Judges. By Donald Dale Jackson

The Honorable Jacob Mishler
BOOK REVIEWS


Reviewed by the Honorable Jacob Mishler**

Judges is a potpourri of history, politics, current and old news items and vignettes of state and federal judges. The author is a news reporter and magazine writer. He surrounds the judicial decisional process with an air of contrived mystery. The author's expressed purpose in writing the book is "to illuminate the character and quality of American Judges." He crisscrossed the country for source material (he lists some 27 pages of source notes), and presumably read extensively in his search. He promises hair raising revelations as he pries into esoterica. The promises are not fulfilled. The book tells us little we didn't know—i.e., that judges are appointed or elected as a political reward or through a personal relationship with a Governor, United States Senator or the President of the United States; there are good judges and bad judges; that the power of the judiciary is awesome; that the decisional process is greatly influenced by ethnic, racial and religious background—and offers no solutions to the problems it enumerates.

The author describes in some detail the various systems used in selecting judges. Both the elective and the appointive systems have brought incompetent judges as well as men and women of extraordinary ability to the bench. Both methods find strong support in tradition, history and vested political interests. Other plans are superficially analyzed. For example, the Colorado Merit plan is described as follows:

The new plan established a nominating commission for each of the state's twenty-two judicial districts and another for appellate courts. Each commission is led by a non-voting Su-

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**Chief Judge, United States District Court, Eastern District of New York.
1. I can think of no class of society that is subject to more public examination and criticism than judges. Judges' written decisions are found in thousands of volumes and countless unpublished opinions. Their courtroom behavior is also the subject of close scrutiny by the media and the general public.
2. P. vii.
3. P. 204.
Supreme Court justice, and includes three attorneys (selected by the chief justice, the attorney general, and the governor) and four laymen named by the governor. In addition, the amendment created a nine-member Commission on Judicial Qualifications (five judges, two lawyers and two laymen) with authority to recommend to the state Supreme Court that a judge be removed.

The governor must fill a vacancy with one of the names submitted by the nominating commission within fifteen days. Judges are appointed for two-year terms, then run on their record on a yes-no “retention ballot,” without opposition. Those at Greene’s level [Judge Greene is a member of Colorado’s highest trial court] are elected for six-year terms. As of 1972, 40 percent of Colorado’s judges had reached office by this process.

There is no perfect plan for selecting judges. Both the elective method and the appointive method have obvious deficiencies. To me, the glaring defect in the Colorado Merit plan is the probationary term of two years and the requirement that the judge run on a “retainer ballot” for a term of six years. Few competent lawyers with substantial practices would give up their practices for such an unpredictable future on the bench. If I were called upon to devise a system for selecting judges, I would borrow the commission feature of the Colorado plan. I would insist on life appointment by the Chief Executive after full and complete investigation and public hearing and confirmation by the legislative body. The prestige of judicial office coupled with the security of life appointment would attract the finest legal talent available. The public’s interest could be safeguarded through a removal procedure.

Other interesting problems and trends in our judicial system are noted, i.e., the wasteful dual system in this country (federal and state), the overlapping jurisdiction of our state courts, activism and traditionalism in the judicial process, and ascendancy of Blacks to the judiciary in the South.

The writing is hurried, uneven and haphazard. A chapter may start with a quotation from the classics, a survey, or a treatise, then meander through a personal history of a judge’s elevation to the bench, sprinkled with pointless conversation and a news story of an unrelated event. The author exercised poor judgment in the selection of material. I got the impression that he used everything he gathered to give the book its bulk (398 pages) plus 47 pages of preface, acknowledgments, source notes and index.
The book contains many inaccuracies, canards and distortions. Some will be apparent to the average reader; many will go unchallenged. I was privy to the events that occurred in the United States District Court for the Eastern District of New York. Two of them deserve mention here.

