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**The Power of Coalitions:
Participation and Governance in California's Public-Private Welfare State**

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Abstract

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Introduction

Social policy is big businesses for a growing number of nonprofit and private firms in the United States. Publicly-supported housing, social services, and health care have long been funded by government but supplied by a mix of nonprofit and for-profit firms. Higher education, historically dominated by nonprofit and public universities, now faces competition from a rapidly growing for-profit sector. Even in public elementary and secondary education, competition from chains of for-profit and nonprofit organizations is throwing up new challenges to the system of free public education that once distinguished the American welfare state.

Despite its pervasiveness, we know little about the political dynamics of the public-private welfare state. There is large literature on nonprofit organizations and contracting for government services. However, because most of this work addresses questions from a public management perspective, it provides little guidance for understanding the public-private welfare state as a target of political struggle. Likewise, there is growing attention to the role of the private sector in providing social benefits,¹ especially in the wake of their recent erosion.² But we have few accounts of the way the divergent interests of private service providers and public beneficiaries are fought out and resolved both in devising legislation and, equally important, in implementing policy. Yet, because private firms – and, we will argue, many nonprofits – engage in service delivery as a profit-making enterprise, their interests regularly collide with those of beneficiaries who want more access to services at lower costs. How do public-private policy arrangements work against the interests of beneficiaries and how can advocates alter the balance of power?

We address this question by analyzing the development of a broad coalition dedicated to improving access to health care in California. Between 1980 and 2010 California's health care policy field shifted from a business-dominated, closed-door pattern of decision making to an open political arena in which a wide-ranging and diversely resourced coalition advocating on behalf of beneficiaries had become an accepted partner in policymaking. California is an especially compelling case to consider in light of the 2010 Affordable Care Act (ACA), which gives states a central role in determining whether or not the landmark law achieves its goals of expanded health care coverage. In contrast to a handful of states, including New York, Massachusetts, and Maryland where access battles in the 1980s and 1990s were fought out through corporatist style negotiations between a shifting cast of labor, hospitals, and insurance companies, California pitted a powerful business community, dedicated to achieving lower costs, against a handful of weak and inexperienced advocacy organizations. The story of how coalitional capacity expanded in California offers important lessons for advocates in similar states seeking to strengthen the voice of beneficiaries as the ACA is implemented.

Our argument emphasizes coalition-building, probing not just which interests combine forces, but also showing how coalitions can expand over time and build their range of capabilities. Much of the work on the American welfare state focuses on constituencies organized around a single policy, such as Social Security. But because public-private social policy arrangements can generate many different constituencies and shifting interests, coalition building is essential for representing broad public interests in these hybrid policy domains. We focus on three processes that build effective coalitions

to influence public private policymaking: The first process creates an initial link between previously unconnected groups and joins them in a policy-focused coalition with multi-faceted resources. The second process enlarges the engaged base by resourcing more diverse groups and expanding alliances with those organizations. Finally, initial successes must institutionalize coalitional engagement by changing the rules of the game using such policy levers as regular hearings, provisions for participation, and transparency. These three elements do not guarantee political success but they allow advocacy coalitions to develop multi-faceted capabilities, including engagement in technical policy decisions, “regulation from below” that documents and challenges exclusionary practices, and electoral mobilization.³

We develop these arguments by examining the development of coalitional capacity among health care advocates in California between 1980 and the present. Our analysis draws on in-depth interviews with key advocates and policymakers in California, primary materials published by advocates, and policy documents, as well as data about grant-making that expanded the range of groups able to engage in health care politics.

Advocacy Groups in American Democracy

Advocacy organizations occupy a pervasive but ill-defined role in contemporary American democracy.⁴ Two recent influential literatures on democratic engagement – studies charting the decline of mass membership organizations and arguments about deliberative democracy – either ignore advocacy groups or fault them for failing to mobilize a regular membership base. We argue that both perspectives overlook the critical role that coalitions of advocacy organizations can play in making public the

invisible politics of the public-private welfare state; developing and mobilizing an organized grassroots base; and changing the rules of the game to ensure a regular public voice in decisions about delivering public-private services.

Civic Engagement and Mass Membership Organizations

In her examination of the shifting forms of civic engagement over the past century, Theda Skocpol depicts the transition from the broad membership organizations of the nineteenth and early twentieth centuries to the contemporary organization of “advocates without members” in dark terms.⁵ As the older membership associations of the nineteenth century declined, she argues, civic engagement deteriorated because the new advocacy organizations saw “members...not as fellow citizens but as consumers with policy preferences.”⁶ Moreover, the shift signaled a move away from associations that united Americans of diverse class backgrounds toward organizations that largely represent the concerns of the professional upper middle class.

There is little doubt that today’s advocacy organizations differ from the mass membership civic organizations and political parties of a century ago. Yet, this argument does not tell us much about the roles that advocacy organizations currently play in American democracy. Recent research suggests that advocacy groups are much more variegated than Skocpol’s analysis suggests. For example, Walker et al. demonstrate that nonmembership advocacy organizations do not displace, but rather complement, the membership organizations that do exist.⁷ They highlight a positive interaction between nonmembership organizations and membership organizations that enhances the efficacy of each. Moreover, they suggest that nonmembership advocacy organizations may be

especially significant in state and local venues, connecting “community organizations with state and local government.”⁸ Other studies of the state and local politics, suggest that advocacy organizations play a crucial role in defending and expanding social programs that serve low-income communities.⁹ Legal advocacy that does not connect to ordinary citizens has long constituted a central activity of such advocacy, but, as we will see, many groups have broadened their activities beyond legal strategies.

In contrasting the voluntary organizations of the past with contemporary “professional” advocates, Skocpol argues that the older mass membership groups forged cross-class alliances to support public programs in ways that are not possible today. Indeed, the explosion in the numbers of advocacy groups makes for a more fragmented organizational universe and one that builds ties on the basis of narrowly-defined, often policy-specific concerns. We argue that in the contemporary context of fragmented organizations and divided interests, advocacy organizations have a particularly important role to play. Advocates can build cultural and institutional bridges among organizations rooted in diverse spatial, racial, ethnic, gender, or class communities. By helping to connect diverse groups, advocates can direct the activities of distinct issue organizations – including organized labor -- toward broader public goals.

Civic Engagement and Deliberative Democracy

A very different body of literature argues that effective policy and deeper democratic engagement can be secured through processes of democratic deliberation and collaborative governance in which participants play central roles in policy implementation. This work takes a much more optimistic view of the contemporary

prospects for connecting meaningful citizen engagement with government activity.¹⁰ However, arguments about collaborative governance are limited by their inattention to the ways that politics determines the scope, meaning, and durability of democratic engagement. These accounts often begin the analysis when the rules creating a space for participation have already been set, or they prescribe appropriate rules for engagement.¹¹ There is much less attention to considering how political decisions establish the rules in the first place, how to ensure that participatory venues remain meaningfully connected to governing outcomes,¹² and how institutions of public engagement can be defended when they are threatened.¹³

This inattention to the rules of the game is particularly problematic in studies of collaborative governance in the United States. The robust forms of citizen engagement in Brazil and Kerala, India that have captured broad scholarly consideration are anchored by political parties – the Workers Party in Brazil and the Communist Party of India (Marxist) in Kerala – that view citizen engagement as a core element of their political strategy.¹⁴ In the United States, by contrast, participatory venues often function as parallel processes to traditional decision-making venues where real power is exercised.¹⁵ Moreover, participatory engagement that does not build power can more easily be dismantled from above. For example, Seattle’s extensive neighborhood planning process, which Carmen Sirianni highlights as a model of collaborative governance, faces ongoing challenges from zoning and development decisions that occur outside the collaborative process.¹⁶ Further, Brazil’s 2013 mass protests of transit, health care, and education services under a Workers Party regime raise questions about the extent to which

governing parties can enact meaningful participatory governance without independent mobilization from below.

