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Slouching Towards National Health Insurance: The New Health Care Politics

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Andrew B. Dunham††

The politics of health care are undergoing a quiet transformation. Relentless inflation in medical costs\(^1\) has prompted a succession of government cost control programs. Each has been widely evaluated for economic ramifications and medical effects; this paper is about their political consequences.

The most recent government attempt to control costs is a change in the way Medicare\(^2\) pays hospitals. The reform, known as Diagnosis-Related Groups (DRGs),\(^3\) was originally sponsored by bureaucrats in the Health Care Financing Administration (HCFA). DRGs passed through Congress at the legislative equivalent of the speed of light: unveiled in late Decem-

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2. Medicare is composed of two separate programs: Part A and Part B. Part A is a program of hospital insurance for persons over age 65 which pays for inpatient hospital care, stays in skilled nursing facilities, and home health services. The sole source of funds for Part A is a trust fund financed by a portion of the Social Security payroll tax; general federal revenues cannot be used to supplement the trust fund. Medicare Part B provides optional supplemental medical insurance which largely pays for physicians' services. Part B revenues are provided by premiums paid by the enrollees, and by general federal revenues. *Congressional Budget Office, Prospects for Medicare's Hospital Insurance Trust Fund: An Information Paper Prepared for Use by the Senate Special Committee on Aging, 98th Cong., 1st Sess.* 1 (1983). Though we focus on Medicare Part A, our analysis is relevant to Part B as well.

3. Briefly, a DRG system classifies each patient by his or her diagnosis into one of more than 400 categories, or diagnosis-related groups. Payment is based on a price set in advance for each group (DRG) rather than on the nature of the services provided or on the cost of treatment.
ber 1982,4 introduced as legislation in late January,5 passed in March,6 signed by the President in April;7 by October 1983, Medicare began to use the extraordinarily complex DRG system to pay hospitals.

The introduction of DRGs is a technical change in Medicare payment procedures that seems trivial compared to comprehensive reform proposals like universal national health insurance or price competition in a restructured health care marketplace. Furthermore, a review of the DRG system’s predecessor in New Jersey suggests that the new federal program will not sufficiently reduce inflation in Medicare costs and that it may bankrupt many hospitals. Yet, this scarcely noticed, swiftly legislated change in Medicare reimbursement may establish the political conditions for a national health system. Ronald Reagan may inadvertently produce what Harry Truman and Lyndon Johnson could not: a government-centered hospital system providing universal coverage.

This article suggests how. We begin with the politics of hospital rate regulation in New Jersey, analyzing its development from industry domination through a regulatory mechanism which resembles the current Medicare, to the state-centered system that uses DRGs to set prices for all payors in all hospitals. We then turn to the adoption of DRGs on the national level, applying the political lessons we drew from New Jersey’s experience and analyzing the consequences of DRGs on national health politics. Finally, we suggest that the traditional model of hospital regulation—powerful interest groups dominating a pliant government—should be replaced by a model in which the groups are dependent on largely autonomous government officials: the evolution of interest group liberalism into state autonomy.

I. New Jersey Discovers DRGs

In the late 1960’s, New Jersey faced dilemmas typical of the American health care economy: alarming inflation, inadequate care for the poor,
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pressure on the state Medicaid budget, insurers who were uneasy over rising hospital charges, and hospitals that were beginning to jockey for competitive advantage. Two powerful interests began to lobby the legislature for assistance.

Blue Cross, the largest private insurer in the state, was caught between politics and inflation. Its premiums were subject to the approval of the Insurance Commissioner, assuring media attention and public resistance to every increase. State officials kept Blue Cross premiums down while rising hospital prices forced its payments up. By 1969 it reported a $13 million deficit. Blue Cross sought legislative relief, arguing that if government were to restrict its income, government should also limit its payments; regulated premiums should be matched by regulated hospital rates.

The hospitals, led by the New Jersey Hospital Association, vigorously resisted government interference with their billing. Like health care providers throughout the United States, they had long insisted on their autonomy. However, in order to mollify Blue Cross, stave off government intervention, and relieve individual hospitals from billing disputes with Blue Cross, the Hospital Association established a voluntary review of hospital budgets. Predictably, a non-binding review directed by hospital officials did not appreciably reduce the inflation in hospital costs.

The hospitals had their own political agenda: They sought certificate of need legislation. This program seeks to limit overall health care costs by

full citation here. We also provide no specific citation for certain events described more thoroughly in POLITICS OF INNOVATION.


10. Each Blue Cross plan is a private health insurer created by special state enabling legislation, which typically exempts the plan from the general insurance laws of the state (including the obligation to maintain the reserve required of commercial insurers) and designates the plan a charitable organization. Blue Cross plans are exempt from federal income taxation. I.R.C. § 501(c)(4) (1984). Such benefits may be based on an image of social reform and utility that does not seem to correspond to the actual characteristics of Blue Cross plans. S. LAW, BLUE CROSS: WHAT WENT WRONG? 9 (1976).

11. The relative contributions of payors to hospital care in New Jersey were recently estimated as: Medicare 40%; Blue Cross 22%; Medicaid 9%; commercial insurers 15%; others (including self-funded groups, self-paying patients, and health maintenance organizations (HMOs)) 14%. HEALTH CARE FINANCING ADMINISTRATION, PUB NO. 03170, DIAGNOSIS-RELATED GROUPS: THE EFFECT IN NEW JERSEY, THE POTENTIAL FOR THE NATION 135 (1984) (Pierce, The Impact of DRGs on Payers) [hereinafter cited as DIAGNOSIS-RELATED GROUPS].


13. DRGs and the Hospitals, supra note 8, at 75.


15. Certificate of need laws prohibit construction or expansion of new health care facilities, or in

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prohibiting the construction of unnecessary health care facilities. The New Jersey hospitals seized on certificate of need as a form of franchise monopoly which could protect them from the competition of new or expanding institutions. They were anxious for the authority to proscribe new facilities but, as with rate review, they sought to regulate themselves rather than relinquish authority to the government.

In 1971, after three years of negotiation and compromise, legislation gave hospitals their certificate of need program—nominally administered by the government—and Blue Cross its rate regulation. The law empowered the Commissioners of Health and Insurance to set the rates that Blue Cross and Medicaid paid for hospital services. In practice, however, the Hospital Association simply continued to operate its own review, now cloaked in the legitimacy of public law. The commissioners relied entirely on the recommendations of Hospital Association reviewers and routinely accepted their findings.

Both the legislative process and its outcome fit traditional models of political behavior. The most interested and influential private parties pressed their interests before the legislature, bargained with each other, received a small benefit, and appeared to lose nothing significant. The result seemed to be an incremental change in policy. Once the bargain was struck, public authority was ceded to the hospital industry itself. Hospital officials dominated both planning and rate setting. Public power was simply used to enforce private choices. Regulation was “acquired by the industry and . . . operated primarily for its benefit.”

However, despite appearances, the politics of regulation were changing in a profound fashion. The new law gave the state the power to inspect and judge individual budget lines in each hospital. This power was immediately returned to the hospital industry, but that merely obscured the fact
that the Department of Health now had formal authority over what hospitals did and how efficiently they did it. The state had quietly penetrated the private world of the New Jersey hospitals.

