How the Affordable Care Act Empowers HHS to Cartelize the Health Care Industry

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Abstract

In this paper I explain how the Department of Health and Human Services has taken on a powerful coordinating role in the provision of health care as a result of the Patient Protection and Affordable Care Act. This paper analyzes the unfurling of that act using the Bootlegger–Baptist model of political economy. By tracing the development of the law and its effect on how health care is delivered, the analysis shows that economic interests became coordinated through the efforts of the White House and the central "televangelist" agency, the Department of Health and Human Services. This development will inevitably result in bureaucratic decisions replacing individuals' choices as the agency takes on an increasingly active and interventionist role in how health care is provided.

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The Patient Protection and Affordable Care Act (ACA) has brought enormous change to the health care industry. It reinvents one-sixth of the US economy through its bundle of new regulations, fees, grants, and other incentives. The affected parties, including consumers, hospitals, insurers, and pharmaceutical companies, have all positioned themselves to meet what will be a significant change in the mode of health care delivery.

At the heart of this new direction is a reorientation of the health care sector guided and designed by the administration of President Barack Obama and the Department of Health and Human Services (HHS). The media has focused more on the bureaucratic pitfalls coinciding with the launch of the department's health care exchange website (www.healthcare.gov) and less on the monumental changes occurring in the industries most directly affected: hospitals, pharmaceutical companies, and insurers. These industries are undergoing major transformations in how they provide services as a result of HHS guidelines.

Although disillusionment with the existing health care system in the United States is widespread, the ACA addresses this issue using top-down, heavy-handed bureaucratic solutions. Essentially, it has enabled HHS to organize the industry as it sees fit. Whether this approach will change the industry for the better is an open question; whether it will largely replace consumer preferences with bureaucratic ones is not. Unfortunately, consumer preferences are host to a number of problems that could easily move health outcomes in a negative direction.

I use Yandle's classic Bootleggers and Baptists theory (Yandle 1983; Smith and Yandle 2014) to explain the ongoing dynamic within the health care industry. HHS has increasingly

coordinated both Bootleggers (economic interests) and Baptists (moral interests). Although the ultimate effect of this change is uncertain, distinct patterns can be discerned using contemporary and historical analysis of trends in the affected industry. In particular, I show how the ACA largely empowers HHS as a vehicle for centralized coordination of the health care industry.

This paper outlines the machinations of HHS in bringing together the major health care industries and consumer groups to coordinate national health care. I use the coordinated Bootlegger and Baptist model as a framework to show how these efforts by HHS largely serve to cartelize the health care industry in a way that places the preferences of government bureaucrats and interests of Bootleggers and Baptists above those of the public.

Bootleggers, Baptists, and Televangelists

Yandle (1983) first introduced the concept of Bootleggers and Baptists to describe how economic and moral interests team up to generate favorable political outcomes. In his original work, he highlights how regulation so often seems to benefit the producers it is supposed to constrain. As he explains, this outcome is a natural result of an environment where public choice considerations dominate public interest concerns. His theory provides a supplement to public choice analysis by exposing how moral interests so often enable the very Bootlegger special interests they are often trying to hinder.

The decades-long fight waged by health proponents against Big Tobacco is an example. Although efforts to reduce the number of smoking-related illnesses have been partially successful, many of these activities have done more to serve the tobacco companies than the consumers. One of the more memorable examples occurred in 1960 when health advocates successfully lobbied to ban certain forms of advertising, which resulted in a reduction in

operating costs (and accompanying higher profits) for larger firms and proved a significant obstacle for new entrants, thus benefiting Big Tobacco (see Kluger 1996; Smith and Yandle 2014, 91–92).

Bootlegger special-interest groups are often successful because they have a much greater economic stake in the trajectory of legislation and so bring much to bear in guiding policy outcomes. Building on the classic public choice works of Olson (1965), Stigler (1971), and Becker (1983, 1985), the argument rests on the assumption that special-interest groups will seek to further their interests through political channels by being both better informed and better motivated to affect political outcomes in a direction they find favorable. Baptist groups may attempt to oppose Bootlegger efforts, but more often they settle for outcomes that appear to be in the public interest but, in actuality, fund Bootlegger profits.

