

**Trigger Unhappy:
What Experience Can Teach Us About Why We Should Not Delay
the Implementation of Public Plan Choice**

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Public plan choice is the only politically viable strategy for expanding access to health insurance and for controlling the cost of health care and improving its quality. A public plan can reduce costs by driving competition in the insurance market which is not currently competitive in most parts of the country. It can offer transparency and accountability, which are lacking in private insurance. It can also improve quality by driving delivery system reform. Proposals are currently being debated, however, that would jeopardize the implementation of public plan choice by instituting a trigger or fallback mechanism under which public plan choice would be implemented only if private insurance failed to meet certain performance goals within a specified time period.

- The trigger proposal is bad public policy—it delays implementation of a promising strategy to address an urgent health care crisis. If implemented on a state by state basis, it is likely to lead to an inefficient and inequitable approach to a national problem.
- The trigger proposal is also unwise politically—73% of Americans support public plan choice, and groups representing 30 million members have made public plan choice a top priority for health care reform.
- Finally, experience also shows us that trigger mechanisms do not work. This memorandum reviews that experience. In summary, it shows that:
 - Our experience with the individual market reforms of the Health Insurance Portability and Accountability Act demonstrates that the federal government finds it very difficult to determine that state approaches to health insurance problems have failed and to implement a federal fallback solution.
 - Our experience with the prescription drug plan fallback provisions of the Medicare Modernization Act demonstrate that fallback solutions that are narrowly focused on one particular metric fail to address broader program failures.
 - Our experience with the Medicare excess general revenue funding provisions of the MMA show that Congress is never bound by its prior decisions. When the political makeup of Congress changes, it can always ignore previously adopted trigger provisions. It is harder for Congress to abolish established programs.
 - Our experience with the sustainable growth rate Medicare physician payment trigger provisions demonstrate that triggers merely set up future political battles, which special interest groups usually win.
- Americans voted overwhelmingly last year for change now, not at some distant time in the future. We need public plan choice now. Further delay is unacceptable.

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Perhaps the most promising idea to emerge from this spring's debate on health care reform is the concept of public plan choice: why limit individuals and groups to private health insurance, why not also give them also the choice of an efficiently-run, potentially lower cost and higher quality public plan?¹ Public plan choice is the only politically viable strategy for bringing down health insurance premiums generally as it introduces competition into health insurance markets now dominated by a handful of huge insurance companies.² It can also offer an efficiently- run, lower-cost option to those who cannot now afford private insurance. Private plans have failed to bargain aggressively with providers to bring down the cost of health care products and services. A public plan can do better. It even has the potential for improving the quality of health care. Public plan competition with private plans has worked in other countries and for state employees.³ Public plan choice is supported, according to polling data, by 73% of votes, including 63% of Republicans.⁴

In recent days, however, a new threat has emerged to public plan choice—the trigger proposal. The idea seems to be that, even through private insurance has failed in 75 years to constrain the growth of premiums or to make health insurance available to all, why not give it one more chance? Congress will endorse the concept of a public plan, but then wait some period of time (seven years has been mentioned) to see if finally private insurance gets on track. If within that period of time private insurance fails to meet some metric, perhaps bringing down premium costs or reducing concentration of markets, then the public plan will be implemented. This could be done at the national level, but some proposals seem to contemplate implementing the trigger on a state by state basis—only if and when private insurers in particular states fail to meet the target would the public plan be implemented in that particular state.

From a cynical perspective, the trigger option seems to make political sense. Congresspersons can say to their constituents that they have voted for a public plan. On the other hand, they can say to the insurance lobby that private insurance will have the market to itself for the foreseeable future, and that the public plan threat may never materialize.

Trigger Proposals Represent Bad Public Policy

The trigger is a bad proposal, however, for three reasons. First, it is bad policy. Health care reform requires cost control. True reform also needs a credible mechanism for expanding insurance to those currently uninsured. The public plan is the one politically viable alternative for accomplishing both. It can also bring transparency and accountability to a market that is currently a black box. We do not have the luxury at this point of passing up, even for a limited period of time, this important reform option.