Three years later, in 1974, a public interest group reported the shocking news: The Hospital Association was conducting government rate reviews—the regulated were regulating themselves. In the atmosphere immediately following Watergate, the report—*Bureaucratic Malpractice*—set off a sensation. Newly elected Governor Brendan Byrne made it his health policy guide. His Commissioner of Health, Joanne Finley, sat through her confirmation hearings with the exposé conspicuous at her side. Following one recommendation in the report, the Department of Health took control of hospital rate review, though it had to borrow the forms from the Hospital Association to do so.

State bureaucrats now had a mechanism with which to try to contain Blue Cross and Medicaid costs. They began to employ it immediately, proposing only a 2.5% increase in 1975 hospital rates. In contrast, hospital-administered rate review had permitted increases averaging more than ten percent. After considerable conflict with angry hospital administrators, state officials relented somewhat, approving rate increases that averaged seven percent—still a low figure by prior standards. The New Jersey hospitals had passed out of loose, industry-dominated regulation into stringent state control over part of the system (Blue Cross and Medicaid). In Section II we will describe a similar evolution in federal health care regulation, which is now seeking to limit hospital costs by controlling just one payor, Medicare.

In New Jersey, the consequences of regulating some payors and not others were swift and dramatic. Partial regulation produced partial results and unanticipated difficulties. Blue Cross and Medicaid benefited; their costs increased less rapidly. However, their gain was achieved at the expense of others. Most hospitals maintained their income by simply shifting costs to the commercial payors. The results were widely compared to squeezing one end of a balloon; all the air merely rushes to the other end. The tighter the controls on Blue Cross and Medicaid, the more the other insurers paid. Within five years, the commercial insurers were paying hospitals roughly thirty percent more than Blue Cross. The state was also protecting its Medicaid Program at the expense of the private insur-

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ers and patients without insurance. The commercial insurers began to call for change.

Urban hospitals found themselves in growing financial trouble due to their mix of patients. They treated a disproportionate number of patients on Blue Cross and Medicaid, which paid less than the commercial insurers. In addition, many of their other patients paid none or only part of their bills. Twenty percent of urban hospital patients had no health insurance, and many more had inadequate coverage. The hospitals had traditionally apportioned these bad debts among the other payors. However, the patients with private coverage lived in the suburbs, and Blue Cross and Medicaid payments were now tightly controlled. The urban hospitals were unable to shift their losses and bad debts; they had no one to shift them to. As many as fifteen large hospitals appeared to be near bankruptcy. The only hospital that remained in Paterson, for instance, reported that it could not afford new mops; one in Newark claimed that it could not make its Social Security contributions.

Even hospitals which could maintain their revenues found the new system burdensome. It was highly bureaucratic and inefficient, involving long rounds of negotiation between each hospital and the Department of Health. As late as May 1979, more than a third of the hospitals had not received their 1978 billing rates for Medicaid and Blue Cross patients, and rate appeals were still pending from as early as 1975, the first year of government-managed rate review. The Hospital Association responded by filing a series of lawsuits and publishing pamphlets with titles such as *Son of Gobbledygook*.

In short, the new system of regulation was widely unpopular, marked by highly visible losers and few winners. Some hospitals approached bankruptcy, commercial health insurers suffered a severe competitive disadvantage, and, for all the difficulties, medical inflation persisted because of cost shifting. Despite the widespread dissatisfaction, none of the affected interests devised a solution. In the past, troubled private organizations had often designed public programs to assist themselves. Blue Cross had first put rate review on the public agenda. Now that the consequences

27. Id.
29. CASE STUDY, supra note 18, at 41.
30. See N.J.H.A. Political Strategy Committee, Historical Perspective of [sic] Hospital Rate-Setting in New Jersey (1975) (hospital industry's description of pending and recent litigation) (on file with the Yale Journal on Regulation).
were proving difficult for a wide range of interests, many called for relief, but none put forward a proposal to secure it.

Politically viable solutions had become difficult to find. It was now clear that the fates of numerous interests were linked together, that assisting one was apt to worsen conditions for others. For instance, regulatory relief for Blue Cross had come at the expense of other insurance companies, inner city hospitals, and patients who paid their bills out of pocket. Adjustments that favored some of these interests were, in turn, likely to harm others. Extending the benefits of rate regulation to the commercial insurers would set back both the hospitals and Blue Cross; paying for indigent care would benefit hospitals but increase Medicaid costs. Many of the affected interests were well-organized and conscious of the threats posed by the others. The political setting made it difficult for one interest group to sponsor a solution that did not alarm other interests.

This unstable policy environment presented an opportunity for governmental entrepreneurs to restructure the hospital system. The Department of Health sought to extend its rate-setting authority to all payors in order to prevent cost shifting and control overall hospital cost inflation.31

In addition, the Department proposed a bold change in rate-setting methods. In the past, most payors had paid hospitals the “usual, customary and reasonable” charges for whatever treatment the hospital provided. This payment method created a perverse financial incentive to increase the cost of health care: because hospitals were paid for the care they actually delivered, they made more money by providing more services. Because rate-setting by the state was also based on the services provided by the hospital,32 rate regulation had not solved the problem. In addition, in setting per diem rates for individual hospitals, the existing regulation had resulted in long negotiations, delays, and arbitrary rates.

The Department of Health moved to solve these problems by proposing legislation that pegged payments in advance to the type of case treated rather than the number of days spent in the hospital.33 The reimbursement mechanism it proposed was based on DRGs. Put simply, DRGs classify all illnesses into 467 categories or “diagnostic groups.” A single price is set for each DRG, based on the average hospital bill for patients in that DRG among roughly similar hospitals. Hospitals receive only a

31. Hospital inflation in New Jersey was 11.7% in 1977. Medicare Hospital Prospective Payment System: Hearings Before the Subcomm. on Health of the House Comm. on Ways and Means, 98th Cong., 1st Sess. 112 (1983) (statement of Charles Pierce, Jr., Deputy Commissioner, New Jersey State Dept. of Health) [hereinafter cited as Hearings].
32. For a description of the complex rate-setting system then in use in New Jersey, known as SHARE, see POLITICS OF INNOVATION, supra note 8, at 26-29.
33. Hearings, supra note 1, at 95 (statement of Dorothy Powers, Chairman, New Jersey Hospital Rate Setting Commission).
fixed price per patient, set by the DRG appropriate for that patient’s diagnosis. Payment is not affected by what services are actually provided or what they cost the hospital. Hospitals that deliver care for less than the DRG amount keep the difference. Those with costs above the price are forced to seek economies—fewer tests, shorter hospital stays, better management—or lose money. In theory, then, hospitals are driven to become more efficient by cutting their costs.

The proposal would give state bureaucrats a powerful role in hospital finance. They would set the prices charged for all patients in all hospitals. Hospital income would be completely controlled by the state. Even hospital endowments—long an emblem of success and community support—would be swallowed into a state fund.

The hospitals vociferously opposed this threat to their autonomy and to their cost-shifting escape valve. They had found government regulation of part of their income burdensome and they lobbied hard to block its extension. The hospitals were assisted by Blue Cross, which sought to maintain its advantage over the unregulated insurers. New Jersey legislators, facing a controversial proposal that was vigorously opposed by the entire hospital industry as well as Blue Cross, did not report the bill out of committee.