When they lose support from above or are set up as parallel procedures, public deliberation processes run the danger of producing “participation without power”.¹⁷ This issue is particularly evident in public deliberations on key policy issues, such as health care, sponsored by nonprofit organizations. Often overseen by professional groups that specialize in organizing such convenings, these deliberations are not formally connected to policymaking or to the mobilization of the individuals engaged in deliberating. Instead such parallel processes become, at best, one of many indicators of public opinion in the broader policy debate; at worst they divert popular engagement away from authentic challenges.¹⁸

The political vulnerability of established collaborative processes and the danger of promoting participation without power underscore the fact that the rules establishing participation are themselves targets of political contestation. Unless these rules can be defended, they are vulnerable to being circumvented or dismantled. And unless they are meaningfully connected to policy levers, public engagement processes end up becoming largely symbolic. Advocacy organizations have important roles to play in creating and bolstering institutions that support civic engagement, in expanding the scope of these democratic processes, and ensuring that they are connected to meaningful outcomes.

Coalition-building and the Public-Private Welfare State

Our argument draws attention to strategies that build diversely-resourced coalitions which represent and mobilize diffuse consumer interests in the public-private

welfare state. Coalitions are essential for successful engagement in public-private policy domains. The complexity of public-private policies means that they engage a greater number of distinct groups. More groups – and more diverse groups – are likely to have an interest in these policies than in policies that deliver “checks in the mail” or those that provide government-delivered services. The groups engaged in public-private policies in turn face multiple possibilities for defining their interests and allies. Decisions about which allies to engage and on what terms are fundamental choices that advocates – and their potential allies – confront.

Yet, decisions about interests and allies are rarely made once and for all. The dynamism created by private sector competition means that opportunities for recalculating group interests and allies periodically reemerge as cost shifting strategies or new policies shape actions and funnel resources in novel ways.¹⁹ This dynamism also means that opportunities are not best depicted as “structures” but rather as periodic openings that may or may not be read as such by different groups. The opportunities created by the gyrations of the actors engaged in public-private policies, accordingly, depend on group capacity and learning over time.

Our approach to understanding how advocates build capacity thus has much in common with Marshall Ganz’s conception of strategic capacity²⁰ and Elisabeth Clemens’s notion of strategic repertoires.²¹ Both emphasize the composition of organizations and processes of group development. For example, Ganz highlights the significance of “borderlands” actors whose diverse ties promote the strategic creativity that allows groups to recognize and exploit opportunities. Clemens portrays shifts in organizational repertoires that enhance their effectiveness. We see both diverse ties and

evolving repertoires as key to building capacity, but because advocacy organizations are often small groups whose main task is to put coalitions together, we examine diverse ties and evolving repertoires as they develop among clusters of organizations rather than within a single organization. We also emphasize the way interaction with government influences groups and coalitions over time. Policies can alter group capacities and connections by providing resources and building connections across different kind of organizations, in the process, expanding repertoires and strategic capacity.

The Power of Coalitions

We highlight three core processes that build such coalitions: 1) coalitional connections that can show how often-hidden policy decisions restrict access to services; 2) mobilization of and increased resources for diverse grassroots organizations and 3) changes to the rules of the game to ensure meaningful public engagement that influences policy outcomes. Such strategies form part of any social advocacy effort, but they are particularly significant in the public-private welfare state, where decisions are often shielded from public scrutiny. These coalition strategies also increase possibilities for recognizing common interests that are masked by the individual experience of consuming privately-delivered benefits.

New Connections to Make the Private Public

Staking out an area of broad common interest and beneficial policy measures is the first crucial step in building effective coalitions. Retrenchment in public programs, such as Social Security, is likely to be visible and contested. By contrast, many private

decisions that limit access to publicly-supported benefits do not become immediate targets of contestation. Given the complexity of the public-private welfare state, it takes diverse capacities to document retrenchment and make it publicly visible.

Private organizations responsible for delivering policy can implement cutbacks quietly through changes in organizational procedure. Advocacy groups with connections to beneficiaries have an important role to play in illuminating patterns of service denial and in bringing them into public view. Retrenchment can also take the form of policy decisions whose obscure technical character hides significant social impacts. Advocacy groups with technical knowledge can clarify what is at stake in such decisions and provoke public debate about the consequences. In performing these roles, advocacy groups make possible democratic engagement around choices that otherwise would remain private and hidden.

Yet, groups with strong technical capacities rarely have the grassroots connections needed to monitor retrenchment through implementation practices; groups with links to beneficiaries generally lack the technical expertise to identify the impact of obscure policy rules. Bringing these resources into a coalition creates new possibilities for coordinating strategic interventions on behalf of excluded beneficiary interests.

Broadening the Base with New Resources

Advocacy organizations can use two strategies for building coalitions. The first unites disparate interests around a broad common agenda. Health care advocates have long built grassroots organizations with mobilizing capabilities – not just “associations without members.” But these groups are often focused on particular diseases or health

statuses, such as AIDS, the disabled, or breast cancer. Umbrella advocacy groups can help to link such groups, bringing them into coalitions that connect their specific interests to the broader public goals in the provision of health care.²²

Such coalition-building activities are critical in ensuring that organized labor's engagement with health policy remains broadly gauged. In the failed 1994 federal effort at comprehensive reform, key segments of organized labor pursued their narrow interests at the expense of comprehensive health reform.²³ Unless it is engaged with a broader coalition, labor can also take similarly narrow approaches in state health politics, at odds with consumer interests.

Increasing funding for under-resourced communities throughout the coalition can help bring to the table groups with under-utilized grassroots capacity and balance power-dynamics between labor and community allies. These coalitions not only enlarge the constituencies for broad-gauged health reform, they also expand the range of political resources at the command of reformers by linking groups with varied levels of technical expertise, mobilizing capabilities, and political connections.

In addition to building broad coalitions among consumers, advocacy groups can build power by disrupting alliances among private providers. The dynamics of market competition mean that private actors are always on the look out for new legislation and regulations to improve their situation. In the health care sector, the much-studied cost-shifting between hospitals, insurers, and the medical profession accentuates the quest for laws that benefit one part of the health care industry at the expense of the others. Such conflicts offer advocates the opportunity to ally with private actors who fear that they will be on the losing side of these regulatory battles.

Changing the Rules of the Game

Advocacy organizations can ensure a role for ongoing civic engagement by pressing for legislation that ensures regular public input into policy decisions. Such legislation can change the terms of policymaking and at the same time strengthen advocates' ability mobilize the public voice. Policies that can help build a virtuous cycle of reform include information transparency, which allow advocates to track and publicize industry changes and health care access and affordability; regularized requirements for consumer participation in health care regulatory decisions; advocate engagement with service delivery; and routinized public funding for diverse grassroots advocates. Such policies can strengthen not just the capacity of coalitions but the capacity for civic engagement of program beneficiaries themselves.²⁴

None of these by themselves can launch a virtuous cycle strengthening advocate and state capacities to monitor the public-private welfare state, but they are the building blocks of successful strategies. They keep advocacy groups engaged with the latest developments affecting consumers, providing them with information to promote legislative remedies where needed. In cases where advocates help administer programs, they are able to obtain bottom-up knowledge about cutbacks that might otherwise remain invisible. At the same time, guarantees for public engagement help to guard against agency capture by industry interests and diminution of public power.