Implementing a trigger mechanism on a state by state basis is a particularly bad idea from a policy perspective. We would lose the potential efficiency gains of a national public plan, and significant inequities would result as Americans in some states where the trigger was pulled would have access to a public plan while in other states public plan choice would be denied if the trigger condition had not been met. Indeed, a person who had public plan choice in one state could lose it by moving to another. A state by state trigger also ignores the fact that health insurance is sold in regional markets. In my home town of Harrisonburg, Virginia, one insurer holds 86% of the market, even though on a statewide basis, no single health insurer holds more than 50%.⁵ The state is thus simultaneously too small a unit to bring us national equity and efficiency and too big a unit to determine whether the private insurance industry is in fact too concentrated or its premiums too high.

Trigger Proposals are Unwise Politically

Second, the trigger proposal is bad politics. As already mentioned, 73% of voters, including 77% of independents, favor public plan choice.⁶ Progressive and labor groups with 30 million members—the core of the political coalition that worked so hard last fall to elect President Obama and our current Congress, support the public plan option as the key to health care reform.⁷ Twenty-eight senators whose votes will be key to passing health care reform, have introduced a sense of the Senate resolution supporting public plan choice. These supporters will see a trigger for what it is—an attempt to deny Americans public plan choice and probably to kill the idea. While the trigger option may gain minimal Republican support, it will alienate the core constituency for health care reform itself.

Experience Teaches Us that Trigger or Fallback Proposals Do Not Work

Third, trigger proposals ignore a long history of failed attempts to use various triggers and “fallback” options in health care before. There is little reason to believe that things would be different this time around. The remainder of this memo will focus on this sorry history.

HIPAA Individual Insurance Market Reforms

A first example of a failed experiment is the approach that Congress used in 1996 when it adopted the portability provisions of the Health Insurance Portability and Accountability Act.⁸ In enacting HIPAA, Congress invited the states to adopt reforms in the group insurance market (guaranteed issue and renewability and limits on pre-existing conditions exclusions) and individual insurance market (guaranteed issue and limits on pre-existing conditions clauses under some circumstances and guaranteed renewability). The Department of Health and Human Services was designated to ensure that states implemented each of these specific requirements on a state by state basis and to use its “fallback” authority to implement the requirements itself against insurers in states that failed substantially to implement any of the requirements.⁹ States were given alternative means of implementing the individual mandate, such as the creation of high risk pools.¹⁰

HIPAA's group market reforms were largely successful, but only because they did not significantly change the existing regulatory landscape. Most states had already implemented the small group market reforms. The states had been much less active in regulating the individual market and a number of states failed to implement the HIPAA reforms. Most states that did implement them chose one of the options permitted by HIPAA other than HIPAA's favored fallback position. Some states, however, simply did not comply. Some of these states notified HHS that they did not intend to comply and helped HHS to itself enforce the law. Others notified HHS that they would not comply at the very last minute before HHS enforcement was to begin and offered HHS no assistance with implementation. Finally, some states simply did not implement parts of the law but failed to communicate this to HHS, leaving HHS uncertain as to how to proceed.

Implementation of the law by HHS was slow and uneven.¹¹ Repeated GAO reports criticized HHS for its failure to enforce the law and implement the federal fallback requirements.¹² The HHS enforcement effort was understaffed and under-resourced, and regulatory enforcement guidance was slow in coming. HHS apparently made minimal efforts to monitor HIPAA compliance by government plans, which was an additional part of its responsibility. Eventually, after more than a decade, compliance was nominally achieved in all states. Testimony presented to the House Oversight Committee last year, however, revealed that compliance oversight at HHS has largely ceased.¹³ The four person office at HHS responsible for compliance relies solely on complaints, and has received only five complaints in the last five years. Blatant violations of the individual plan guaranteed renewal provisions widely reported in the press had been completely ignored by HHS.

The lesson to be gained from the HIPAA experience is that the implementation by a federal agency of a trigger mechanism on a state-by-state basis is delicate and difficult, particularly if the administration is not strongly committed to reform. In our federal system there is a powerful tradition of deference by the federal government to the states, particularly in the area of health and insurance regulation. It is difficult for a federal agency to determine that a state has failed to implement a federal law, and even more difficult for the agency to step in and take over when a state fails. The lesson here is that a trigger mechanism that would require a federal agency to take over insurance markets from state oversight on a state by state basis by implementing a public plan is unlikely to succeed.