Of course, not all Bootlegger efforts are successful. (An example of how the insurance industry failed to block a financially painful provision in the ACA is shown later.) Two factors weigh against Bootlegger efforts. First, the more Bootleggers can hide behind Baptist support, the better are their chances of success. By extension, the less Baptist support available, the greater the chances are that Bootleggers will fail to acquire legislative benefits or, in some cases, attract rent-extracting penalties. This points to the second factor—government is not simply a neutral broker. In many cases, government is more interested in taking gains away from economic interests to support its pet projects. The seminal work of Fred McChesney (1987, 1997) illustrates this propensity for rent extraction. I illustrate this propensity in this paper using recent efforts of HHS to encourage funding enrollment in the new health care exchanges under the group Enroll America. Indeed, the line between rent extraction and rent-seeking is often a thin one.

Yandle et al. (2007) also speak to this point and expand on the original Bootlegger and Baptist theory by incorporating political coordinators—appropriately labeled "televangelists"—into the fold. These televangelists represent an evolution of the simpler Bootlegger and Baptist coalition by incorporating political entrepreneurs into the mix. Even the classic works noted previously usually keep politicians in the background. Nevertheless, a keen political operative can provide interest groups with far more firepower in affecting political outcomes. The ability to coordinate and move among interested players on both sides of the Bootlegger and Baptist divide allows for greater cooperation and focus on politically attractive objectives.

In their case study on the 1998 Master Settlement Agreement with Big Tobacco, Yandle et al. (2007) show how attorneys general from 46 states teamed up to transfer regulatory benefits away from the federal government to these states. In that case, the attorneys general provided just the sort of televangelism needed to outmaneuver their federal counterpart. Although the context of the study is Big Tobacco, the idea that politicians serve as powerful stewards of Bootlegger and Baptist coalitions can be generalized to a number of different areas. As I show, the health care industry is increasingly becoming a collection of Bootlegger and Baptist interests coordinated by the televangelist HHS.

The Rise of the Affordable Care Act

This coordinated cartelization came to fruition when the Patient Protection and Affordable Care Act, popularly known as Obamacare, became law on March 23, 2010.[1] The event marked the culmination of a yearlong struggle to push through one of President Barack Obama's marquee agenda items. Obama was not the first president to push for expanded health care. It has long

[1] This section draws in part from Smith and Yandle (2014).

been one of the most regulated segments of the US economy (see Béland and Waddan 2012). Lyndon Johnson successfully pushed Medicare and Medicaid into law in 1965, and George W. Bush added coverage for medications to Medicare. Perhaps the most ambitious previous effort was that of First Couple Bill and Hillary Clinton in the 1990s. In each of these efforts, a vast Baptist choir sang the praises of government-assisted health care. But lurking in the background—and sometimes in the back row of the choir—were pharmaceutical, insurance, and other health care Bootleggers ready to expand sales to the regulated sector.

As I demonstrate, the ACA bill's primary supporters constantly shaped and reshaped the initiative to garner Bootlegger support, even while heaping public scorn on big business elements in the health care sector. Instead of simply expanding subsidies and requiring health care providers nationwide to supply services to all in need or giving indigent citizens access to the Veteran Administration's hospitals, the president's plan requires all uninsured citizens to purchase health insurance or pay a stiff annual penalty.

The leading Bootlegger—the insurance industry—was identified from the outset, or so it seems. After all, how could any insurance company oppose a plan requiring every citizen to buy an expensive insurance product every year? Surely the insurance firms would be the happiest Bootleggers on the planet. But ultimately, events did not turn out well for the insurance Bootleggers.

News coverage of the ACA helps identify the key Baptist themes. In March 2010, the *Economist* (2010a) came out in support of the president's project. Although acknowledging some of the bill's flaws, the influential news weekly supported the package for two related reasons: the ethical imperative of universal health care coverage and the law's potential to lower health care costs. Both elements made the ACA "morally desirable" (*Economist* 2010a). Yet, just one week

later, without wavering from its Baptist position, the *Economist* lamented, "This newspaper supported the final version of Obamacare, but only because we have long maintained that a country as rich as America should provide decent health coverage to all its citizens. Because the bill does almost nothing to control costs, it was a huge missed opportunity" (*Economist* 2010b). The newspaper's earlier misplaced optimism that the bill would lower health care costs went unaddressed.