Jackson makes much of the late Judge George Rosling's display of anger during the well publicized skyjacking trial of Garrett Brock Trapnell. This lengthy trial, which eventually ended in a hung jury, generated considerable interest in the news media and in the general public. The public heard and viewed the skyjacking and witnessed the dramatic shoot-out between Trapnell and the F.B.I. agents, disguised as a relief crew at John F. Kennedy Airport on January 29, 1972. Public interest was heightened through news stories of Mr. Trapnell's past history of violent crime and his prior success in the use of legal defenses based on lack of mental capacity. Mr. Trapnell interposed the same defense to the skyjacking. The Government claimed that Trapnell had the mental capacity to both appreciate the criminality of his conduct and conform his conduct to the requirements of the law, and further that he had merely feigned insanity when faced with criminal charges in the past.

From the date of Trapnell's arrest on January 29, 1972, to the date of the commencement of the trial on December 11, 1972, the court had to deal with an extraordinary number of pretrial motions. In this busy court judges are assigned cases under the individual assignment system. Cases are scheduled for trial six to eight weeks in advance of the trial. The Trapnell trial time was estimated to be about two weeks. It was a five week trial. The evidentiary part of the trial was completed on January 10, 1973 and the case given to the jury on January 11, 1973. Disruption in the trial schedule is something a judge deals with every day. Every delay requires conferences with lawyers for the purpose of rescheduling trial dates, conferences between lawyers and judges of other courts to rearrange trial dates in those courts, and endless telephone calls.

After the first day of deliberation, juror No. 4 wrote a letter

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4. In layman's language, his defense of insanity had gained him many acquittals for earlier criminal acts.
5. Five motions were for psychiatric examinations.
6. The United States District Court for the Eastern District of New York has one of the most congested criminal calendars in the country.
to Judge Rosling complaining that the other jurors were attempting to coerce a verdict. The court disclosed the letter to the lawyers and the defendant's counsel moved for a mistrial. Judge Rosling directed continued deliberation, charging the jurors on their duty to confer with each other and cautioning the jurors against coercing a verdict. The normal reaction of a busy judge beset by the problems presented by a mistrial is one of helplessness and frustration, which deepens with the awareness of the ever increasing backlog of cases demanding immediate trial.

Judge Rosling held court on Saturday, January 13, 1974. On that day the Foreman reported to him that eleven jurors had arrived at a verdict of guilty soon after the jurors started deliberating and that from the outset juror No. 4 sat in a corner mute, and refused to discuss the case with the other jurors. I did not witness the scene reported by the newspapers but I can well understand the irritation, and even anger, that led Judge Rosling to utter the inappropriate statement. He realized the dissenting juror had been employed as a psychiatric social worker all her life. It appeared to him that the juror came to the jury box with a fixed notion about the case. Judge Rosling believed the juror had violated her oath to decide the case on the evidence. Mr. Jackson saw nothing more than an angry, irascible judge. Mr. Jackson's interest did not go beyond repeating the news report of that day. He might have learned something of the deep emotional distress that is experienced by a dedicated trial judge when he is faced with a retrial after a mistrial. He might have recorded the feeling of exasperation and frustration in the realization of wasted time and money, the fleeting doubt as to the viability of the jury system. Judge Rosling would have conceded the inappropriateness of his statement; he would have told Mr. Jackson of his surprise at the press report. As it is written, Mr. Jackson's report of the incident is superficial and uninstructive.

The other subject of which I have personal knowledge is repetition of a charge of a conflict of interest made against a judge of this bench in the New York Daily News. The author reports that the Second Circuit Judicial Council stated that "no action by the Council is warranted." The reader is left with the impression

7. Jackson reports that Judge Rosling "threatened to have the juror investigated by FBI agents to 'see whether she was performing her jury functions or some other functions.'" P. 156.
8. P. 275.
that the conflict of interest was established, but that the breach was not serious enough for action by the Council, or worse yet, that the Council merely protected a "member of the club." The charge was baseless. A full explanation was made to the Daily News reporter but not adequately reported in the newspaper. The judge, having no forum in which to defend himself, voluntarily made a full disclosure to the Chief Judge of the Circuit. The information was available to the author through a telephone call. Mr. Jackson again missed an opportunity to tell us something about the character of American judges.