California: From Laggard to Leader

Between 1980 and 2010, California's consumers went from laggards to leaders in their capacity to influence state health care policy. Health care consumer advocates

barely existed in 1980 but over the next three decades California advocates increased their capacity using a three-pronged strategy : 1) by forming coalitions; 2) by winning policies for state-supported redistribution of resources to diverse unions and advocates; and 3) by changing state-level rules of the game for policy-making.

As Ganz²⁵ and Clemens²⁶ would have us expect, this positive trajectory began with a pooling of resources and innovation-sparking collaboration between advocates within the coalition of labor, diverse consumer communities, and new health care specific organizations. But the political contests that followed in California reveal that subordinate groups do not necessarily gain exclusive or sufficient political capacity through collaboration or resource sharing with other subordinate groups and sympathetic elites. Rather, advocates had to win strategic contests with political and industry opponents over state policies to change the rules of policymaking and redirect financial and other resources to advocacy.

In contrast to the picture of advocates as divorced from the grassroots, advocates in California used their increasing resources and deep ties to diverse communities to build further collaboration across community and class boundaries. Advocates won enough capacity through this virtuous cycle to defeat industry and political opponents again in contests over the rules of the game for regulating health care. In doing so, advocates established new authorities, resources, and deliberative spaces for democratic engagement and regulation from below by diverse communities. These changed rules of the game even empowered advocacy organizations to directly provide and regulate health care services. In this process of political struggle we find an origin story that is missing from the participatory democracy literature.

State of Disrepair – The Emergence of Health Care Consumer Advocates in the 1980s

California's response to medical inflation, recession, and budget shortfalls in 1982 revealed the absence of advocates for consumers or the public interest in the health care field.²⁷ California business leaders and insurers met little resistance as they sought to reduce the cost of health care. Together with their allies in the state legislature, they pushed for decisive changes that would result in cost reductions from insurers and hospitals. The market-oriented deregulation, called selective contracting, passed over the objections of divided hospitals, insurers, and doctors. Neither consumer advocates nor unions played a meaningful role in shaping the reform.²⁸

The 1982 reforms set off a chain reaction of interest and organizational shifts in the health industry that extracted savings at the expense of consumers and labor. Selective contracting aimed to reduce costs for large employers by making hospitals and doctors compete for contracts with insurers and Medi-Cal (California's name for Medicaid) to provide services at fixed rates. Insurers would pass those savings along, especially to large employers with big, relatively healthy risk pools. At the same time, the state capped expenditures on Medi-Cal.²⁹

Hospitals reacted with a wave of consolidations throughout the 1980s and 1990s as they sought to cut costs,³⁰ access capital, and negotiate higher reimbursement rates with insurers.³¹ The shift hurt healthcare workers, contributing to layoffs and forced concessions from unions. Even with the consolidations, the 1982 reforms made it harder for hospitals and doctors to recoup the costs of caring for the uninsured by charging higher rates to Medi-Cal and the privately insured. Unable to cost shift, they resorted to denying emergency care to the uninsured – a practice that became known as “patient

dumping.” Highly visible health care failures like patient dumping and the joint squeeze on labor and health care consumers would help new advocacy entrepreneurs to start articulating the shared interests between diverse consumer communities and labor.

Ignition: Making Hidden Decisions Public

Though patient dumping brought labor and consumers together, these allies had little experience in the health care arena. Even core leaders in the coalition, such as Consumers Union and the San Francisco organization Public Advocates had little experience with health care issues and no staff dedicated full-time to health care in 1984. Advocacy entrepreneurs from Consumers Union and Public Advocates sought to overcome this dearth by forming the Health Access Coalition. Health Access initially included health care unions and Northern California’s dense network of advocates for low-income communities, communities of color, and consumers. The coalition pieced together the capacity it needed to stop the dumping from the diverse contributions of its partners.

The New Coalition Takes Shape

Health Access quickly enhanced this capacity by reaching out to different groups with diverse repertoires, consistent with the strategic capacity literature.³² Consumer advocates used their ties to labor to gather reports and stories of patient dumping deaths. Rank and file nurses and health care workers alerted the coalition through their unions. CNA, SEIU, and consumers union combined resources to set a legislative agenda that

channeled public outrage at the dumping. CNA's lobbyist at the time, Beth Capell, recalls:

We had enough stories of patient dumping that we were able to deliver basically a story of somebody dying or being severely harmed every day for the last three months of the legislative session.³³

Advocates used the stories of patient dumping to push health policy out of the shielded decision making processes into the public arena. This new visibility gave them leverage to combat fierce opposition from two powerful private interests – the California Hospital Association and the California Medical Association. Patient stories provided the frame for longtime Assembly Health Committee Chair Burt Margolin and his staff as they crafted legislative debate. The final measure of the coalition's growing capacity came with the imposition of criminal penalties and fines for patient dumping when Republican Governor Duke Dukmejian signed Margolin's Assembly Bill 3403 in 1986.

Health Access remained a durable coalition because advocates and labor both felt they needed each other to develop adequate capacity for major reforms. Jim Shultz, an organizer for Consumers Union at the time, explains:

It was the creation of Health Access which allowed us to do this as part of a network. And it was the expansion of the network to include academics and others who were able to give us a very strong policy and research base to what we were doing beyond what we had in house... Consumers Union doesn't have a grassroots base... we would work really closely with groups like the PTA. So when we had to do grassroots lobbying member visits it was CNA, the nurses, right? That's who had the base. Labor.

Seniors were really important. AARP, Grey Panthers... And then there began this conversation... maybe we should be working on the big picture thing. Maybe we need to look at system reform... alright how do we, given that we can't win the big thing what will build toward it?³⁴

Labor lacked the public credibility of consumer groups. Consumers Union lacked a grassroots base. AARP and the Grey Panthers could not match labor's lobbying and grassroots political structures. Together, however, they had united to win legislation to stop patient dumping and had begun to contemplate tackling daunting systemic reform of California's health care system.

Broadening the Base with Resources for Activating New Constituencies

After its initial victory, California's health care coalition used its diverse skill set to leverage a much wider base of grassroots support. By inserting a public claim into the hidden process in which HMOs converted from nonprofit to for-profit organizations, the coalition loosened a windfall of new resources dedicated to the public interest. These resources in turn sparked a flourishing of interracial and cross-class involvement in health policy-making – quite a contrast to the image of advocates without members.

HMO Conversion and the Development of an Advocacy Resource Base

The new resources for California advocates came from strategic actions to regulate the conversion of non-profit HMOs to for-profit status. Many of California's HMOs switched from non-profit to for-profit status before advocates at Consumers Union even began working on the issue in 1985. Conversion to for-profit status gave

HMOs access to equity markets for capital to upgrade technologies, especially their data systems. But the conversion to for-profit status also created obligations to owners or shareholders that could subvert the interests of HMO members and consumers.

California advocates turned the conversion of non-profit HMOs to for-profit companies into an opportunity to permanently expand their own capacity by laying claim to the huge pools of resources that conversion made available.