“Fallback” Prescription Drug Plans

A second experience that we can learn from is the fallback provisions of the Medicare Modernization Act (MMA). The MMA implemented a program for providing coverage for outpatient drugs through private prescription drug plans and Medicare Advantage plans. These plans were heavily subsidized by the federal government, which funds three quarters of the premiums for most Medicare beneficiaries, higher percentages for lower income beneficiaries, and reinsurance for catastrophic benefits for all. PDP and MA plans are, however, private, largely profit-making plans. There was some concern when the legislation was adopted that

private “at risk” plans might not emerge in all regions of the country, thus provision was made in the bill for “limited risk” plans, where the federal government would assume even more of the risk, or “fallback” plans, where the federal government would assume all of the risk, to be implemented in regions where two or more PDP or MA plans failed to materialize.¹⁴ These were not, as has been reported erroneously, public plans, merely private plans where the government took on more of the risk.

It turned out that PDPs and MA plans did emerge in all regions of the country, and, as far as I know, the fallback option was never implemented. This does not, however, mean that the drug program has been a success. It has been plagued with marketing fraud, with situations where plans have changed formularies or drug charges in mid-year once beneficiaries are locked in, with high cost-sharing, and with a general failure to control the steady escalation of drug costs.¹⁵ The “trigger” of implementing fallback plans, however, is narrowly targeted on one metric—number of plans in a particular market—and thus was never implemented. The lesson to be learned is that if we once again adopt a trigger mechanism narrowly targeted on a single metric—such as plan market concentration—we may never get public plan choice despite the continued failure of private insurance plans to accomplish many other health care reform goals.

The MMA “Excess General Revenue Funding” Trigger

The third experience teaches a different lesson. In another part of the MMA, the then dominant Republican majority in Congress imposed a trigger mechanism that would force radical changes onto the Medicare program if its then current financing mechanism continued to “deteriorate,” as they believed that it would.¹⁶ The Trustees of the Medicare Trust Fund were directed to state in their annual report each year whether the general revenue funding of the Medicare program was expected to exceed 45% in each of the succeeding seven years. If such a report were made in two successive years, a “Medicare Funding Warning” would be initiated. The President was then required to submit to Congress within 15 days of the “Medicare Funding Warning” legislation to address the funding situation. Congress was supposed to address this legislation under special expedited procedures. The idea, obviously, was to force changes in the Medicare program that the then dominant Republicans desired but did not yet see as politically feasible.

In 2006, 2007, 2008, and again this year, the Trustees made the required determination of “excess general revenue Medicare funding.”¹⁷ In 2008, in response to the 2007 warning, President Bush submitted legislation to Congress to address the issue. By then, however, the Democrats had taken control of Congress, and the proposed legislation was ignored. In January of this year, a strengthened Democratic majority passed a joint resolution that the legislation would not apply to the 111th Congress.¹⁸ It is unlikely to ever be acted on if the Democrats remain in power.

The lesson is obvious. Congress cannot bind itself to take action in the future; it can always change its mind. “Trigger” legislation merely postpones final action on an issue. A public plan trigger would merely delay the implementation of a public plan, and if the

Republicans made gains in the mid-term elections, or if a Republican president was elected in 2012, the opportunity to achieve public plan choice would be lost. If, on the other hand, a public plan were begun now and achieved a large enrollment (and, as anticipated, real success in holding down cost and extending access), it would be much more difficult to eliminate the program if the political makeup of the country changed.

The Medicare Sustainable Growth Rate Formula

A similar lesson can be gained from the experience of Congress with the sustainable growth rate formula for Medicare physician payment. The basic idea of the formula was that increases in the prices that Medicare pays physicians for particular procedures should be keyed to the cost of services provided by physicians so that the increase in the total cost to Medicare of physician services (which is a function of price and volume) should be held to a sustainable level.¹⁹ The formula thus represents a “trigger” of sorts, increases in volume trigger decreases in price. The problem is, of course, that continuous, dramatic, increases in volume from year to year have demanded, if the formula is to be followed, dramatic decreases in price. The result has been Kabuki theater. Every year physicians come to Congress complaining that Medicare payments to physicians are being cut. Every year Congress intervenes to put the safety back on—to keep the trigger from being pulled. Currently physician Medicare payments are set to be cut 21% in 2010 because Congress continues to delay pulling the trigger. It is clear to everyone this will not happen. Once again, a trigger does not make a decision, it merely delays it, and special interest lobbying can be counted on to come back year after year to make certain a trigger is never pulled.

