
1972	Moscone	SB 770	Single payer; all employers covered by UI.	Universal coverage.	Property, payroll and income taxes.
1978	Hart	AB 1207	Insurance market reform; voluntary employer participation.	Voluntary program with little effect.	Employer and employee premiums and state General Fund.
1980	Bannai	AB 3068	Insurance market reform; employer mandated coverage for employees.	Employer-based program expansion exclusive of the unemployed, uninsured.	Employer and employee premiums and employer premiums must at least equal employees' deductibles and co-payments.

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California Legislative Health Care Reform, 1918 to 2007

Year	Author	Bill Number	General Description	Effect of Proposal on Number of Uninsured Indigent	Tax Rate/Tax Base
1982	Torres	AB 1262	Insurance reforms; carriers required to offer plans to individuals.	Voluntary program with little effect.	Premiums, co-payments, and deductibles.
1988	Campbell	AB 2647	Resolution for National Health Care.	Universal health care coverage.	No fiscal details.
1989	Brown, Keene; Keene, Maddy	AB 350 and SB 1207	Voluntary employer-sponsored health care coverage; small group market.	Limited effect.	Tax credit - \$25 per month per covered individual or 25 percent of cost of health coverage.
1989	Margolin	AB 328	All employers mandated to participate, prepaid health plan; insurance market reforms with mandatory basic health coverage for all residents with no other health care coverage.	Employer based program with many uninsured remaining.	Premiums, payroll tax on employers and employees, tax on self-employed and portion of Proposition 99 tax receipts, annual General Fund appropriation, UI health insurance tax.
1990	Margolin, Conference Committee Report	AB 1521	Pay-or-Play, individual mandate.	Universal health care coverage for all persons of the state.	Premiums, Proposition 99 funding, General Fund appropriation, payroll tax as surcharge.
1990	Petris	SB 308, SB 2868, and SB 36 of 1992	Single payer.	Universal health care coverage for all persons of the state.	General Fund appropriation.

Table 1
California Legislative Health Care Reform, 1918 to 2007

Year	Author	Bill Number	General Description	Effect of Proposal on Number of Uninsured Indigent	Tax Rate/Tax Base
1990	Speaker Brown	AB 3032	Employer mandate to provide health care coverage.	Program would leave many uninsured.	Premiums, Proposition 99 funding, General Fund appropriation.
1992	Margolin, Keene	AB 502 and SB 6	Combined health, automobile and Workers' Compensation insurance; eliminated employer-based coverage.	Universal, no details.	Financing from employer and employee assessments.
1992	Speaker Brown, Minority Leader Maddy	AB 2001, SB 248, and Proposition 166	Mandate on all employers; commission to develop program for uninsured.	Universal coverage after program developed.	Premiums, percentage of payroll as premium surcharge.
1992		Proposition 166	Mandate on all employers.	Uninsured remaining.	Premiums, percentage of payroll as premium surcharge; employee contributions limited to 2% of payroll.
1992	Senator Maddy, Speaker Brown	SB 248, Proposition 166 and AB 2001.	Employer mandate.	Uninsured remaining after implementation.	Premiums, percentage of payroll as premium surcharge.

Table 1
California Legislative Health Care Reform, 1918 to 2007

Year	Author	Bill Number	General Description	Effect of Proposal on Number of Uninsured Indigent	Tax Rate/Tax Base
1992	Margolin	AB 1672	Small group insurance reforms.	Voluntary; small employer-based program, small reduction in the number of uninsured.	Employee premiums.
1994	Margolin, Conference Committee Report	AB 16	Single payer integrating Worker's Compensation and automobile coverage with health care coverage.	Universal coverage, covered all residents of the state.	Premiums, co-payments and deductibles.
1994		Proposition 186	Single payer.	Universal health care coverage.	General Fund appropriations.
1998	Lee	SB 2123	Study bill to determine path to achieving universal health care coverage.	Universal coverage.	None specified.
1999	Solis	SB 480	Study bill with report to Legislature on options to establish universal health care.	Program not established, no effect on the number of uninsured.	Unspecified.
2002	Speier	SB 1414	Pay-or-Play.	Employer based program, many uninsured remaining.	Progressive payroll tax.
2003	Frommer	AB 1527	Establish Pay-or-Play system.	Pay-or-Play system, leaves many uninsured remaining.	Employer fee and other unspecified.
2003	Frommer	AB 1528	Commission on quality and cost containment.	No effect on number of uninsured.	None specified.

Table 1
California Legislative Health Care Reform, 1918 to 2007

Year	Author	Bill Number	General Description	Effect of Proposal on Number of Uninsured Indigent	Tax Rate/Tax Base
2003	President Pro Temp Burton	SB 2	Pay or-Play; employers covered by UI.	Excluded employers and employees; uninsured not included in proposal.	Employer pays at least 80%; employee pays up to 20% of the cost of health care coverage.
2004		Proposition 72	Repeals employer mandate enacted with SB 2.	Reverses attempt to decrease uninsured.	Repeals requirement of employer and employee contributions.
2005	Nation	AB 1670	Individual mandate on residents.	Universal coverage.	Residents' premiums.
2006	Kuehl	SB 840	Single payer.	Universal coverage.	General Fund Appropriation.
2006	Nation	AB 1952	Employer mandate and individual mandate.	Universal coverage.	7% of payroll by employers; employee co-payments.
2006	Richman	AB 2450	Individual mandate.	Universal coverage.	Tax on health care service plans that equals and is in lieu of all the other taxes paid.

Table 1
California Legislative Health Care Reform, 1918 to 2007

Year	Author	Bill Number	General Description	Effect of Proposal on Number of Uninsured Indigent	Tax Rate/Tax Base
2007	Governor Schwarzenegger	None introduced	Employer and individual mandates.	Significant, estimated to include more than three quarters of uninsured.	0%-4% sliding scale on payroll; equivalent to 4% fee on hospitals, Federal funds, revenues generated by leasing state lottery, county indigent funds, contributions on sliding scale for those in insurance pool; cost containment measures.
2007	Assembly Speaker Nuñez, President Pro Tempore Perata	AB 8	Employer mandate.	Significant, estimated to include more than two thirds of uninsured.	Employers 7.5% of Social Security base wages; employee's maximum premium contribution would be 5% of income.
2007	Runner	20 legislative proposals	States the intent of the Legislature to develop a program to improve access to health care services.	Market oriented program with little effect on the number of uninsured.	Tax credits and redistribution of public funds.
2007	Assembly Republican Caucus	17 legislative proposals	Expand health care coverage without resorting to new mandates, tax increases, or public programs.	Market oriented program with little effect on the number of uninsured.	Expenditures by individuals and tax credits.

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