Consumers Union consciously tackled the issue because the self-dealing involved in conversions provided an opportunity to recapture public assets for consumer-based policy advocacy. Judith Bell, the Directing Attorney for the San Francisco office of Consumers Union at the time, describes how the issue emerged on the advocates' radar screen:

The conversion issue came up through what I would call opportunistic advocacy... these conversions began to appear on the business pages and we began to think... so what does it mean to take a company that which is owned by the state and turn it into private property?... We had this amazing chart, which showed the valuation that was done at the time of conversion... The valuation at one point for one of them was \$400,000 dollars and then just a few years later sold for \$40 million dollars.³⁵

Legal research by Consumers Union attorneys determined a basis for capturing assets from the converted non-profits similar to “cy près” settlements to class action lawsuits which fund public interest advocacy. California law required new for-profit entities to purchase the assets of the existing non-profit when making a conversion.³⁶ The amount exchanged for the non-profit entities then had to be deposited in a new or existing

philanthropic organization with a similar purpose to the converting non-profit. The process for determining the value of the non-profit assets for sale and for deciding who would control the philanthropic organization funded by the conversion was less clear. As a result, the conversions were rife for abuses like those described by Bell.

In tackling this issue, California's consumer-labor coalition won a conversion system that would become a national model for funding health care policy advocacy. Consumers Union developed legislation and shopped around for a well-positioned legislator to carry it. The bill, AB 2990, established a process for non-profits to create new foundations with assets equal to the value of the converted non-profit organization. Passed in 1986 with bi-partisan support, the bill reflected the bipartisan consensus on defending public claims to non-profit assets.³⁷ In 1991, the conversion legislation guided the creation of the \$1.3 billion Wellness Foundation from the conversion of Healthnet, an HMO and insurer. Advocates appointed to the Wellness board by the Department of Corporations steered its giving to help new and enlarged health policy advocacy groups.³⁸

California advocates tightened the conversion process further in 1991 through a hard-fought contest with the insurance giant Blue Cross. Blue Cross initiated efforts to sell off its Wellpoint subsidiary and keep all of the assets. Consumers Union, with support from Health Access affiliates, wanted make sure that the philanthropies funded by conversions received payments equal in market-value to the assets that the new for-profit organizations received. The 1986 legislation left the possibility for new non-profits to purchase assets for their much lower "brick-and-mortar" value, rather than a market value that reflected how much profit the assets could generate.

In fact, consumer advocates won much more than they originally thought possible. Assembly member Phil Isenberg carried the initial legislation, which sought only \$30 million from Blue Cross' Wellpoint conversion. At first, the bill lacked adequate support but conflicts between the Republican Governor Pete Wilson and Blue Cross created a more favorable political climate.³⁹ The appointment of a consumer ally, attorney Gary Mendoza, to lead the Department of Corporations, further opened the door to a much more favorable conversion process.

Led by Consumers Union, advocates deftly combined the capacity offered by state officials like Mendoza and their own grassroots capacity to stir up anger against Blue Cross. The Department of Corporations determined that an initial public offering by Blue Cross would garner far more investment than the advocates were seeking. In the end, advocates secured \$3.3 billion in shares in Wellpoint for foundations to support health advocacy. Bell says of coordinating with Mendoza:

He was the Corporations Commissioner at the time and we were incredibly lucky because he was an inside advocate... he'd call me up and we would talk about sort of the inside outside strategy and these things like, you need to make me do this. I'd be like, okay, I'm gonna make you do this. And then we'd do all sorts of public advocacy that then would create pressure on the department that would allow the commissioner to act... He needed pressure from the outside to give him a combination of cover and a combination of saying these are public demands.⁴⁰

Blue Cross did not want advocates antagonistic to its agenda to control such a large funding source. As a result Mendoza negotiated to create two foundations – the

California Health Care Foundation (CHCF) with a board drawn from Blue Cross's own charitable foundation board and the California Endowment, with a board of advocates appointed by the Corporations Commissioner. The smaller CHCF received \$700 million while the Endowment would eventually manage \$4 billion in assets. The coup de grace came with the passage of legislation that codified as law the process used by Mendoza for the Blue Cross conversion.⁴¹

Capitalizing Diverse Advocates

The massive funding of advocacy-oriented foundations by the insurance conversions helped expand California's health care coalition to involve more diverse disadvantaged communities, permanently shifting the balance of advocacy around health care policy. This shift is evident in the grants offered by the California Endowment. The Endowment awarded a large and growing share of its grants to organizations grounded in diverse, low-income communities.

We analyze the California Endowment's capitalization of advocates by using a data set built from data available on the Endowment's website until 2010.⁴² The Endowment provided information for all of the 10,639 grants it awarded from 1999 through 2009, including searchable keywords to categorize grants.⁴³ We reviewed the 1,225 grants coded with relevant keywords for this study and identified among them 1114 grants to 610 organizations totaling \$435.6 million that either supported a health care policy advocacy project or supported overhead for an organization involved in health care policy advocacy.⁴⁴ We also coded the "primary activity" and "primary community" of each organization receiving the 1114 grants. Advocacy and research are examples of a

“primary activity” while “primary communities” range from communities of color to women.

The distribution of grants to organizations rooted in diverse communities paints a very different picture of today’s policy advocates than Skocpol’s professional elites. We coded Endowment grant recipients by the following types of primary communities: 1) “general,” 2) “chronic disease” groups, 3) “communities of color,” 4) “poor” communities, 5) “seniors,” 6) “women,” and 7) lesbian, gay, bisexual, trans, and queer or “LGBTQ.” We coded as “general” those groups that do not work primarily with one particular community. Such general organizations, including Health Access and the Institute for Health Policy Solutions, often work with multiple diverse communities across class, racial, and other boundaries. Further, the Endowment bolstered the need for such umbrella organizations by strengthening diffuse organizations based primarily in one underserved community or another.

The top 25 recipients of Endowment grants in dollars include organizations that work primarily with communities of color, women, chronic disease patients, and poor people (see Figure 1). Organizations such as Legal Services of Northern California, Asian and Pacific Islander Health Forum, and Planned Parenthood affiliates work on the ground with consumers and grassroots activists on a daily basis. Sometimes these groups both provide services and mobilize communities for policy advocacy. These groups work in inter-racial and cross class coalitions through organizations like Health Access at the state level and Coalition for Humane Immigrant Rights of Los Angeles at the local level. National inter-racial and cross class allies such as Families USA can stay connected to the grassroots by collaborating with these local coalitions and organizations.

Figure 1: Top 25 Recipients of Endowment Grants by Total Dollars Received

Organization	Primary Activity	Primary Community	Total Dollars Awarded	Total Grants Awarded
University of California	Research	General	\$18,371,154	19
Public Health Institute	Advocacy	General	\$18,130,831	23
California State University	Research	General	\$13,063,076	8
Children NOW	Advocacy	Poor	\$12,839,944	13
Tides	Advocacy	Poor	\$10,820,265	11
Neighborhood Legal Services of Los Angeles County	Consumer Assistance	People of Color	\$8,195,277	5
Community Health Councils, Inc.	Advocacy	Poor	\$7,303,750	5
Families USA Foundation, Inc.	Advocacy	General	\$6,762,505	16
California Center for Public Health Advocacy	Advocacy	Poor	\$6,209,484	5
GMMB: Social Change Advertising, Political Consulting, Advocacy	Advocacy	General	\$5,600,000	1
National Health Law Program, Inc.	Advocacy	Poor	\$5,482,165	7
California Rural Legal Assistance	Consumer Assistance	People of Color	\$5,267,649	11
California Planned Parenthood	Advocacy	Women	\$4,600,000	5
Asian and Pacific Islander American Health Forum	Advocacy	People of Color	\$4,030,242	6
Pacific Institute for Community Organizations	Advocacy	General	\$3,973,375	2
Alameda Health Consortium	Advocacy	Poor	\$3,880,503	6
Children's Defense Fund	Advocacy	Poor	\$3,699,855	2
Legal Services of Northern California	Consumer Assistance	Poor	\$3,694,213	4
PolicyLink	Advocacy	Poor	\$3,503,734	8
Liberty Hill Foundation	Advocacy	Poor	\$3,349,297	4
California Medical Association Foundation	Advocacy	General	\$3,295,484	4
Asian Pacific American Legal Center of Southern California, Inc.	Consumer Assistance	People of Color	\$3,039,822	7
American Lung Association of California	Consumer Assistance	Chronic Disease	\$3,006,462	13
Central Valley Health Network Inc.	Services	Poor	\$2,950,000	5
California Primary Care Association	Advocacy	Poor	\$2,900,000	4