Although the bill was defeated in New Jersey, it caught the attention of federal officials in Washington. HCFA, which oversees Medicare and Medicaid, had been seeking state experiments in controlling hospital costs. It granted the New Jersey Department of Health $3 million with which to design an all-payor DRG program. In the meantime, the difficulties of partial regulation as well as the demands for reform persisted.

Two years later, the Department of Health tried again. This time Department officials added a provision to the bill designed to gain political support: the cost of patients who did not fully pay their bills—uncompensated care—would be split among all payors and factored into the rates. For the first time, treating an uninsured patient would pay a hospital as much as treating one covered by a commercial carrier.

The new proposal significantly altered the political coalitions. It was an unambiguous reprieve for the urban hospitals, which embraced the new plan. Their administrators—the most outspoken were extremely articulate nuns—gave gripping legislative testimony. Motivated by the cost-

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34. See S. 1454, 196th Leg., 1st Sess. (1976) (on file with the Yale Journal on Regulation); CASE STUDY, supra note 18, at 47.
35. See CASE STUDY, supra note 18, at 47.
38. See Where Fixed Hospital Rates are Easing the Pain, BUS. WK., July 25, 1983, at 44, 48.
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shifting, the private insurance companies joined the coalition, their actuarial tables forming a somber counterpoint to the dramatic stories about ghetto hospitals. HCFA provided further support by promising to waive the normal Medicare payment procedure so that state officials could set rates for all payors, including Medicare. Crucially, the Medicare waiver was expected to be worth an extra $60 million in federal funds, since Medicare would assume a share of the uncompensated care.9 Opponents of the proposal were put in the politically difficult position of arguing against added federal funds for urban hospitals that unquestionably needed assistance in providing health care for the poor.

Many hospital administrators continued to oppose this government encroachment on their institutions. However, opposing the proposed legislation would have split the Hospital Association.40 A united hospital industry had defeated a similar bill; a divided one could only bargain over its terms.41 Blue Cross officials also understood the new political realities and, extracting what they could, acquiesced.42

The law passed easily.43 A system in which DRGs set hospital prices for all payors would be implemented in three phases between 1980 and 1982.44 Hospitals anxious to participate were included in the first group. The tactical consequence was a fresh opportunity for political opponents. The most adamant advocates of the all-payer DRG system were included immediately; others were then free to oppose further implementation.

The Hospital Association returned to the legislature arguing that so radical an innovation should proceed more slowly. It proposed suspending

39. It was expected that Medicare and Medicaid would pay shares of the cost of uncompensated care proportionate to their overall shares of hospital reimbursement. The New Jersey Commissioner of Health noted in 1983 that Medicare was in fact bearing $65 million of the $170 million uncompensated care burden during that year. New Jersey's Hospital Reimbursement System: Hearing Before the House Select Comm. on Aging, 98th Cong., 1st Sess. 5 (1983) (statement of J. Richard Goldstein, M.D., Commissioner, New Jersey Dept. of Health) [hereinafter cited as Hearing].

40. See CASE STUDY, supra note 18, at 58-59.

41. See id. at 59. For example, the Hospital Association succeeded in dissuading the Department of Health from expropriating hospital endowments.


implementation after the first year and waiting until the system could be appraised. It also charged that the Department of Health was exceeding its statutory authority: Neither the legislation nor the testimony that preceded it had ever mentioned DRGs. Though the Department of Health, funded by HCFA, had been preparing a DRG system for two years, the term did not appear in the tersely worded bill that the Department had submitted. Even the general notion of paying hospitals on the basis of the cases they treated was mentioned only elliptically.46

The legislators were annoyed by the controversy. They had not heard of DRGs and had only a vague understanding of the bill they had passed. Legislative hearings were scheduled. Before they could be held, however, a letter arrived from HCFA: the federal government wanted a DRG experiment.46 Without it, HCFA would not grant a Medicare waiver; New Jersey would lose its estimated $60 million, the opportunity to set rates for all payors, and its plan for covering uncompensated care. Extraordinarily, a coalition of federal and state bureaucrats were forbidding the New Jersey Legislature from tampering with the implementation of a law that it had passed. The legislature meekly complied. One branch, the Assembly, passed a resolution merely condemning the implementation process. The legislators had neither the political incentives nor the technical expertise to seek alternatives to the all-payer DRG system that was already partly in place.

The Assembly resolution symbolizes a lesson that DRG opponents swiftly learned: Once the program began to operate, it became difficult for interest groups to shape policy.47 The free flow of legislative politics, dominated by elected representatives who prefer compromise to conflict, had ended. The traditional pattern of bureaucratic politics, in which industry dominates administrators, never emerged. Instead, the industry found itself confronting government officials intent on controlling costs.


46. Letter from Stephen Pelovitz, HCFA Project Officer, to Bruce Vladeck, Assistant Commissioner of Health in New Jersey (July 11, 1978), described in POLITICS OF INNOVATION, supra note 8, at 80-81.

47. Although group lobbying was no longer effective, some commentators argue that individual hospitals in New Jersey still were able to effect favorable and unique DRG rates for themselves. Weiner, Greene & Sapolsky, The Theory and Practice of DRG Implementation (Oct. 1984) (unpublished draft on file with the Yale Journal on Regulation). These authors believe that the same pressures for individualization of DRG rates for specific hospitals will exist in the national Medicare DRG system recently enacted, despite its present structure which permits few individualizing adjustments. Id.
For physicians the new program was a sharp departure. Despite all the worry over inflation, medical judgment had remained largely beyond the reach of public policy. Now DRGs denied hospitals full reimbursement when physicians prescribed more services than their colleagues. Hospital administrators knew exactly which physicians were losing money for their institutions. The extra test or the additional hospital day was no longer a simple matter of individual professional judgment; hospitals would now make more by pressuring their physicians to do less. State officials were using their new role in hospital finance to reshape the patterns of medical practice.

The hospitals of New Jersey were suddenly thrust into a system dominated by bureaucrats working for the Department of Health. One incident illustrates the point. When DRGs were implemented, officials were immediately confronted with a public relations debacle over an anomalous case: A finger broken in a softball game led to a $6,000 bill for one night in a hospital. The incident received widespread publicity. The media had been hard-pressed to explain the all-payor DRG system, but it was simple to understand a government cost control effort that resulted in $6,000 fingers. In fact, a pin had been inserted in a joint, placing the patient in a DRG dominated by costly hip operations. The incident may have comforted opponents of the program, but in reality it only demonstrated the extent of the state’s new authority. Government officials made adjustments while hospital officials, powerless and embarrassed by the publicity, could only exhort them to act swiftly.

The New Jersey hospital system had evolved from one dominated by providers and marked by indifferent state efforts to control costs, to one in which the state exerted stringent regulation over part of the system. That situation proved enormously unstable. Marked by insolvent urban hospitals, widespread cost shifting, and continued inflation, it lasted less than five years. In the following section we argue that the federal system has now reached a very similar point. In New Jersey, partial regulation quickly created the political conditions that led to a government-dominated hospital system. Is the national experience with partial regulation likely to be any different than New Jersey’s? In Section II we argue that the problems, the politics, and the policy outcomes are likely to be very similar.