The abrupt shift in the newspaper's analysis reflects the difficulty supporters had in reconciling their Baptist vision of universal health coverage with the disappointing outcome of the final bill. One can easily understand why many grew frustrated with the final law (Saad 2010). The public's desires (as proclaimed by Baptists) can quickly be distorted when Bootleggers enter the political process. A brief digression on the passage of the ACA will shed light not only on the machinations of Bootleggers but also on the role of the White House and HHS as televangelists in coordinating so many disparate interests.

The Road to the Affordable Care Act

For an understanding and appreciation of the significance of this coordinated Bootlegger and Baptist political milestone, I first look at the beginnings of the original bill to show how these various interests came together. Placing health care at the forefront of his domestic agenda, President Obama wasted no time in publicizing his vision for reform. In his first State of the Union address, the president claimed, "The cost of our health care has weighed down our economy and the conscience of our nation long enough. So let there be no doubt: health care reform cannot wait, it must not wait, and it will not wait another year" (Obama 2009). He followed up with a whirlwind campaign to create support for his keystone legislation. Town hall

forums and campaign-style appearances were part of a broader effort to convince the American public that health care reform was not only desirable but also mandatory for a modern democracy in the 21st century. In an address to Congress, Obama argued, "We are the only democracy—the only advanced democracy, the only wealthy nation—that allows such hardship for millions of its people" (*New York Times* 2009).

To avoid the failure of previous health care reform efforts, Obama began developing a coalition of special-interest groups early in the initiative. In fact, one of the chief strategies of the White House was to "neutralize the opposition," an approach that reflected the shortcomings of the Clinton effort 15 years before (see Staff of the *Washington Post* 2010, 22). The president found many Baptists (and even a few early Bootleggers) willing to support his cause. For example, a joint statement in January 2009 from the American Cancer Society, American Medical Association, Families USA, Pharmaceutical Research and Manufacturers of America, Regence BlueCross BlueShield, and Service Employees International Union declared, "In order to fix the ailing economy, the nation needs health care reform that addresses the related problems of health care costs and people losing health coverage" (*Reuters* 2009). The Bootleggers and Baptists were clearly on board.

But the president faced a hard sell with the public at large. A Gallup poll showed that nearly half the country disapproved of new government interventions in the private health care system. This disapproval increased as debate continued on the issue: from a low of 28 percent disapproval in 2007 to a high of 50 percent in mid-2009 (Gallup 2010). A similar trend appeared when respondents were asked whether they favored preserving the current system or overhauling it through government intervention. In November 2007, 41 percent of those polled favored replacing the current system, and by November 2009, this number had dropped to 32

percent. As debate continued and the rationally ignorant became more informed, Americans were less inclined to approve of government intervention in the private health care system (Newport 2009b).

One reason for voters' increasing wariness may have been a fear of higher costs under a public health care system. Even though the United States was spending the largest share of gross domestic product on health care across developed nations, the adjustment problem posed by the ACA remained (OECD 2012). Firms in the health care sector looked warily at the potential for rising costs as a result of new coverage requirements and restrictions on pricing. In 2009, Americans were just waking up from the economic nightmare of the 2008 financial crisis and suffering the effects of the global recession that followed. Unsurprisingly, 70 percent of Americans described economic issues as the nation's top problem, and only 16 percent cited health care (Newport 2009a). In September 2009, 38 percent of those polled cited cost as the biggest problem. Only 15 percent saw too many uninsured persons as the biggest problem. In other words, more than twice as many respondents were chiefly concerned about cost than were concerned about lack of coverage (Saad 2009).

In response to the conversation in Washington, an unlikely alliance of Bootleggers and Baptists emerged to guide the legislation. In March 2009, the president met with the elite of the Bootlegger interests, including "leaders from organized labor and the American Medical Association, corporate executives, consumer advocates and officials from the U.S. Chamber of Commerce," together with well-known lobbyists from pharmaceutical and insurance interests. These "strange bedfellows," as they called themselves, were not really strange at all because they had a common economic interest in ensuring the bill would benefit them. In addition, the veiled threat loomed that failure to get on board could put these interests in a difficult position should

the bill pass without their help. As the US Chamber of Commerce president Thomas J. Donahue stated, "If you don't get in this game . . . you're on the menu" (see Staff of the *Washington Post* 2010, 22–23).

