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The Legislative Trigger and the Public Health Care Option

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With Democrats joining Republicans in the Senate in saying that a public plan should not be a part of the final health care reform bill, attention has moved to the idea of keeping a public plan in reserve as a last resort if other reforms fail to work as advertised. The idea is that a "trigger" would implement a government-run public option in any state not achieving certain outcomes in a specific period.

But while the trigger idea may seem like a reasonable compromise, it is unworkable and would actually slow down or undermine creative solutions to coverage gaps at the state level.

What Is a Trigger? A trigger is a legislative tool that would put in place automatic benchmarks that, if not met, would unleash the government-run system into the market. For example, if 95 percent of Americans as defined by the bill do not have adequate health coverage by a certain date, the public option would go into effect.

Does It Encourage Reform? No. What a trigger does is hold off reforms until future, uncertain circumstances. The public option would essentially become law today but not go into effect unless certain coverage criteria have not been met in the future. So there is little reason for Congress to make sensible but tough reforms today that have short-term political cost if a "solution" would automatically go into place in some future Congress.

Moreover, states have little incentive to reform their health care systems if in several years the federal government will declare them to have failed its test and impose a public plan on them.

How Would Criteria Be Determined? Whatever trigger number Members of Congress come up with would be difficult to measure with any accuracy.

What if a state hits the target by "covering" 99 percent of healthy people who rarely need a doctor (e.g., young adults) but leaves the same percentage of its sick population uncovered? Imagine the complicated rules that states would have to comply with to ascertain if they reached the target without fudging in this way. And imagine the gaming that would take place by governors who either want a public plan (who would work to keep coverage below 95 percent) or who strongly do not (who would inflate coverage).

So who decides if a state meets the target? A health panel? The health czar in the House bill? The President?

Wouldn't a Trigger Encourage Innovation in the States? No. Who is to say what is the best approach for each individual state other than that individual state?

Say a state with a high uninsured rate, such as Texas (27 percent uninsured today), makes tremendous progress in expanding coverage using innovative market-based approaches not favored by the

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Obama Administration and reaches 90 percent coverage. Under the trigger idea, the health czar could pull the trigger anyway and order the state to stop what it is doing and create a public plan instead.

So states like Arizona, California, Florida, Louisiana, Mississippi, Nevada, Oklahoma, Texas, or Utah—some of which are currently experimenting with innovative reforms—could be forced to accept a public plan no matter how much progress they had made.

Would a Public Plan Be a Viable Solution Five to 10 Years from Now? Nobody knows, but most likely the answer is no. Other approaches to health care reform will have been developed and tried by then—approaches that even liberals might prefer to a public plan. Triggering automatic imposition of a public plan in five or 10 years (or whatever the time is before the trigger is pulled) means locking in what will then be an old solution that does not take account of anything learned in the meantime.

Had Congress enacted a trigger to save President Bill Clinton's health care plan, the trigger would no doubt have been to force states to implement HMOs at exactly the time everyone was moving away from that overly rigid version of managed care. That mistake should not be repeated.

Is There a Precedent for This? No. Some claim that the proposed trigger is simply what Republicans used as a fallback in the 2003 Medicare drug legislation, in case private plans did not emerge. That is untrue. That legislation actually prohibited a "governmental entity" or public plan as the fallback, stating that every plan sponsor must be a "nongovernmental entity."

Who Is Best Able to Fix the Problems with Health Care? The states, with real encouragement from Washington. There is a good reason that the U.S. has a federal system: It works.

And there is precedent for allowing states to lead the way in reforming ineffective federal programs: Encouraging states to experiment helped fix the welfare system by allowing controversial work requirements and time-limited benefits to be tried in a few states first.

If the federal government wants to push states to improve coverage, it can set agreed targets with individual states. The states can propose ways of achieving those goals—including removal of bureaucratic and statutory rules that block innovation. If a state does not reach those goals, then Washington could propose a new agreement with the state based on what has been learned in the meantime from other, more successful states—not a predetermined public plan designed by committee years earlier.

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