Organizations based primarily in particular underserved communities received \$300.5 million in grant funding or 69% of Endowment grants for policy advocacy. Figures 2 and 3 show that grants to organizations based in poor communities outpaced those to all other groups for much of the decade and totaled nearly \$187 million over the 10-year period. Grants to organizations working primarily in communities of color received \$75.2 million over the same period. Chronic disease groups such as obesity, breast cancer, and AIDS organizations took in \$22.6 million over the period. Advocates for the seniors, women, and LGBTQ communities received 59 grants all together totaling \$15.7 million over the period.

The Endowment also funded the creation of new organizations grounded in specific underserved communities. These organizations include California Pan-Ethnic Health Network, the California Black Health Network (CBHN), Latino Issues Forum, and Latino Coalition for a Healthy California (LCHC). California's conversion foundations enhanced grassroots participation by putting resources in the hands of organizations with strong roots in diverse communities.

Diverse leadership, community-based missions, and a range of organizational activities reinforce the commitment of organizations to the interests of communities that are underserved by the private-public welfare state. Likewise, these qualities and organizational activities can increase a group's capacity to mobilize consumers for policy change. We found that Endowment grants have increased coalition capacity by supporting four key types of primary activities by grant recipients: 1) Advocacy, 2) Service, 3) Consumer Assistance, and 4) Research.

Figure 2: California Endowment Advocacy Grant Funds by Primary Communities

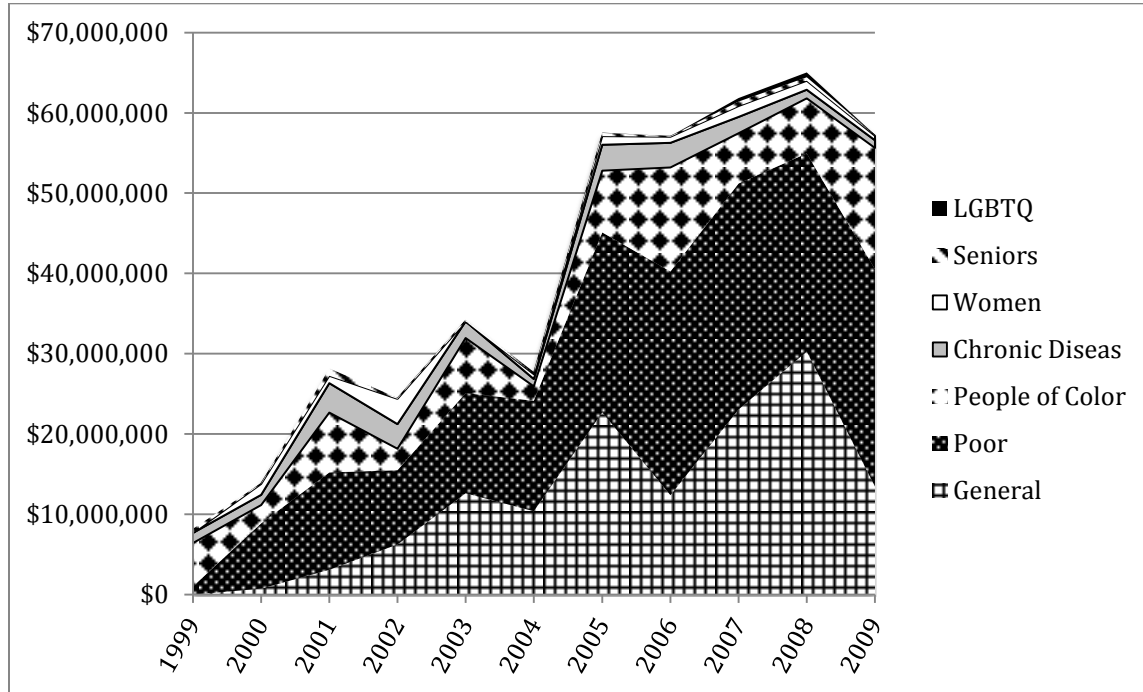


Figure 3: Summary Statistics for California Endowment Advocacy Grants by Recipients' Primary Community, 1999-2009

Primary Community	Total Funds Awarded	Total Grants Awarded	Mean Grant Amount	Std. Dev.	Min Grant Amount	Max Grant Amount
Poor	\$186,973,171	445	\$420,164	\$550,108	\$1,000	\$5,000,000
General	\$135,033,201	292	\$462,442	\$767,906	\$10,000	\$5,600,000
People of Color	\$75,245,960	221	\$340,479	\$401,859	\$1,000	\$2,544,402
Chronic Disease	\$22,630,749	97	\$233,307	\$228,620	\$2,000	\$1,000,000
Women	\$10,921,467	33	\$330,954	\$554,141	\$5,000	\$3,000,000
Seniors	\$3,697,322	19	\$194,596	\$172,602	\$10,000	\$704,367
LGBTQ	\$1,076,738	7	\$153,820	\$113,635	\$45,000	\$350,000
All Grants	\$435,578,607	1114	\$391,004	\$571,120	\$1,000	\$5,600,000

“Advocacy” organizations are those where policy advocacy is the primary activity of an organization. These groups engage with consumers primarily around advocacy activities like grassroots lobbying, educational forums, public hearings, and protests.

These groups received the largest block of grants for policy advocacy throughout the period for which complete data is available – 752 grants totaling \$286.8 million (see Figure 4 and Figure 5). Health Access, Asian and Pacific Islander American Health Forum, and Consumers Union would fall squarely in this category.