49. I.e., state regulation of Blue Cross and Medicaid reimbursement rates from 1974 to 1978.
II. DRGs and the Politics of Medicare

The passage and implementation of Medicare in 1965 fit the traditional pattern of American medical politics: industry domination. The law begins by forbidding government intrusion into the practice of medicine—an affirmation of professional autonomy that precedes any statement of entitlement or broader purpose. The implementation of the Act was even more clearly dominated by the industry. Reimbursement standards were loose and extremely generous; Medicare paid the “current costs” of services, including “all necessary and proper expenses.” Partly as a consequence, Medicare outlays soared, exacerbating a general medical inflation.

The same political dynamic that created the problem confounded its solution. A succession of strategies designed to contain costs was unsuccessful, at least in part because each was dominated by health care providers. Voluntary health planning agencies, established in 1966, were directed largely by local hospital administrators and proved ineffectual.

52. When Medicare was first enacted, it paid hospitals (under Part A) the “reasonable cost” of their services. Health Insurance for the Aged Act, Pub. L. No. 89-97, sec. 102(a), § 1314(b), 79 Stat. 286 (1965) (codified as amended at 42 U.S.C. § 1395(b)(1) (1982)). Regulations soon defined “reasonable cost” as “current costs” including “all necessary and proper expenses.” 42 C.F.R. § 405.402 (1966). In 1972, Congress changed hospital reimbursement to the lesser of “reasonable cost” and “customary charges,” and defined “reasonable cost” as “the cost actually incurred, excluding . . . any part . . . found to be unnecessary in the efficient delivery of needed health services . . . .” Social Security Amendments of 1972, Pub. L. No. 92-603, §§ 223(a), 233(a), 86 Stat. 1329, 1393, 1411 (codified at 42 U.S.C. §§ 1395f(b)(1), 1395x(v)(1)(A) (1982)).
53. Medicare reimbursement was at first purely retrospective: payments were for actual costs incurred. See supra note 52. The Social Security Amendments of 1972 authorized the Secretary of HEW to set prospective limits on reimbursement of such costs, based on “estimates of the costs necessary in the efficient delivery of needed health services . . . .” Pub. L. No. 92-603, § 223(b), 86 Stat. 1329, 1393, (codified at 42 U.S.C. § 1395x(v)(1)(A) (1982)). Since 1974 the Secretary set prospective limits annually, allowing adjustments for different types of hospitals. When a hospital’s routine per diem charges for its Medicare patients were above the limit, the excess was not reimbursed; however, if the charges fell below the limit, the hospital was reimbursed only in the amount of the charges. “Section 223” limits thus offered no incentive to cut costs below the reimbursement limit. Because the limit was set at a certain percentage over the mean costs of similar hospitals, the result was to drive up the mean cost of hospital care. See Lundy, Hospital Cost Containment 2, 4-5 (Cong. Research Serv., Issue Brief No. IB82072, Jan. 10, 1983), reprinted in [3 1983 Transfer Binder] BIOETHICS REP. (UPA), at Literature 176, 184.
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Six years later, Congress established review boards designed to identify and limit excessive use of Medicare services. However, deferring to medical power and expertise, Congress vested judgments about appropriate use in physician boards which were generally reluctant to criticize colleagues. The certificate of need agencies, mandated nationally in 1974, were given highly circumscribed authority and often served the interests of local providers. In 1979, Congress turned aside the Carter Administration's cost containment proposal partly in deference to the industry's "Voluntary Effort" at controlling health care costs.

A. The Adoption of DRGs by Medicare

In the absence of more powerful measures, costs continued to rise. Between 1967 and 1982, Medicare expenditures for inpatient hospital services grew at an average annual rate of 19.2%. In the four years that followed the industry's "Voluntary Effort," Medicare and Medicaid outlays grew from $51 billion to $83 billion. Even with the stringent limits mandated by Congress in 1982, Medicare threatened to bankrupt its trust fund by 1988 and exacerbate the federal deficit. The mounting costs generated strong political pressures for a solution.

NEWS 7842, 7879.


58. See P. STARR, supra note 14, at 400-04; Turner, HEW Begins Medical Review; AMA, Hospitals Mount Opposition, NAT. J. REP., Jan. 19, 1974, at 90.


60. In December 1977, a "Voluntary Effort" to control health care cost increases was launched by a number of medical professional organizations, including the American Hospital Association, the American Medical Association, the Blue Cross/Blue Shield Associations, the Federation of American Hospitals, the Health Industry Manufacturers Association, the Health Insurance Association of America, the National Association of Counties, a consumer affairs organization and a business representative. Lundy, supra note 53, at 8. In place of the Carter Administration's hospital cost control bill, H.R. 2626, 96th Cong., 1st Sess. (1979), which would have established mandatory cost controls if certain voluntary limits were exceeded, the House of Representatives substituted and passed a bill which merely would have established a commission to monitor and encourage the "Voluntary Effort." H.R. 5635, 96th Cong., 1st Sess., 125 CONG. REC. 32,716, 32,750, 32,752 (1979) (not enacted into law).

61. See supra note 1.


65. CONGRESSIONAL BUDGET OFFICE, CHANGING THE STRUCTURE OF MEDICARE BENEFITS: ISSUES AND OPTIONS, at xi-xii, 66 (1983); Controlling Health Care Costs: State, Local, and Private
In September 1982, Congress ordered the Department of Health and Human Services to propose a reform in Medicare reimbursement.66 HCFA (which is within the Department of Health and Human Services) had been supporting research, development, demonstrations, and evaluations in cost control since the early 1970's.67 The New Jersey DRG system was one of its demonstration projects. In December 1982, HCFA proposed to Congress a nationwide DRG system for Medicare.68 Congress, anxious for a remedy, quickly approved the plan.69

Federal officials finally had an effective mechanism with which to try to control Medicare costs. To that end, they could use DRGs in two analytically separate ways. By providing a fixed rate, set in advance, DRGs may promote efficiency in the long run by giving hospitals an incentive to deliver less expensive care. However, DRGs can also be used to reduce program costs immediately; officials can employ them as a price control device, directly reducing the amount Medicare pays for hospital services. Like the New Jersey Department of Health in 1975, federal officials immediately began to use their rate-setting mechanism to press down hospital prices. Originally, the statute mandated that 1985 DRG prices would rise by the inflation rate in the “market basket” of goods and services that hospitals buy, plus an additional one percent for advances in technology.70 Before Congress took action, the Reagan Administration reversed itself and pressed for elimination of the one percent. In the Deficit Reduction Act of 1984, Congress reduced the technology allowance to 0.25%.71

That reduction was just the start of the squeeze. The Secretary of Health and Human Services announced that the 1985 rise in Medicare DRG prices would be 5.6%72—extremely low by past standards. In the 1986 budget, the Reagan Administration is pressing still further, propos-

67. Lundy, supra note 53, at 6-7. See Esposito, Medicare's Prospective Payment Demonstration Program, in DIAGNOSIS-RELATED GROUPS, supra note 11, at 18, 19.
72. 49 Fed. Reg. 27,422, 27,433 (1984) (rate increase held to 5.6% despite estimated “market basket plus one” of 7.4%, because of the budget neutrality requirement of § 1886(e)(1) of the Social Security Act, and “other adjustments”).
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...ing to freeze DRG prices in 1986 at their 1985 levels. What is striking is how quickly federal officials began squeezing DRG payments to hospitals.