Under the umbrella of coalitions such as Health Economy Now, these groups lobbied on an ongoing basis to shape health care reform in their favor. This particular coalition included the Pharmaceutical Research and Manufacturers of America, the AARP, the American Medical Association, Business Roundtable, Families USA, and the Service Employees International Union, among others (Fox.news.com 2009).

Although consensus existed on the broader aims of reform—expanding coverage, reducing costs, and improving the overall quality of the system—these goals were vague enough to allow ample room for Bootleggers and Baptists to operate. The more imprecise the ends of a reform campaign were, the greater the opportunity would be for Bootleggers to fill in their desired fine print when choosing the means. And of course, with 17 percent of the economy weighing in the balance, suitably designed health care reform legislation could pump billions of dollars in the direction of the hard-working Bootleggers.

Initially, proponents of the bill advocated for the so-called public option, whereby the federal government would establish a publicly sponsored and funded insurance agency that would compete directly with private insurers. Supporters of the public option claimed that it would reduce costs by putting competitive pressure on private insurers. In the planners' ideal world, the public option would extend coverage to all in need, insulated from the bottom-line pressures that prevent private insurers from extending money-losing coverage.

Although a public option appeared compatible with the broader goals of health care reform, it met fierce resistance from lobbyists. Several hospital Bootleggers, such as the

Federation of American Hospitals, opposed the policy, fearing it would result in a reduction of rates paid for services; they preferred higher-priced health care. The lobbyists met with key legislative leaders, such as Senator Max Baucus (D-MT), then chair of the Senate Committee on Finance, to quash the plans for such an option (Kirkpatrick 2009).

Of course, this opposition was not without its price. Senator Baucus went so far as to ask five of the nation's largest pharmaceutical companies, "What are you in for?" After all, the bill was going to be expensive, and legislators saw the potential benefit to Bootleggers as a way of leveraging them into covering some of these costs. As Senator Baucus stated, "Health reform will benefit you. But you don't get these benefits for free." Obviously, the industry did not need to write a check on the spot, but they would need to accept items such as smaller federal reimbursements or new fees in the final bill (see Staff of the *Washington Post* 2010, 25).

The insurance industry represented another major Bootlegger. Although no love was lost between Washington and the insurance industry, at least in public utterances, battle lines were drawn on particular fronts of health care reform. The industry pursued two major goals: (1) eliminating the public option and (2) expanding its market base through mandatory coverage (*Wall Street Journal* 2009). Like hospitals, the insurance industry saw the public option as a direct threat to its bottom line, though for different reasons. For private insurers, a public insurance agency would act as a government-subsidized competitor, able to draw customers away at prices below the competitive market rate, an unacceptable result. Their second goal represented potential pork that might be extracted from an otherwise potentially dangerous bill. After all, even if the insurance Bootleggers received these new customers, such expansion would almost certainly be accompanied by greater oversight and regulation of their practices (Pickert 2009a).

Owing in part to the opposition of hospitals and the insurance industry, the public option soon lost momentum, even with some of its chief supporters. Most notably, the Senate Finance Committee voted down the public option amendment, with several Democrats joining Republicans in dissent, including Max Baucus (D-MT), one of the larger bill's chief architects (CNN.com 2009). At a town hall meeting in August 2009, President Obama sought to downplay the centrality of the public option to his larger reform ambitions: "The public option, whether we have it or we don't have it, is not the entirety of health care reform. . . . This is just one sliver of it, one aspect of it" (Stolberg 2009). Later, he signaled through HHS Secretary Kathleen Sebelius that the public option could be dropped. By the end of the year, the option was off the table (Stolberg 2009).