Figure 4: California Endowment Advocacy Grant Funds by Primary Activity

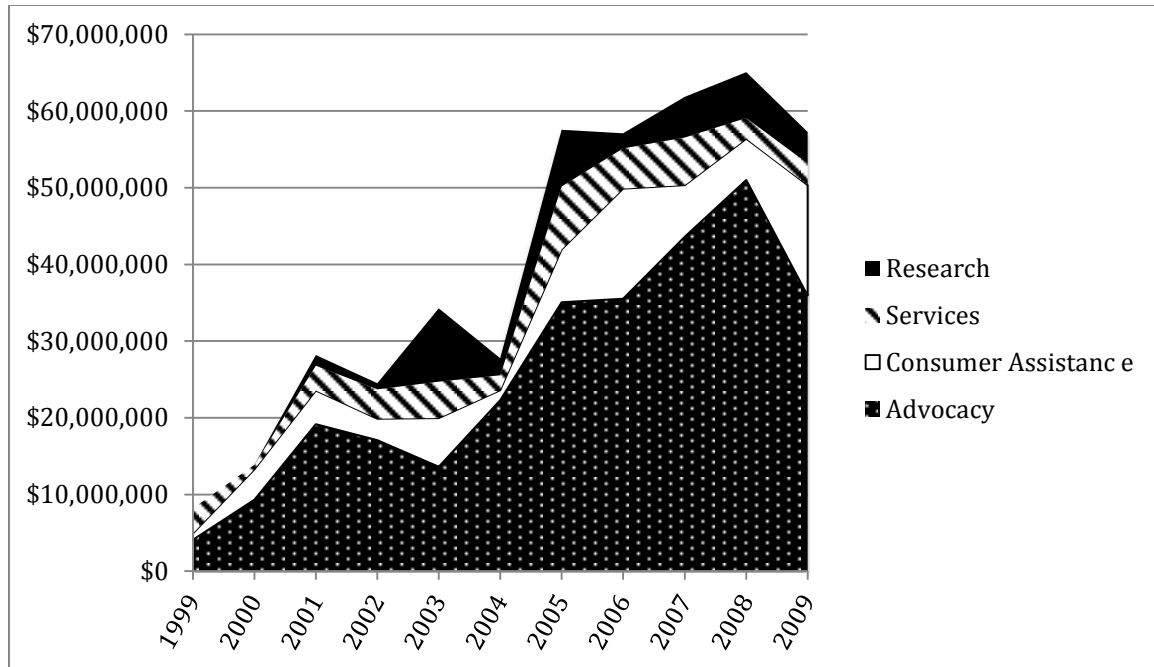


Figure 5: Summary Statistics for California Endowment Advocacy Grants by Recipients’ Primary Activities, 1999-2009

Primary Activity	Total Funds Awarded	Total Grants Awarded	Mean Grant Amount	Std. Dev.	Min Grant Amount	Max Grant Amount
Advocacy	\$286,772,498	752	\$381,346	\$569,291	\$5,600,000	\$1,500
Consumer Assistance	\$67,320,735	181	\$371,938	\$448,450	\$2,600,000	\$1,000
Research	\$38,638,230	58	\$666,176	\$1,078,385	\$5,043,853	\$7,500
Service	\$42,847,144	123	\$348,351	\$318,885	\$2,496,244	\$10,000
All Grants	\$435,578,607	1114	\$391,004	\$571,120	\$5,600,000	\$1,000

“Service” organizations are those that deliver direct services to underserved communities, such as a community clinic. Such organizations sometimes include clients and community activists on their boards and engage in health care policy advocacy, but

not as their primary purpose. Service organizations received 123 grants supporting advocacy totaling \$42.8 million.

Similarly, “Consumer Assistance” groups include legal aid organizations that help consumers learn their rights to and access insurance and services. These organizations have intimate knowledge of barriers to health care that motivate and inform their policy advocacy work. Consumer Assistance organizations received 181 grants that supporting advocacy totaling \$67.3 million.

“Research” organizations received the least grant funding from the Endowment. These organizations research disparities in access and health outcomes that motivate their participation in policy advocacy. Such organizations received 58 grants totaling \$38.6 million.

The Health Care Coalition and Labor Growth

Between 1985 and 2010, health care worker unions increasingly prioritized alliances with consumers and presented themselves as frontline advocates for patients and consumers. SEIU, in particular, coordinated closely with advocates in an alliance that strengthened each. Through a deliberative process developed by Executive Director Dean Tipps, the SEIU California State Council had decided to make comprehensive health care reform its highest priority.⁴⁵

The coalition simultaneously strengthened labor and boosted advocate power. The legislative pressure on hospitals from SEIU and its health care reform allies helped nearly 25,000 workers to unionize with SEIU at the hitherto non-union Catholic Healthcare West, Daughters of Charity, and Tenet hospital systems. For example,

consumer support helped SEIU pass seismic retrofit requirements for hospitals. The hospitals needed political support from SEIU and consumers to win public support for bond financing of the retrofits. Hospitals decided to end their opposition to unionization and instead work together with SEIU in Sacramento. Likewise, consumer support helped labor pass legislation to allow unionization of nearly 300,000 homecare workers. At the same time, SEIU – and particularly what would become its United Healthcare Workers West (UHW-W) affiliate in 2004 – devoted its growing financial resources and organizing staff to turn out members and sympathetic voters for its favored candidates and initiatives.

The growing power of advocates and labor was evident in a range of new health care policies enacted in California over the next decade. Together, consumers and labor could mobilize thousands of activists for grassroots activities such as rallies and letter-writing. They could mobilize millions more to support comprehensive reform and a consumer agenda on the ballot. Moreover, advocates would continue to increase their capacity by changing the rules of the game for policy making and regulation of the insurance and hospital industries.

Participation that Counts: Rules of the Game and Regulation from Below

With this enriched base of organization, advocates helped enact new legislation that changed the rules of the game for health care policymaking. Three types of policies empowered advocates, consumers, and health care workers to regulate the industry from below. First, transparency policies gave consumers access to industry data to police and regulate access and quality problems. Second, deliberative rules of the game required

public spaces and regulatory review for policy and insurance rate changes. Third, consumer assistance policies funded and gave authority to advocates to mobilize consumers to enroll in and access insurance and care programs.

Transparency Policies

The creation of the state Department of Managed Health Care (DMHC) in 1999 boosted all three forms of regulation from below. Capell conceived the idea for DMHC as the lobbyist for both Health Access and SEIU. Beginning with transparency, DMHC would collect data on HMO service provision and administer regulations in a single agency, independent of the Department of Corporations that formerly reviewed most HMO related regulations.⁴⁶ DMHC provided a point of access and a source of data and analysis as advocates broadened their agenda to take incremental steps towards comprehensive reform.

New data and transparency allowed advocates to expand their reach. Beginning in 2001, advocates supported legislation to protect language access, stop hospital overcharging of the uninsured, expand Medi-Cal, protect prescription drug coverage, and require hospital reporting of charity care. The new DMHC, data tracking required by the charity care and hospital charging initiatives, and continued funding from conversion foundations all provided resources that enhanced advocate capacity. Capell of Health Access offers a picture of how advocates harnessed their new transparency and grassroots resources:

First the hospitals denied there was a problem. Then they started doing voluntary guidelines so we went to try and see if they were complying

with their voluntary guidelines. Of course they were not. And so there was a study done... where people went out to hospital emergency rooms to see if they had signs and, you know, there was basic consumer mystery shopper kind of stuff. And it turned out that the hospitals weren't complying with their own voluntary guidelines... that kind of capacity which is a combination of policy analysis, field capacity.⁴⁷

Capell's account highlights how advocates funded by conversion foundations coordinated through Health Access and tapped analytical support from the other conversion-funded foundation, the California Health Care Foundation. At the same time, the foundations conducted policy and opinion research that, along with SEIU's research, helped advocates craft policies and campaign messages designed to overcome opposition messages that stoked fears about changes in health care.⁴⁸

Regulation from Below Through Consumer Assistance Programs

DMHC gave new authority and resources to consumer advocates to “regulate from below” access to insurance and hospital services. DMHC granted money to organizations, such as the Health Consumer Alliance, Central California Legal Services, and Bay Area Legal Aid to assist consumers with enrollment in HMOs, unwarranted denial of claims, and access to health care services. In addition to providing resources and expertise to consumers, the consumer assistance programs provided advocates with first-hand knowledge about access, affordability, and quality problems and violations. Advocates in turn could use this knowledge to work with consumers to enforce existing policies and develop new policies to solve problems. Advocates could mobilize the

credibility and authenticity of the affected consumers themselves in policy and regulatory deliberations.