Industry resistance may occasionally moderate cuts in Medicare prices. For instance, the Administration relented somewhat from the prices that it had proposed for 1985, in part because it was facing an election. However, the political setting has changed. Hospital officials must now contend with HCFA over prices that they once set themselves with only loose federal supervision. Rate determinations are being made in bureaucratic arenas by administrators who are more concerned with inflation and deficits than with pacifying medical constituents.

Nevertheless, there has been no broad antipathy to bureaucrats, complex regulations, or the squeeze on Medicare rates. Rather, the new system is invoking the rhetoric and symbols of market competition. Forbes introduced the stringent regulation of Medicare prices with a headline that trumpeted, "[H]ospitals have finally been pushed off the dole and into competition. . . . Some may not survive. . . ."

The new Medicare is designed in a way that makes marketplace rhetoric plausible. Since payments for each DRG are based on the industry's average costs, hospitals are pitted in a form of indirect competition with one another. In theory, the more efficient hospitals will provide care for less than the industry average and turn a profit on their Medicare patients.

B. The Instability of Medicare DRGs

Partly because the symbols of market competition make DRG price regulation widely acceptable, officials have been able to seek short-term Medicare cost savings by limiting reimbursement levels. However, attempting to reduce costs in this manner inevitably establishes the conditions that will undermine the Medicare DRG system: insolvency of urban hospitals, cost shifting, and ultimately persistent inflation.

Precisely the same dynamic that threatened to crush the urban hospitals in New Jersey is now set into motion across the United States. Even before DRGs, Medicare payments did not fully cover hospitals' costs.75


74. Teitelman, Taking the Cure, FORBES, June 4, 1984, at 82. Interestingly, the free market rhetoric has not abated in the face of the extensive price controls involved in a DRG system. It would seem that DRGs are not generally understood to be price controls. In a recent survey of various lay and professional groups, health care price controls were deemed unacceptable but DRGs were widely approved. Hearing, supra note 65, at 10, 15, 20 (statement of Humphrey Taylor, President, Louis Harris & Associates, Inc.).

75. Hearings, supra note 31, at 161 (statement of Kevin P. Rowland, Continental Association of
The present Medicare squeeze will worsen the disparity. Inner city and rural hospitals with many Medicare patients will experience large losses on these patients. Typically, these hospitals also have a large number of indigent patients. As in New Jersey, they cannot shift their uncompensated costs; they do not have enough paying customers to shift them to.

Many of these hospitals will be pushed toward ruin. While DRGs ostensibly thrust hospitals into competition, the real world of DRGs is a good deal more Calvinist—redemption and perdition turn on a number of factors entirely beyond a hospital’s control. The competition of the new Medicare DRGs will be the same competition that was induced by partial rate regulation in New Jersey: the competition for the right mix of patients. Winning and losing will be less a consequence of efficiency than of who—if anyone—is paying the bills.

Hospitals with fewer Medicare recipients will have the same incentive as their New Jersey predecessors did in a partially regulated system: to shift their excess costs to the other payors. Prices for the unregulated payors will swiftly balloon. The differential between regulated and unregulated payors in New Jersey reached thirty percent in six years; the same forces are now at work across the nation. Congress is already hearing the balloon metaphors.


77. “Competition” for self-financing patients may take many forms: simply refusing to admit uninsured indigents, Medicare patients and Medicaid patients; closing emergency rooms (the sole source of treatment for many indigents); relocating to wealthier areas; establishing ambulatory care branches and merging with hospitals in such areas; refusing to provide less lucrative services and providing instead either services more lucrative in themselves or more likely to attract wealthier patients (e.g., “wellness centers”). Hospitals have been “dumping” poor patients not only by refusing to admit them, but by transferring them or refusing them treatment even when such actions result in serious injury or death. Wall St. J., Mar. 8, 1985, at 33, col. 4. Such incidents will not disappear without structural reform; the number of hospitals offering free care will continue to dwindle as the ranks of the uninsured indigents swell. Id.


79. Medicare reimbursement has already resulted in cost shifting of $6 billion in 1982. Hearings, supra note 31, at 161 (statement of Kevin P. Rowland, Continental Association of Resolute Employers); Hearings, supra note 1, at 212 (statement of John F. Troy, Health Insurance Association of America) (cost shifting equalled $5.8 billion in 1982); see also Ginsburg & Sloan, Hospital Cost Shifting, 310 NEW ENG. J. MED. 893, 893 (1984) (cost shifting in 1981 estimated by the Health Insurance Association of America to be $4.8 billion); J. MEYER, PASSING THE HEALTH CARE BUCK: WHO PAYS THE HIDDEN COST? 7 (1983) (independent researchers found cost shifting in 1981 to be about $3.8 billion). Further Medicare budget tightening will result in more cost shifting. Hearings, supra note 1, at 212 (statement of John F. Troy, Health Insurance Association of America).

80. See supra p. 267; see, e.g., Hearing, supra note 65, at 1 (statement of Sen. John Heinz, Chairman); Hearings, supra note 1, at 213 (statement of John F. Troy, Health Insurance Association of America).
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for a government attempt to control its program costs while failing to address the underlying problem of general medical inflation.

Commercial insurers will pass on the costs, largely to corporations which pay insurance premiums for their employees. Corporations and labor unions are already troubled by rising health care costs;\(^8\) soaring rates will substantially increase their concern. Many will demand action.\(^8\) Some may seek other ways to reduce the cost of health benefits, such as reducing coverage or self-insuring. These moves, in turn, will increase the alarm of the hospitals and commercial insurers, respectively.

With many costs simply shifted, medical inflation will continue. Although DRGs reduce the incentives to be profligate with Medicare funds, there is no change in the hospitals' incentives regarding other payors. To the extent that hospitals continue to buy excessive and expensive goods and services for their other patients, the "market basket" cost of hospital care will continue to rise and Medicare will remain under the steady pressure of rising hospital costs.\(^8\) In addition, although DRGs give government officials considerable leverage over price, they provide no control over volume. As the population ages and intensity of treatment for the elderly increases, Medicare costs will continue to rise.\(^8\) Even with DRGs, Medicare is still projected to be the fastest growing major federal domestic program.\(^8\)

In short, Medicare DRGs are likely to be devastating for hospitals that treat mainly Medicare beneficiaries and patients who cannot fully pay their bills. The Medicare DRG program will threaten the commercial health insurers and constitute a growing problem to the corporations that pay the insurance premiums. For all the problems it creates, the program will prove insufficient to balance the Medicare trust fund or to ease the

81. See, e.g., Kempner, Employer Commitment Seen in Controlling Benefit Costs, HOSPITALS, May 1, 1984, at 18. See generally Hearing, supra note 65, at 97-103 (statement of Deborah Chollet, Employee Benefit Research Institute) (describing employers' efforts to control health care costs).


83. Currently, DRG prices are required to rise by the same percentage as the "market basket" of goods that hospitals buy. Social Security Act § 1886(b)(3)(B), 42 U.S.C. § 1395(b)(3)(B) (1982). However, the link to market basket prices is not likely to survive budget cutting efforts for long; apparently, the Reagan Administration has already effectively abandoned it. See supra note 72 and text accompanying note 73.

84. See CONGRESSIONAL BUDGET OFFICE, supra note 65, at 5 (aging of population plus greater intensity of medical care for elderly will increase Medicare program costs 2.2% annually).

federal deficit. The present DRG system will generate pressure for its reform.