Bootlegger and Baptist Coalition Breaks Down

However, the insurance industry Bootleggers did not stop there. They attempted to massage the bill further, primarily by seeking to reduce the new cost burdens imposed by the legislation. In October 2009, America's Health Insurance Plans, the major health industry lobbying organization, released a report by PricewaterhouseCoopers (2008) showing that the latest version of the bill would increase private insurance premiums. Although congressional leaders widely panned the report for a variety of supposed shortcomings, insiders reluctantly admitted that the bill's ultimate effect on private plans was uncertain. One congressional aide claimed, "It's impossible to figure out what the bottom-line impact is" (Pickert 2009b).

The insurance industry received numerous public reprimands for focusing so intensely on profit. House Majority Leader Nancy Pelosi (D-CA) even went so far as to label insurers "immoral villains" (Thrush 2009). Nevertheless, the controversy struck a chord with the public.

Popular concern about rising costs in the wake of the Great Recession translated into reluctance by members of Congress—and not just Republicans—who were united in opposition. The industry further indirectly picketed the bill by supporting the powerful Chamber of Commerce (Hacker 2011).

Many Democrats faced constituencies hostile to the idea of a federal health care mandate. Senator Blanche Lincoln (D-AR), for example, attracted criticism from both sides of the political aisle by opposing the public option but subsequently voting for the reform once the public option had been removed (Weisenthal 2010). Representative Betsy Markey (D-CO) encountered more one-sided hostility from her largely conservative district (Villegas 2010). Pennsylvania Senator Arlen Specter, fighting an uphill battle against his own party after pivoting to support the president's agenda, shed his Republican affiliation only to be defeated in a Democratic primary in a state where polls showed that a majority of voters opposed government health care mandates (Klein 2010). Legislators realized that they risked shortening their political tenure by supporting an increasingly unpopular initiative.

At a critical moment, one politician became a linchpin for the entire reform effort: Senator Ben Nelson (D-NE) represented the key vote needed to push filibuster-proof legislation forward in the Senate. Nelson not only felt pressure from the bill's supporters (Bender 2009), but also received direct assistance from a major Bootlegger. The lobbying group Pharmaceutical Research and Manufacturers of America (PhRMA) spent $150 million on an advertising campaign in Nelson's home state of Nebraska. What was their price for this service? Language would be inserted into the bill barring the importation (or reimportation) of cheaper drugs manufactured or sold abroad. Eliminating foreign competition was just what the doctor ordered

(*Wall Street Journal* 2012). In December 2009, with the importation ban in place, Senator Nelson announced his support for the ACA (Jonsson 2009).[2]

Pharmaceutical companies already had agreed to support reform in early 2009. In addition to allowing the concession on imported drugs, the administration promised not to repeal an existing rule enacted under the Medicare Act of 2003 during the George W. Bush administration. That rule prevented government from negotiating drug prices under Medicare and Medicaid, a restriction that generates hundreds of billions of dollars for the pharmaceutical industry (*Houston Chronicle* 2009).

In contrast, private insurers began to view reform as a losing deal. Although the insurance industry succeeded in eliminating the public option, ensuring mandated coverage, and generating public fear over costs, one measure threatened to overwhelm any Bootlegger gains. That provision established a minimum medical loss ratio (MLR), specialist jargon for the percentage of insurance premiums spent on actual health care services. Insurance companies would have to reduce overhead costs and refund premium dollars if they failed to meet the proposed 80 percent MLR threshold (Pickert 2009c). The amount to be rebated retroactively for 2011 transactions alone rose to a nontrivial $1.1 billion (Ungar 2012, 2).

The MLR provision devastated an already shaky alliance between the Bootlegger insurance industry and the Baptist health care reform advocates. A report from PricewaterhouseCoopers released in October 2009 was just the start of a protracted, largely secretive effort to block reform. America's Health Insurance Plans, the insurance industry's super-lobby firm, spent $102.4 million in just over 15 months, funneling the money into negative

[2] Senator Nelson eventually retired in 2011, after receiving heavy criticism for his role in the passage of the ACA. The former Senator now serves as a lobbyist and steward for health care groups in Washington, DC (Millman 2013).

advertisements run by the Chamber of Commerce (Ungar 2012). Clearly, the honeymoon between Bootlegger insurers and Baptist reform advocates was over.