Chapter XV entitled "Portrait in Ermine" is by far the best written part of the book. The focus on a single court—the Supreme Court—makes the subject manageable. Moreover, the topic lends itself well to the purposes of the book. In tracing the history of the Supreme Court, Jackson highlights many informative and often overlooked details. We have only had 100 Supreme Court Justices in the history of the Court. The Supreme Court under Washington was a six member Court, increased to seven under Jefferson, and then to nine under Jackson. We may have forgotten that Lincoln was given the opportunity to pack the Supreme Court when Congress increased the number from seven to ten. Lincoln appointed five Justices in three years. Mr. Jackson also reminds us that the Reconstruction Congress that sought to remove Andrew Johnson curbed his appointive power by reducing the number of Justices to seven. The Court was increased to its present size in 1869.

This chapter is flavored with incidents displaying the personality of some of our Justices. The author describes the behavior of Justice James McReynolds as "a cantankerous Tennessean who had been Wilson’s Attorney General before he reached the court in 1914." Mr. Justice Frankfurter described McReynolds as "a hater." Chief Justice Taft said of him that he was "selfish to the last degree . . . fuller of prejudice than any man I have ever known, and one who seemed to delight in making others uncomfortable." The chapter makes easy reading and at times is exciting. The writing is marred by the incorporation of a description of a visit the author made with Chief Justice Burger to the Maryland State Penitentiary in Baltimore. If this were deleted, Chapter XV might very well serve as a separately published monograph.

10. Id.
11. Id.
When a book is prefaced, as is Blue Cross: What Went Wrong?, with statements that its authors have “produced scholarly analyses of major aspects of health services delivery”; when it includes 858 footnotes; when it identifies itself as the “collective effort of the Health Law Project of the University of Pennsylvania”; and when it is published under the equally academic auspices of the Yale University Press, one has a right to expect that however critical its conclusions, it will state facts accurately and will not omit important data even when they are contrary to its thesis.

These standards of truth and probity this critique of the Blue Cross system fails sadly to meet.

It makes many material misstatements of fact; it makes no mention of significant events that run counter to its thesis; it omits important and easily available data; it depicts as current, circumstances which have long since changed and, worst of all,

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1. According to its Foreword, “[d]ozens of people contributed to this book,” (Foreword at ix), but hereafter this review will, for convenience, refer to Ms. Sylvia Law who is identified as the “Principal Author” and whose picture appears on the dust jacket.

2. Foreword at ix.

3. Id.

4. While some of the misstatements are noted hereafter, the complete catalog would require too much space. They range from the unimportant, such as identifying Mr. Robert Ball as Actuary of HEW (p.61), when actually he was Commissioner of Social Security in HEW, to more serious errors such as stating that the Pennsylvania statute (Pennsylvania is the Health Law Project’s home state) “is silent on the review of reimbursement rates to hospitals” (p.14), when actually Pa. Stat. Ann. tit. 40, §6124 (a) (Supp. 1974) provides specifically for their approval by the state authorities.

In any event, to conserve space in this article I have not specifically cited all the pages and lines where these errors in fact occur. A complete statement of the errors is on file in the offices of the Hofstra Law Review.

5. See text accompanying notes 21-39 and 52-55 infra.

6. See text accompanying notes 66-96 infra.

7. Neither in the text nor in any referenced footnote does the author mention that the frontispiece quotation from Herman and Ann Somers was written sixteen years ago. Thus, there is no way for the reader to put in time perspective the charge, to which the
it repeatedly uses the technique of innuendo to mislead the reader.\textsuperscript{8}

I use the word "sadly" for two reasons. First, a lot of work and effort must have gone into the book's preparation, and some of its background material, particularly that with regard to legislative history, is informative. The second source of my regret is that I am in complete and wholehearted agreement with the book's finding that health care financing should be "primarily responsive and accountable to the public interest"\textsuperscript{9} and also with its three basic themes and assumptions, which are:\textsuperscript{10}

1. "that the issues involved with the financing of health services are fundamentally ones of public and social policy;"
2. "that, in the absence of countervailing pressures, any organization or bureaucracy will attempt to maximize institutional autonomy and stability, particularly financial stability;"
3. "the fundamental powerlessness of the consumer of health and hospital care."