Finally, history counsels us to put no trust in promises of the health care industry that it will do better in the future. In the face of President Carter’s efforts in 1977 and 1978 to impose hospital cost controls, the hospital industry undertook its “voluntary effort” to control hospital cost increases. For one year, hospital cost increases were held in check. With the failure of Carter’s legislative efforts in 1979, however, hospital rates rose at rates far exceeding those promised by the voluntary effort, ultimately leading to Medicare prospective payment in 1982.²⁰ During the Clinton health care initiative of the early 1990s, again, health care cost growth slowed, only to increase again in the late 1990s when the treat of reform disappeared. Now is the time to finally implement meaningful reforms, not to fall one more time for meaningless promises.

History teaches us that trigger mechanisms are difficult to implement, too narrow in their focus, and can too easily be reversed if the political landscape changes. In 2008, America voted for change now. The private health insurance industry has had 75 years to bring access and cost control and has failed. Americans who are satisfied with private insurance plans should continue to have access to them. But the tens of millions of Americans for whom private insurance has failed need change now, not seven years from now.

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⁴ Lake Research Partners, Voter Support for a Public Health Insurance Plan (2009), available at <http://healthcareforamericanow.org/page/-/documents%20for%20download/Memo.HCAN.f3.012809.pdf>

⁵ See HCAN, *supra* note 2, at A87, A88. See also on state implementation of public plans, Timothy Jost, State Run Programs Are Not a Viable Option for Creating a Public Plan (2009), available from jostt@wlu.edu.

⁶ See Lake Research, *supra* note 4.

⁷ See Mike Hall, Coalition Set to Fight for Public Option in Health Care Reform (2009), available at <http://blog.aflcio.org/2009/06/02/coalition-set-to-fight-for-public-option-in-health-care-reform/>

⁸ 42 U.S.C. §§ 300gg, 300gg-11, 300gg-12, 300gg-41, 300gg-42

⁹ 42 U.S.C. § 300gg-61.

¹⁰ 42 U.S.C. § 300gg-41(c).

¹¹ See Karen Pollitz, et al., Early Experience with “New Federalism” in Health Insurance Regulation, *Health Aff.*, 19(4), July./Aug. 2000, at 7.

¹² See GAO, Private Health Insurance: Federal Role in Enforcing New Standards Continues to Evolve (GAO-01-652R, May 7, 2001); GAO, Implementation of HIPAA: Progress Slow in Enforcing Federal Standards in Nonconforming States (GAO/HEH-00-85, March 31, 2000); GAO, HCFA Cautious in Enforcing Federal HIPAA Standards in States Lacking Conforming Laws (GAO/HEHS-98-21R, July 22, 1998).

¹³ See House Committee on Oversight and Government Reform, Hearing on Business Practices in the Individual Insurance Market: Termination of Coverage, July 17, 2008, <http://oversight.house.gov/documents/20080818093759.pdf>

¹⁴ 42 U.S.C. §§ 1395w-103(a)(1), 1395w-111(f), (g).

¹⁵ See, e.g. Center for Medicare Advocacy, *It's Time for a Real Medicare Prescription Drug Plan*, (2009), available at http://www.medicareadvocacy.org/PartD_09_02.12.RealMedicareDrugBenefit.htm; Families USA, *Medicare Part D Drug Prices are Climbing Quickly* (2007), available at <http://www.familiesusa.org/assets/pdfs/medicare-part-d-drug-prices.PDF>.

¹⁶ Pub. L. 108-173, §§ 801 - 804, codified at 31 U.S.C. § 1105, 42 U.S.C. § 1395i, note.

¹⁷ See 2009 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds (2009), at 38-39.

¹⁸ H.R. 5, § 3(e).

¹⁹ 42 U.S.C. § 1395w-4(f).

²⁰ See Jonathan Oberlander, *The Political Life of Medicare* (University of Chicago Press, 2003), 121-22..