HHS as Coordinating Televangelist

Despite these protestations, the ACA soon became national law. But the coordinated efforts among the three major Bootlegger groups—insurers, hospitals, and pharmaceutical companies—did not end. In fact, HHS was just getting warmed up (Cannon 2013).

Reining in the Bootleggers, Part 1: Insurers

HHS wasted no time in flexing its political muscle. In a tersely worded letter to America's Health Insurance Plans, Kathleen Sebelius, the newly appointed secretary of Health and Human Services, demanded that insurers cease and desist in any efforts to scare customers about rate hikes or reduced services as a result of the ACA. Sebelius said, "I urge you to inform your members that there will be zero tolerance for this type of misinformation and unjustified rate increases. . . . Simply stated, we will not stand idly by as insurers blame their premium hikes and increased profits on the requirement that they provide consumers with basic protections" (Robertson 2010).

Obviously sore from their loss in the political arena, insurance groups sought to place any future blame for rate hikes with the administration (Adamy 2010). Not to be undermined, HHS emphasized that open hostility to the new law would jeopardize access to the new exchanges. Although the law as a whole may have set insurers back, access to the new exchanges represented not only billions of dollars in possible revenue (or political protection), but also potential new customers spurred by the individual mandate.

Having set the tone for insurers attempting to break ranks with the administration, HHS moved on to fundraising, the next item on its agenda. Fundraising may seem a peculiar task for a government agency, especially HHS, which has one of the largest budgets in the federal government. Nevertheless, Sebelius faced a particularly difficult challenge in funding outreach efforts to increase enrollment, in part because Republican lawmakers had stripped HHS of funding where possible in an effort to curtail enrollment in the unpopular program. Undeterred, Sebelius turned to her Bootleggers to fill the gap in funding. The nonprofit—and, at least purportedly, nonpartisan—group Enroll America is the primary vehicle used by the administration in public outreach. Sebelius apparently called major health care companies directly to solicit funding for the organization. Although no specific threats have been discovered, the insinuation that the administration would look favorably on companies that complied with her request was clear (Kliff 2013a).

An investigation into whether Secretary Sebelius overstepped her legal authority in contacting these organizations is ongoing, and data are accordingly sparse. However, several targets have been identified, including H&R Block, Kaiser Permanente, Johnson & Johnson, and Ascension Health, together with (most appropriately for this paper) religious organizations. Of course, HHS denies any wrongdoing, but reports from the supposed targets say otherwise. They claim there was a clear insinuation that they needed to open their wallets as the collection plate circled around (Kliff 2013a).

Hence, this rent-extracting effort by HHS shows how greater entanglement with a televangelist coordinator may result in Bootlegger returns but at a price. As a sort of return for these donations, HHS is authorized to subsidize insurers found footing the bill for losses incurred

under the federal exchanges.[3] Using so-called risk corridors, the ACA authorizes the administration to compensate insurers for unexpected losses up to 50 percent for costs exceeding 3 percent and 80 percent for costs more than 8 percent of projected losses (Radnofsky and Dooren 2014). This approach has become known as an insurance bailout and, in turn, has been used as a rallying cry by those opposed to the law.

Most ironically, however, the risk corridors can actually cost companies more. If insurers find claims are less expensive than their estimates, they pay into the system rather than drawing money out of it. Indeed, the Congressional Budget Office estimated that this was the most likely scenario for 2014 (Dooren 2014). So much for bailouts![4]

Of course, the larger issue is that the risk corridors intertwine the interests of Bootleggers with those of televangelist coordinators by pooling risk. Because no obvious private alternatives exist, the insurance industry can hedge against the risk of larger premiums only by working with government. Thus, any attempt to break away from the system would jeopardize the firm's position. HHS can therefore use the mechanism as an additional means of reining in wayward Bootleggers (and extract a few rents too!).

Reining in the Bootleggers, Part 2: Hospitals

The second group of Bootleggers, hospitals, has plenty of benefits for its interests. In March 2014, the administration made a funding request for the training of more than 13,000 new medical

[3] Of course, the ACA already provided for this protection, regardless of whether firms provided ex post financial support for Enroll America. But this provision could have been used to coerce firms into giving their support, just as Senator Baucus did with pharmaceutical companies during the bill's passage.