Rules of the Game: Deliberative Spaces

DMHC also provided new deliberative spaces for consumers' and their organizations to make policy. Lawmakers would ultimately give DMHC the power to delay and review rate increases by insurers. Rate review involves public hearings and requires HMOs to justify rate increases under scrutiny for technical or actuarial errors. Such public deliberation over rate increases led Anthem Blue Cross to reduce a planned rate increase in 2012. Even before gaining rate review authority, DMHC provided a forum for advocates to identify problems and incubate policy solutions. Wright says of DMHC:

It was a platform by which to do additional reforms... When you're involved and you also have good relationships with the regulator so you can see... the people at the top saying "We're getting an awful lot of complaints about this or... We're seeing that there's a trend in the industry this way towards sort of much more scaled back plans." And then that sort of instigates "Well maybe we should push legislation or run a campaign on that."⁴⁹

DMHC adds to advocate capacity not just by providing data but by making analytic capacity of the state accessible to the public. Here we see a complementarity between regulation from below and traditional regulation by the state.

The growth of advocate capacity – as labor allies, as well-funded policy makers, and as regulators from below – made it difficult to make major policy changes without their approval. The growing power of advocates was noted in interviews with their frequent opponents President Duane Dauner of the California Hospital Association⁵⁰ and former Blue Cross lobbyist Brent Barnhart.⁵¹ In the wake of this capacity growth, even Republic Governor Arnold Schwarzenegger sought advocates out for negotiations over his attempt at comprehensive health care reform in 2007. Wright of Health Access contrasts advocate participation in the decision making process between the 2007 reform and the 1982 deregulation where advocates were absent:

The Schwarzenegger administration... I mean I can't complain that we haven't had access to them... they were doing round tables [to negotiate a consensus for health care reform legislation] where they were like, you know, only two providers, two labor, two consumers, two insurance and two whatever, Health Access and AARP were the two consumers.⁵²

The Coalition and Universal Access to Care

Beginning in 2003, the alliance of consumers, labor, and the nonprofit hospital sector launched a major campaign to expand access to health care. In the context of California's political system, where controversial initiatives become ballot measures, this endeavor required all the skills assembled by health advocates: policy expertise, lobbying capabilities, and grassroots mobilization. Although the recession and the state's

dysfunctional revenue system ultimately doomed the state-level campaign, the coalition that fought for expanding health care access played a central role in city and national campaigns for health care access. It is now centrally engaged with implementing the Affordable Care Act in California.

The quest for universal access began in 2003, when non-profit hospitals joined the diverse alliance of consumer advocates and labor through their new peace arrangements with health care unions to support a new law to require all employers to provide insurance to employees. Sponsored by Democratic State Senate President John Burton, the bill passed the legislature but faced a challenge on the ballot the following year. The drive to defend the new law showcased how far the grassroots capacity of advocates had come. Unions mobilized thousands of volunteers in a get-out-the-vote effort, including phone calls and door knocking to union and sympathetic voters. Hospitals and insurers provided financial support for the campaign to counterbalance massive opposition from employers of low-wage workers. Unions also spent lavishly on the paid media that is essential for any ballot campaign in California. They came within a hair of winning, with 49.7% of the vote.⁵³

Fresh from this defeat, coalition members played a central role in the campaign to pass Healthy San Francisco, the first citywide access to care program, enacted in 2006. Building on the ties forged during the state-wide campaign, labor unions (most of whose members had health care), and community activist groups, including the Senior Action Network, ACORN and Health Access California, threw their support behind a pay or play law that guaranteed health access for all uninsured San Francisco residents.⁵⁴

The coalition renewed its campaign for statewide reform in 2007, modeled on Massachusetts's 2006 play or pay plan. A new It's Our Healthcare coalition received prominent funding from SEIU. The coalition pushed for broad reform principles such as universality, affordability, and accessibility of care, along with concrete proposals, including a state-level public insurer. SEIU formed a separate coalition – Together for Healthcare – with business and medical interests that supported reform. Together for Healthcare drew together SEIU, AARP, Catholic Healthcare West, Kaiser Permanente, the Health Net insurance company, Blue Shield, the California Medical Association, and the Silicon Valley Leadership Group business organization. Together for Healthcare aimed to counter the massive expenditure advocates anticipated from Blue Cross to kill the reform.

Participants in the 2007 reform push offer many accounts of how the reform failed, but the legislation's narrow defeat should not distract from the dramatic expansion of advocate capacity in California. After passing the Assembly, a reform bill supported by the governor -- and by most advocates, providing some amendments – failed to make it out of the Senate Health Committee in January of 2008. By that time the state's massive budget deficit loomed and legislators rejected the measure as unaffordable.⁵⁵

The deterioration of state finances and the growing focus on health care in the presidential election led advocates to concentrate on possibilities for federal reform. Seasoned from the 2007 fight, California advocates mobilized thousands of supporters for rallies, lobby visits, letter-writing and petitions in the 2009 and 2010 push for federal reform. In March of 2010, every Democratic member of California's delegation voted for the final legislation, the Affordable Care Act.

Figure 6: Covered California Grant Recipients with their Total Endowment Grants

Organization	Date of First Grant	# of Grants	Total Funds Received
Access California Services	7/3/03	6	\$185,000
Asian Pacific American Legal Center	March 13, 2003	30	\$10,137,937
Bienestar Human Services, Inc.	March 3, 2003	7	\$1,572,717
California Black Health Network	May 11, 1999	11	\$735,952
California Council of Churches	August 6, 1999	5	\$990,075
California Health Collaborative	March 31, 1999	12	\$4,464,318
California NAACP	August 12, 2002	2	\$377,401
California Rural Indian Health Board, Inc.	December 11, 2000	6	\$2,053,015
Coalition for Humane Immigrant Rights of Los Angeles	January 10, 2002	3	\$50,000
Community Health Councils	October 23, 2000	16	\$9,667,656
Council of Community Clinics	February 7, 2000	11	\$3,600,450
East Bay Agency for Children	December 6, 1999	1	\$107,046
Fresno Healthy Communities Access Partners	January 29, 2008	4	\$419,750
Planned Parenthood Mar Monte, Inc.	March 1, 2003	2	\$43,000
Redwood Community Health Coalition	August 1, 2000	9	\$6,600,444
Social Advocates for Youth (SAY), San Diego, Inc.	February 7, 2001	8	\$1,302,957
Solano Coalition for Better Health	February 21, 2000	13	\$2,190,956
The Actors Fund			
The Los Angeles Gay and Lesbian Community Services Center	September 29, 1999	4	\$635,000
United Ways of California	October 8, 2009	1	\$250,000
Vision y Compromiso	April 26, 2004	7	\$225,000
TOTAL		158	\$45,608,674

Later that year, California became the first state to pass legislation to create an insurance exchange; the organizational network built over the previous twenty-five years geared up to help implement the ACA. California’s strong base of organizations serving low-income, immigrant, and communities of color – many of them funded for years by the California Endowment and the Wellness Foundation – mobilized to conduct outreach campaigns. Of the 48 organizations that received the first grants from Covered California to launch outreach campaigns in 2013, 23 were community-based organizations, and 21

of these had been supported by the Endowment (see Figure 6).⁵⁶ These groups possess the language skills and culturally appropriate community connections to enroll participants in the new exchange and in the expanded Medi-Cal program.

The coalition's ability to influence the technically complex implementing decisions, lobby for the legislation needed to implement the ACA, and to enroll participants in the new programs will be key to the success of the ACA in California. And, as the first to implement the health exchanges, California's experience has become a critical national model.