C. The New Politics of National Health Insurance

The present DRG system is unstable: Both the number of politically powerful losers and the New Jersey precedent suggest that a wide array of interests will press Congress for action. This coalition will include influential constituents of even a conservative Republican Administration, most notably large business corporations. The public sector is likely to join private interests in seeking comprehensive reform: state governments troubled by Medicaid costs, local officials alarmed about the survival of urban hospitals, HCFA administrators concerned about Medicare costs (and not averse to enhancing their role and power), and a Congress and President concerned about the federal deficit. Inaction will exacerbate the difficulties and demands for reform.

When a future Congress or blue-ribbon Presidential Commission confronts these problems, where can it turn? There will continue to be few plausible alternatives, even fewer politically expedient ones. However, there may now be a health policy option that conforms to the peculiar requirements of American political reform. The most likely reform is what occurred in New Jersey: an extension of DRGs to cover all payors, factoring into the rates the cost of uncompensated care. Whatever the substantive merits of the program, its politics will make it compelling. It can plausibly promise two desirable outcomes that will generate the political support necessary for its adoption: medical cost control and financial relief for hospitals that serve the poor.

Setting uniform prices for all payors would eliminate the cost shifting that undermines current efforts to control medical inflation. In addition, the incentives for efficiency built into a prospective DRG system would apply fully to treatment of all patients, not just publicly supported ones. Public officials would wield a type of monopsony power, balancing the traditional power of the medical industry over both prices and demand for service. Regulators would finally have a mechanism with which to constrain inflation.

In contrast to most quick solutions offered amidst cost crises, an all-payor DRG system which factors in the cost of uncompensated care combines an effort to reduce inflation with assistance to the institutions that serve the poor. Routinely reimbursing hospitals for bad debts and charity

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care would have sweeping ramifications. For the first time, hospitals throughout the United States would be paid equally for all patients, regardless of their wealth or insurance. For the unsponsored poor and the hospitals that treat them, this provision would roughly approximate a universal national health insurance.

Unlike previous public health insurance schemes, this one would not look like welfare or socialized medicine. In fact, it would not directly help the poor, only the hospitals that serve them—a politically crucial difference which is likely to diffuse challenges grounded in antipathy to welfare. More important, it is part of a program that is widely perceived not as welfare but as the symbolic reverse: an effort to thrust free market competition into the hospital sector. Largely for these reasons, the reform occurred in New Jersey with little reference to poverty and none to welfare. A program that appears to seek cost control through competition is not apt to trigger the politics of redistribution—the broad coalitions that generally mobilize to dispute welfare proposals in the United States.

In further contrast to traditional welfare programs, this program requires little visible extension of public taxes. An all-payor DRG system imposes a hidden tax, divided among all insurance premiums, private and public, to pay hospitals for serving the uninsured. An occasional academician may argue that indirect taxes are taxes all the same, but the politics that attend them are radically different. The broad antipathy to new taxes is not aroused.

Equally important, both the extension to all payors and the inclusion of the cost of uncompensated care could be introduced without legislating sweeping new health plans. American politics is far better geared for small adjustments to existing programs than for large programmatic transformations. Extending DRGs would have precisely that unexciting, incremental, technical look. It merely extends a method of computing insurance payments that is already in use for more than a third of hospital revenue. Past reform proposals have failed in part because of their sweeping non-incremental appearance. “Removing the financial barrier to medicine”—watchwords of the New Deal and Great Society—connotes


88. See Lowi, American Business, Public Policy, Case-Studies, and Political Theory, 16 WORLD POL. 677 (1964).

welfare and big government.\textsuperscript{90} Seeking genuine markets in the hospital sector employs the correct political symbols but would require bold new forms of organizational behavior and ambitious, uncertain, long-term changes throughout the medical economy.\textsuperscript{91} By contrast, extending DRGs to all payors and including the cost of uncompensated care would sound less like a radical new program than like a technical adjustment to an existing one. It differs from past reform proposals by conforming to the incremental bias of the American political process.

But what of the hospital industry? Is it not likely to present a powerful political obstacle? In the past, the hospitals have presented a united political front, articulated by vigorous trade associations in a relatively unambiguous voice. Both the programs they helped design and those they fought to defeat reinforced their solidarity by distributing benefits and burdens more or less uniformly across the industry.\textsuperscript{92} Over the past decade, however, their political unity has begun to decay as the industry has grown more competitive. The new Medicare system will rapidly erode it further: this payment mechanism is designed to have an impact that varies across institutions. Different hospitals face different economic conditions and consequently have different political interests.

The new Medicare will provoke financial crisis for hospitals with many indigent patients and a limited capacity to shift costs. These hospitals—and the public officials who are concerned about keeping them open—will welcome whatever assistance is offered. Occasional grants may at times provide temporary relief, but they are not likely to survive federal budget cutting efforts for long.\textsuperscript{93} In contrast, the most solvent hospitals—shifting costs and turning away indigents as they boast about their

\textsuperscript{90} See Politics of Medicare, supra note 87, at 5-28.

\textsuperscript{91} See Dunham, Morone & White, Restoring Medical Markets: Implications for the Poor, 7 J. Health Pol'y, Pol'y & L. 488 (1982).

\textsuperscript{92} For example, the Hill-Burton program, Hospital Survey and Construction Act, Pub. L. No. 79-725, 60 Stat. 1040 (1946) (current version at 42 U.S.C. §§ 291-291o (1982)), provided grants for the construction of new facilities; it helped many hospitals and harmed virtually none. See Rosenblatt, supra note 55, at 265-76. The industry fought Medicare through the early 1960's and then, switching sides at the last moment, enjoyed the financial bonanza that followed; this too was a broad benefit to the industry as a whole. See Politics of Medicare, supra note 87, at 29-81; see also Rosenblatt, supra note 55, at 264-86. Hospitals viewed the regulatory schemes of the Carter years as harmful and easily defeated them despite increasing public concern about rising costs. See Lundy, supra note 53, at 7-8.

\textsuperscript{93} The teaching hospital subsidy is a good illustration. Teaching hospitals receive an additional payment for the indirect costs of medical education. Social Security Act § 1886(d)(5)(B), 42 U.S.C.A. § 1395ww(d)(5)(B) (West 1983); 42 C.F.R. § 405.477d(5)(2) (1984). This is an important subsidy to the many urban hospitals which are also teaching hospitals. However, the Reagan Administration's new budget would reduce the teaching hospital subsidy by half, illustrating the vulnerability of such special accommodations. See Demkovich, Administration Taking Aim at Subsidies for Hospitals' Medical Education Costs, 17 Nat. J. 309 (1985).
efficiency—will fight further federal encroachment on their revenues. There will be prestigious medical centers in each camp.

Aggressive hospital administrators may even welcome a system in which all hospital prices are set by DRGs, or at least prefer it to other forms of government intervention. An “efficient” hospital that treats patients at lower than average costs might do quite well. Health planners may view the outcome as systems rationalization; in the more traditional rhetoric of American politics, it is the result of competition in the hospital sector. Under either label, the political fissures that have already begun to appear in the hospital industry are likely to be exacerbated, neutralizing a major political barrier to government price setting for all payors—precisely as it did in New Jersey.