[4] One could argue that the mere possibility of coverage was itself beneficial, all else being equal. However, the difference between this and other insured activities is that firms are basically coerced into joining the system under terms dictated to them. If sufficient demand to insure these activities existed, surely private markets would emerge. The fact that government has taken the reins with no obvious alternatives suggests, at the very least, that the arrangement is less than actuarially fair.

residents during the coming decade, together with a request for generous support for new federal health centers and mental health providers (Dooren and Burton 2014). But perhaps the most gratuitous benefit is one not anticipated by the designers of the law: hospitals can now cover uninsured patients by simply buying insurance for them on the new federal exchanges. Uninsured patients are one of the larger costs faced by hospitals. In theory, the law will exert pressure on people still without insurance through the individual mandate, though the level of enforcement of this unpopular component remains to be seen. In the meantime, hospitals have taken it on themselves to directly subsidize uninsured patients by purchasing insurance in the new exchanges. For example, the University of Wisconsin Health announced a $2 million pilot program to help purchase insurance for nearby low-income residents (Johnson 2013). Although this approach will certainly extend coverage to some who would not otherwise have it, the hospital inevitably will be allowed to pass on these previously incurred costs to insurance companies.

This development has not gone unnoticed by insurance companies, which oppose the unexpected influx of new patient claims at discounted insurance rates. The administration is somewhat divided on the issue, recognizing the negative impact it would have on the exchanges. Nevertheless, Secretary Sebelius has given the green light to the general practice of hospitals procuring insurance for those without it from the new exchanges (Carlson 2013).

Reining in the Bootleggers, Part 3: Pharmaceutical Companies

The individual mandate and possibility of new insurance customers in the nascent exchanges provide the potential for enormous growth for the third Bootlegger group, pharmaceutical companies. Daemmrich (2013, 152) argues that "over the course of its implementation in coming years, the ACA will significantly expand prescription drug use, including at the relative expense

of other health services." He goes on to forecast a more than 200 percent increase in industry revenues by 2020. This figure is unsurprising given that the ACA not only brings many new customers into the fold, but also offers additional support to programs associated with prescription medicines such as mental health counseling.

What about the Baptists?

And what about the Baptists? Never letting a good Baptist go to waste, HHS has reached out as a would-be televangelist to many popularly supported initiatives in an attempt to cover its interventionist efforts in a fine moral sheen. For example, HHS launched an initiative to reduce ethnic and racial health disparities even before the ACA became national law. By pooling its efforts with groups at a health summit in 2008, HHS was able to launch the "National Partnership for Action to End Health Disparities, which includes community- and faith-based organizations, businesses, health care and insurance industries, academe, cities and counties, states, tribes, and federal agencies" (Koh, Graham, and Glied 2011, 1823).

And the ACA itself provides numerous benefits to popular initiatives such as the Community Health Center Fund. "The fund will invest $11 billion over five years in ongoing operations at federally qualified community health centers; the expansion of preventive and primary health care services; major construction and renovation projects at existing sites; and the creation of new health centers in medically underserved areas" (Koh, Graham, and Glied 2011, 1825). Clearly, the Baptists are lining up at the barbecue as well.

Although the main thrust of the law is to correct perceived market failures in the health care industry, these projects nevertheless represent crucial signals to Baptist groups that keep the public sympathetic to the overall goals of the law. Having placated these groups, HHS can better

impose a sometimes-cumbersome (even unworkable) structure on its somewhat reluctant Bootlegger allies.

Discussion

The ACA has been a game changer for the health industry in a number of ways. The most significant change is the set of newly integrated ties among HHS, insurers, pharmaceutical companies, and hospitals. As Oberlander (2010, 1114–15) said just after the law was passed, "Arguably the most consequential decision that reformers made in 2009 was to work with, rather than against, health system stakeholders. . . . The administration negotiated deals with health industry groups to support reform in exchange for the promise of having millions of newly insured patients to treat."

This maneuvering by the Obama administration could be considered a cop-out or just another instance of powerful special-interest groups corrupting the purity of progressive reform with no strings attached. The Bootlegger and Baptist lens provides another story. By co-opting these groups early in the process, the administration ensured that they would be permanently entangled with government decision makers such as HHS (see Wagner 2009).