Conclusion

Built over twenty-five years, California's multi-resourced coalition connected disparate groups under an organizational umbrella, made available significant new resources to support broad-based organizational development, and changed policy rules to ensure itself a place at the table in health care decisions. The connections among groups meant that individual denial of service could become a public problem and that technical policy choices could be properly understood as political decisions. Service providers could act as the eyes and ears of the coalition, providing valuable on the ground information about the impact of policy. These diverse skills and connections are essential to influencing the often-volatile market conditions inherent in public-private health care provision and the frequently obscure policy decisions that nonetheless carry enormous significance for beneficiaries.

Does the California experience carry any lessons for other states implementing the ACA? After all, few states have all the organizational ingredients for assembling a

multi-resourced coalition and they do not have twenty-five years to build one. The three elements of California's experience suggest several strategies. The first is to connect existing groups into an umbrella organization for sharing information and coordinating action, much as the creation of Health Access did in California. Many states, even those hostile to the reform, now contain some of the elements to build this initial connection. SEIU and the National Nurses Union have organized tens of thousands of new members in Colorado, Florida, and Texas over the last ten years.⁵⁷ Further, the two unions have hired hundreds of organizers in these states to support further organizing by health care workers. In many states, the nonprofit hospital sector may become a valuable ally, especially in states that have rejected Medicaid expansion.

State policies for redistributing resources to advocates and unions need not take the exact same form in other states as they did in California. The ACA itself provides funds to support enrollment efforts, through its community assistance program. Some states, like California, have already drawn on these funds to engage community organizations in outreach. But others have left funds in the hands of state departments of insurance. Still others still others have refused to apply to the program or have returned the funds to the federal government.⁵⁸

Philanthropy has a role to play in states that fail to apply to the consumer assistance program or that do not distribute funds to community-based organizations. Because the bulk of HMOs have already converted to for-profit status, major new sources of philanthropic funds dedicated to health advocacy are unlikely to emerge as they did in California.⁵⁹ Yet, at the state and local level, some 300 health foundations can support community-based advocacy, although many of them traditionally eschew funding

advocacy.⁶⁰ National foundations can also step up to seed advocacy groups critical for conducting outreach and monitoring implementation of the ACA. Atlantic Philanthropies, for example, played a significant role in funding Health Care for America Now (HCAN), the leading consumer coalition pressing for passage of the Affordable Care Act.⁶¹

Finally, the ACA has changed the rules of the game, providing levers for organizations to monitor implementation and challenge service exclusions. New regulations in the ACA tilt the scales a bit to make advocacy easier and more effective. These include, among others, provisions that nonprofit hospitals provide charitable care, requirements for a community health needs assessment, and rules requiring insurance companies to spend 85% of their premium dollars on health care (medical loss ratio). These rules open the door for advocates to challenge business practices that deny services, to insist on transparency, and ultimately to secure a seat at the table as key decisions about health care are made.

The Affordable Care Act represents a major step towards universal health care as a public interest, but states hold the key to its success. California health care advocates charted one route to greater capacity that we can now measure against efforts in other states and policy areas.

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- ³⁵ Judith Bell, former Consumers Union Directing Attorney, interview by authors (1 July 2010)
- ³⁶ Most states where Blue Cross has converted from non-profit to for-profit have enacted some form of regulations to preserve charitable assets from Blue Cross – 33 states, the District of Columbia and the Commonwealth of Puerto Rico had such regulations by

2004 according Community Catalyst, *Conversion and Preservation of Charitable Assets of Blue Cross and Blue Shield Plans: How States Have Protected or Failed to Protect the Public Interest* (Cambridge, MA: Community Catalyst, 2004).

³⁷ Ibid.

³⁸ The first Wellness board included doctors, nurses, and health advocates. The Board selected a prominent mental health advocate Gary L. Yates as its Executive Director according to former Consumer Union Health Advocate Jim Shultz, interview by authors. Yates made Wellness a “core funder” of the Health Access coalition according to Executive Director Anthony Wright, interview by authors (10 June 2010).

³⁹ Phil Isenberg, Former California State Assemblymember, interview by authors (5 January 2010).

⁴⁰ Bell, interview by authors.

⁴¹ Isenberg, interview by authors.

⁴² California Endowment, "Grant Finder" (accessed 11 August 2010), http://grantfinder.calendow.org/grantfinder_inter.

⁴³ The relevant keywords for this study were affordable, advocacy, affordability, health care advocacy, health care policy, health care reform, health reform, and public policy.

⁴⁴ Our analysis does not look at grants awarded by the Endowment to primary or secondary schools or public agencies for services or public education. We include grants to universities for such activities only if the projects would yield information from consumers that could be used for health care policy advocacy. Likewise, we do include grants for consumer assistance to clinics and hospitals as these activities can

yield information that can be used for policy advocacy and these institutions tend to have a mission of serving indigent populations.

⁴⁵ Dean Tipps, former SEIU California State Council Executive Director, interview by authors, (16 June 2010).

⁴⁶ Capell, interview by authors and Wright, interview by authors.

⁴⁷ Capell, interview by authors.

⁴⁸ Wright, interview with authors.

⁴⁹ Ibid.

⁵⁰ Duane Dauner, California Hospital Association President. Interview with authors (11 June).

⁵¹ Brent Barnhart, interview with authors. (8 June 2010)

⁵² Wright, interview with authors.

⁵³ Ibid.

⁵⁴ Jacob Grumbach, "Testing City Limits: Local Redistribution and the Rise of Health San Francisco" (unpublished mss, University of California, Berkeley, 2013).

⁵⁵ Peter Harbage, Len M. Nichols, and Leif Wellington Haase, "Why the States' budget Gap Shouldn't Derail Health Care Reform," *New America Foundation* (15 January 2008),

http://www.newamerica.net/files/nafmigration/Harbage_Nichols_Haase_1_15_08.pdf.

⁵⁶ For a list of organizations that received the first grants from the new health exchange see Covered California. "Outreach and Education Grant Program Notice of Intent to Award" (14 May 2014),

<http://www.healthexchange.ca.gov/Documents/COVERED%20CA%20->

[%20Grantee%20Profiles%20-%205-14-13.pdf](#). To see which Covered California grant recipients had received funding from the California Endowment, the authors used the database they constructed using California Endowment, "Grant Finder."

⁵⁷ Steve Early, *The Civil Wars in US Labor: Birth of a New Workers' Movement Or Death Throes of the Old?* (Chicago: Haymarket Books, 2011) and Robert H. Zieger, ed. *Life and Labor in the New New South* (Gainesville: University Press of Florida, 2012).

⁵⁸ Rachel Grob, Mark Schlesinger, Sarah Davis, Deborah Cohen, and Joshua Lapps, "The Affordable Care Act's Plan for Consumer Assistance with Insurance Moves States Forward But Remains a Work in Progress," *Health Affairs* 32, no.2 (2013): 347-356.

⁵⁹ Community Catalyst, *Conversion and Preservation of Charitable Assets of Blue Cross and Blue Shield Plans: How States Have Protected or Failed to Protect the Public Interest* (2004)

http://www.communitycatalyst.org/doc_store/publications/conversion_and_preservation_of_charitable_assets_of_blue_cross_and_blue_shield_plans_mar04.pdf.

⁶⁰ Rick Cohen, "The Role of Philanthropy and Advocacy in Health care Reform Implementation," *NonProfit Quarterly Newswire* (26 February 2013),

<http://www.nonprofitquarterly.org/philanthropy/21836-the-role-of-philanthropy-and-advocacy-in-health-care-reform-implementation.html>.

⁶¹ Ibid. and Jacobs, Lawrence R. and Theda Skocpol, *Health Care Reform and American Politics: What Everyone Needs To Know* (New York: Oxford University Press, 2010).