In short, extension of DRGs is likely not for its inherent merits but for its political advantages. There will be widespread calls for action in the nation’s health system: government officials, insurers, business corporations, unions, and some hospitals will seek relief from the current system. HCFA will have a solution that extends its power, solves some problems, and is already administratively in place. The change appears conservative, merely extending a mechanism that is in widespread use. It does not involve visible new taxes, “untested” new legislation, or the appearance of income redistribution or welfare. On the contrary, it is a technical adjustment that is more likely to mobilize the symbolism of competition and capitalism than of welfare and socialized medicine. These features are apt to deflect broad public notice, much less widespread criticism. Moreover, it is likely to generate the same bureaucratic support that propelled it forward, both in New Jersey and into Medicare.

Timid, incremental measures are likely to precede the changes we predict. Refinements in DRG methodology could introduce further technical complexities (and perhaps a new set of acronyms). A recurring federal impulse to send the problem to the state level 94 will continue to appear, providing the mirage of a solution that is painless in Washington. However, the stubborn realities of medical inflation, rooted deep in the structure and financing of the industry—and all the consequent political dilemmas that we have noted—will remain until comparatively radical action is undertaken.

Despite the relatively quiescent politics that would accompany the change, extending DRGs and factoring in the cost of uncompensated care would establish a national health system of sorts. Government officials would set rates for all payors in all hospitals. These changes would

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amount to an unprecedented public intervention into the practice of medicine, and a broad subsidy for hospital care to the poor. This outcome approximates the bargaining systems characteristic of Western European health policies. Whatever the effects on American hospitals—the problems that are cured, the unforeseen ones that are caused—the ensuing health care politics are likely to revolve around government administrators: setting prices, solving problems, reshaping American medical practice.

After a half century of political thunder over the socialized medicine implicit in programs such as Medicare or national health insurance, the state is poised to assume a role at the center of the American health care system. And yet, in the American fashion, proponents will insist that the state is not bargaining and setting rates so much as tending a complex formula that promotes competition and revitalizes health care markets. Ironically, national health insurance may arrive quietly, with scarcely an interest demurring.

III. The New Health Care Politics: A Dense Environment and the Autonomy of the State

We have told the same story in both of the preceding sections. A series of apparently incremental reforms—each responding to immediate problems, each inadvertently setting the conditions for further change—have recast the politics of health care. In New Jersey, an industry that was powerful and autonomous in 1970 is now dominated by state officials. On the federal level, a similar process is underway. Health providers with enough political influence to shape Medicare to their own purposes in 1965 now find that public officials are using the program to pressure their industry—the latest step, we have argued, in an evolution toward the national health insurance that providers have long battled to avert.

These are not simply new details of health policy but a change in the political rules by which it is fashioned. An entirely new model of politics is emerging. The traditional pattern—powerful private interests dominating a pliant state—is now less evident than its reverse—interests reliant on an increasingly powerful political center.

95. See generally W. GLASER, HEALTH INSURANCE BARGAINING (1978) (discussing European systems).
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A. The Traditional Model: Industry Dominance

Private interest groups generally dominated health politics. They often initiated political action, setting the public agenda with programs that they designed or blocking proposals they perceived as threats. Their influence over government officials was predictable.

Legislators are rewarded for developing allies and avoiding enmity; their incentives are to shun controversy while distributing benefits to constituents who are sufficiently organized to remember until the next election. Hospital and medical associations were well-organized, well-financed, and attentive to political issues. Other groups participated in health politics: liberal reformers battled long and hard to pass Medicare; public interest groups like the one that disseminated Bureaucratic Malpractice mobilized public sympathy for reform causes. In the end, however, the sustained interest of the health care professionals generally dominated health care legislation.

The industry's dominance was still more pronounced in bureaucratic arenas. With its livelihood on the agenda, the industry actively participated in the time-consuming and arcane politics of administration; the groups that had mobilized to oppose them in legislative settings rarely pursued issues to the regulatory agencies. Industry power was bolstered by expertise; matters of political administration were routinely turned into technical questions that only members of the profession seemed equipped to resolve. The most interested private parties often dominate or "capture" the public agencies that oversee them. In the health system, that dominance was systematic and pervasive.

The traditional dynamics of health care politics were rooted in the skewed representation of American policy-making. Each group unabashedly pursued its own self interest, though not all interests were organized or active. The most interested parties—for health issues, health providers—sustained their attention and concentrated their resources on the programs that most affected them. In addition, the health providers were able to evoke deference from many other groups. The political outcome was not mere professional dominance but a broad ceding of public authority directly to the profession.

98. On the concept of a political agenda, see R. COBB & C. ELDER, PARTICIPATION IN AMERICAN POLITICS (1972); J. KINGDON, AGENDAS, ALTERNATIVES, AND PUBLIC POLICIES (1984).


This political pattern appeared repeatedly in the preceding sections. In New Jersey, for example, Blue Cross proposed rate regulation to ameliorate its own market position. The program that emerged was promptly turned over to the hospitals. They implemented it by simply continuing their old rate review under the imprimatur of the Commissioner of Health. On the federal level, the Hill-Burton Act financed hospital construction where and when hospital administrators sought funds for it. The one burden imposed on hospitals by the legislation—a specified amount of charity care—was simply left to the discretion of the hospitals. Regulations implementing charity care provisions were not written until pressure from litigation made such regulations valuable to the industry, twenty-five years later. Though hospitals and physicians initially opposed the passage of Medicare, they dominated its implementation. When, partly as a consequence of their dominance, rising costs became a public problem, the solutions that were attempted were placed in the hands of health care providers—voluntary planning councils, voluntary cost controls, boards of physicians identifying Medicare abuse.

Insofar as this traditional model is still operating, the prospects for new programs are clear: the all-payor system in New Jersey, Medicare DRGs, even the form of national health insurance we predict, will come under steady pressure from the industry. Administrative officials will increasingly cater to its wishes, rates will be set more loosely, and, with time, the programs will be captured by the industry. Eventually, the DRG "solution" will be replaced by another scheme and the cycle will begin again.

Our expectation is different. Industry dominance over medical programs is increasingly difficult to achieve. Instead, a new model of politics has begun to appear. Both sides of the political equation are different; the behavior of both private interest groups and public officials has begun to change.


104. See supra notes 54-56.

105. See supra note 60.

106. See supra notes 57-58.

107. See, e.g., Hearing, supra note 65, at 51 (statement of Frank A. Sloan, Executive Director, Health Policy Center, Vanderbilt University) (all-payor system eventually would evolve to offer price protection for the benefit of individual hospitals and insurers); see also Rose, supra note 103, at 168.

B. The New Interest Group Politics: A Dense Environment

Programs are captured when interests mobilize to grab benefits while the costs are diffused over broad populations. Since those who bear the costs are not organized around the issue, they are not likely to resist. Few political interests concerned themselves, in 1966, over how Medicare would pay hospitals or, in 1971, over how rate regulation would actually operate in New Jersey.

In the new political context—what we call a dense environment—groups find themselves in a network of large, well-organized corporate interests whose destinies have become visibly linked. When one jockeys for advantage, there are clear, often immediate consequences for the others. Political groups have sharp incentives to attend to one another's political behavior. As a result, it is more difficult for a single interest to dominate even its own regulation.