To reinforce this coordinated arrangement—and in a move reminiscent of the infamous TARP (Troubled Asset Relief Program) meeting between George W. Bush administration officials and Wall Street executives—President Obama presided over a conference of his health secretary and insurance executives in April 2013 in which he said, "We're all in this together," noting that business and government were now "joined at the hip" (Calmes 2013). Consider the parallels between this meeting and the one Treasury Secretary Henry Paulson had with banking industry's top executive in late 2008. Paulson was quoted as saying that noncompliance with his

financial bailout plan would leave detractors "vulnerable and exposed" (Easton 2009). Each occasion illustrates powerful coordinating efforts at the very highest level of government.

Thompson and Gusmano (2013) note that the law represents further extension and discretion of the executive branch of government. The law endows administrators with "vast latitude to shape who gets, what, when, and how from the ACA" (Thompson and Gusmano 2013, p. s7). Administrators are using this latitude to rein in Bootlegger and Baptist groups toward their collective goals. Whether these goals are in the public interest is a moot point. The salient factor is whose preferences are being considered at public and private levels. Clearly, the bureaucrats are gaining ground on this measure, one act of televangelism at a time.

The danger here is that political decision making is difficult to stop when it replaces market decision making. Hagel and Grinder (2005) explain how transferring decision making into the political domain tends to lead to only more of the same. They quite presciently argue that the difficulties in information accumulation and instability caused by political interference only exacerbate the need for bureaucrats to further consolidate power. In the case of the ACA, this circumstance is already apparent in how the law has unfolded. As elements of the law become unworkable (or politically unsupportable)—such as the CLASS (Community Living Assistance Services and Supports) Act (Wayne and Armstrong 2011), employer mandates (Kliff 2013b), and small business health exchanges (Kliff 2013c)—these components are jettisoned in favor of greater consolidation within the bureaucratic apparatus. In other words, bringing these parties into the fold is better than alienating whole sectors of the economy.

Ikeda (2005) further outlines this incremental process by which bureaucratic management replaces market process. He explains how a number of factors support incremental intervention once started. Part of his explanation rests on persistent error, in which bureaucrats fail to correct

their behavior even when given countervailing evidence. For example, insurers' protestations that the ACA would lead to rate hikes were blamed on greed rather than taken at face value as evidence of the law placing additional costs on insurers.

Ikeda (2005) also shows how ideology plays a role in increasing intervention. As society becomes accustomed to government providing the service, further intervention becomes easier to justify. The Bootlegger and Baptist framework buttresses this observation in that interest groups brought into the fold by a political coordinator such as HHS will inevitably adjust their operations to the point where incremental intervention becomes easier to manage and reversion to market process more difficult. Indeed, when these groups are fully entrenched in the political process, they often become the loudest supporters of greater government intervention in market processes.

Conclusion

In this paper, I show how the development of the Patient Protection and Affordable Care Act enabled the Department of Human and Health Services to coordinate Bootlegger and Baptist interests in a way that permanently entangles these various industries with bureaucratic decision making. The irony is that we have seen this development before, when HHS was known as the Department of Health, Education, and Welfare and was largely responsible for the passage of the Health Maintenance Organization Act of 1973. This act gave birth to the health maintenance organization (HMO) model. Today, its counterpart is the accountable care organization (ACO). Like their HMO ancestors, ACOs provide bundles of health services through consumer networks, thereby decreasing competition through the well-known practice of tying and, in turn, reducing consumer choices to those ultimately approved by government bureaucrats.

In a subsequent paper, I will further examine this trend of relying on consumer networks to bundle health care services. By grouping providers, insurers reduce the set of choices open to consumers in favor of offering the lowest-cost package. Tradeoffs between cost and choice are nothing new, but their encouragement by the ACA is novel.

This approach has already generated negative feedback from consumers, who complain of the limited set of choices of the new networks and lack of access to desired providers. To date, the administration has reacted by doubling down on the ACO strategy, suggesting new regulations and reforms that will only further constrain insurers in how they balance decisions about providers and cost considerations. Once again, market decisions are removed, to be replaced by the cries of the televangelist.

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