A dense interest group environment has three major characteristics. First, the most important political actors are large. Even the small actions of large organizations can have sweeping effects. The regulation of Blue Cross payments in New Jersey quickly pushed the urban hospitals toward insolvency and threatened corporate insurers. The sheer size of Blue Cross makes its behavior consequential for a large number of interests. Its political victories can induce widespread losses.

Second, the interests are well organized. They have the capacity to acquire necessary information, improve their strategic position, and oppose the political demands of other groups. They are primed for political action.

In the traditional politics, these first two characteristics—size and organization—lead to capture. The third dimension of the new politics makes capture unlikely: the fates of the large organizations are interpenetrated. The actions of one affect numerous others. For instance, the capture of rate regulation by hospitals would now affect an enormous array of public and private interests. State budgets would feel additional pressure from Medicaid. Medicare costs would rise; the threat to the Medicare trust fund would be exacerbated; the federal deficit would worsen. Private insurers, their marketing decisions complicated by the uncertainty of uncontrolled inflation, would pass the higher hospital costs on to their corporate clients. Corporations, in turn, could self-insure or cut employee benefits. When corporations self-insure, insurers lose business; when corporations cut benefits, they risk conflict with unions, and hospitals face

more patients with less insurance. In a dense environment even capture may rebound to the hospitals’ disadvantage.

In short, a dense political environment replaces the relationship between interests seeking benefits and the state distributing them with a far more intricate system of interaction. Different organizations—some in apparently different sectors of the economy—are visibly linked. The narrow pursuit of individual self-interest—the mainspring of traditional American politics\(^1\)—becomes less effective; a narrowly focused distribution of benefits to mobilized interests becomes more difficult to effect. In the new political setting, benefits cannot be allocated to one claimant without regard to others. Different actors cannot be dealt with in a series of separate transactions. The traditional mechanisms of American politics—interest groups mobilizing for benefits, seeking to capture government agencies, lobbying for political pork—now result in stalemate.

C. **State Autonomy: Bureaucrats at the Political Center**

A dense political environment is unstable. Groups check each other politically, but continue to take private actions that send ripples of undesirable consequences through the interconnected system. Public problems such as medical inflation or financing indigent care affect a wide range of private interests. Yet solutions are difficult to devise. Political choices are full of potential losers cognizant of the potential threats. Interest groups face intricate problems while they block one another’s policy proposals.

This setting breaks the traditional politics of industry capture. Private interests continue to place issues on the political agenda, lobby for programs they favor, and assail those that cause them harm. However, the problems they face require coordinated, even “counterintuitive” action.\(^1\)

Though numerous interests were harmed by the partial regulation in New Jersey, none hit upon a program that would further its own interests without offending other organized groups. Many demanded assistance; none developed a solution. As their problems mounted, the pressure for action increased. With private interests blocking one another, public officials became a likely source of reform. Rather than merely responding to private interests, they began to look for, design and implement new policies that responded to the systemic difficulties. In the process, they enhanced their power and advanced their careers. They became policy entre-

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preneurs, identified with the programs they had sponsored. "Capture" no longer described their behavior.

Administrative agencies rather than legislatures are likely to be the crucial actors in a dense environment. Politics which demand technical expertise, a capacity to devise comprehensive programs, and a disposition to deny narrow, self-interested claims is more apt to be bureaucratic than legislative. Legislators typically have neither the time, the incentives, nor the expertise to design complex programs that take account of the intricate interactions of a dense environment. The toothless Assembly resolution in New Jersey, condemning a DRG plan that the legislature would not revoke, demonstrates both the wish to distribute benefits to a mobilized constituency and the difficulty of doing so in a dense policy environment. Although some legislators, relying on expert staff, may try to play a more active role, most prefer the more traditional one pressed upon them by their electoral incentives: responding to the narrow constituent demands that are set before them. Insofar as they pursue this role in a dense policy environment, they defer substantive policy choices to the bureaucracy.

The result is growing administrative authority over the health care industry. Public administrators devise new policies, induce legislators to enact them, and then implement the programs. Federal officials assist their local counterparts: recall that DRGs were developed in New Jersey with an HCFA grant, enacted with HCFA’s promise of a Medicare waiver, and fully implemented for all payors when HCFA insisted on an all-payor experiment. State and local officials form associations and open Washington offices in order to influence federal administrators and lobby Congress. They behave almost like the private interest groups of the traditional model, organizing to lobby federal administrators and legislators for relief from their difficulties.

The contours of an increasingly autonomous bureaucratic establishment are unclear. If the traditional pattern of political deference to mobilized interests continues, public problems are not likely to be solved. A growing


113. National health bills almost always have been associated with individual members of Congress: The Hill-Burton Act is known by the names of the Congressmen who sponsored it; Medicare was fundamentally shaped by Rep. Wilbur Mills, see POLITICS OF MEDICARE, supra note 87, at 62-70. By contrast, the Medicare DRG system, like its New Jersey predecessor, is a bureaucratic initiative, not identified with any particular legislators.

body of pessimistic commentary postulates continued stalemate, punctuated by crisis.116

However, in the DRG cases that we described above, administrators seized their opportunities. In New Jersey, an extremely technical program was designed by a loose coalition of federal administrators, state bureaucrats, and policy researchers both in and out of government. Taken together, they formed an "issue network" of specialists searching for solutions to public problems.116 There was a steady rotation of these individuals: academic specialists joined the Department of Health, bringing their former colleagues into public deliberations; members of the Department of Health moved to jobs with HCFA and other state governments, extending the network of shared perceptions grounded in technical training. In both Trenton and Washington there was a sustained attention to new proposals from policy entrepreneurs.117

This is in no way to suggest the triumph of expertise over politics,118 only that the locus of health care politics has changed to the bureaucracy.119 Administrators who shake off the old politics and devise new programs will not routinely succeed. However, in the new politics, their failures and partial successes are likely to result in further penetration of the health industry by the state. Public officials will be charged with righting the consequences—both predictable and unanticipated—of their own interventions.120 In New Jersey, state responsibility for setting Blue Cross premiums led to increasingly stringent efforts at partial rate regulation which—after widespread problems—led to state control over all payors for all hospitals. In Washington, the financing of health benefits for the elderly contributed to general health care inflation which led, in turn, to a series of programs culminating in the stringent regulation of Medicare. We have predicted that the new Medicare will result in widespread distress and, eventually, the same type of powerful intervention that occurred in New Jersey.

118. See G. MCCONNELL, supra note 102 at 43-48; see also Morone, The Citizen Role in Health Politics: Democratic Wishes and Sensible Reforms, in HEALTH POLITICS AND POLICY 243, 244, 248 (T. Litman & L. Robins ed. 1984).
120. See F. HAYEK, THE ROAD TO SERFDOM (1944) (government intervention inevitably leads to further government intervention); L. BROWN, supra note 115, at 1-8.
The irony of the DRG story is that it emerges from an Administration that arrived in Washington full of free market rhetoric and promises of relief from bureaucratic meddling. Four years later, its major health initiative—widely pronounced competitive—thrusts public administrators into the center of the hospital system. The bureaucrats' role in the DRG program does not fit the traditional models of American politics. Private interests are increasingly caught in the stalemate of a dense policy environment; they are more and more reliant on the public officials whom they once dominated. This new political configuration, and the instability of the Medicare DRG system it has produced, set the conditions for the next development: the politically untroubled passage of a national health insurance system.