It is indeed depressing that so much labor on such worthy themes has not blossomed into a useful study.

Within the context of those three themes, the book develops its thesis of how Blue Cross "went wrong." In so doing, Ms. Law maintains that:

\begin{itemize}
  \item \textsuperscript{8} The charge of intentional deception is as grave as it is difficult to prove. Knowing men's minds is no simple task.
  \item \textsuperscript{9} The scores of factual misstatements in the book are probably due mostly to oversight, ignorance or carelessness rather than conscious intent. Surely, nobody in his or her right mind would intentionally misstate a fact that rebuttal could effectively disprove except, perhaps, a schemer anticipating that the gain outweighs the risk. It is for that reason that purposeful deception is usually by way of concealment and/or innuendo. It is fully demonstrated here when the natural conclusions drawn by the reader from the text of the book differ from the true state of facts on occasions too numerous for coincidence.
  \item \textsuperscript{10} One other consideration: while Ms. Law is principal author, this work is, as noted, a multiple effort. In the book, the loaded innuendoes seem to run in streaks. They alternate with strata where recital of facts is only minimally adorned with hyperbole. These different styles could well signify different writers, and so the apportionment of censure becomes even more difficult, except perhaps under the doctrine of \textit{respondeat superior}.
\end{itemize}
1. "[h]ospital representatives currently dominate Blue Cross boards;"\textsuperscript{11}

2. "the problem is [such] provider representatives are primarily responsible to hospitals rather than subscribers or the public. It is unrealistic to expect that, as Blue Cross board members, hospital representatives will challenge hospital policies on cost control, area planning or reorientation of services;"\textsuperscript{12}

3. "public planning is doomed to fail unless Blue Cross coordinates reimbursement with the public planning processes. Blue Cross has, with few exceptions, failed on each of these points;"\textsuperscript{13} \\
\textsuperscript{13}"[t]he picture that emerges is one of total unaccountability."\textsuperscript{14}

This refrain—that there is a malign and cozy collusion whereby a complacent hospital-dominated Blue Cross system overpays hospitals with no controls imposed and few questions asked—is repeated many times throughout the book.\textsuperscript{15} As an example, Ms. Law states that "[o]nly one instance can be found in which a local Blue Cross Plan, or state official supervising such plan, has attempted to limit hospital reimbursement to a reasonable level for allowable items."\textsuperscript{16} The instance cited is Pennsylvania.

I submit that Ms. Law's reiterated assertions that Blue Cross is a creature of the hospitals\textsuperscript{17} which makes no attempt to limit reimbursements, coupled with her assertion that only Pennsylvania has made such attempts, is grossly misleading in view of the significant limitations on such payments in a number of other states\textsuperscript{18} and the District of Columbia. These payment limitations

\textsuperscript{11} P. 26.
\textsuperscript{12} P. 27. See also pp. 29, 65.
\textsuperscript{13} P. 94.
\textsuperscript{14} P. 96.
\textsuperscript{15} Pp. 60, 61, 64, 65, 67-69, 89-93, 96.
\textsuperscript{16} P. 89.
\textsuperscript{17} Pp. 6, 10, 19, 26, 27, 97.
\textsuperscript{18} E.g., Massachusetts, Michigan, New York, Rhode Island and West Virginia.

Massachusetts: For 1974, the Blue Cross Plan's interim payments to each hospital cannot exceed 6.87% of the 1973 payments, adjusted for changes in occupancy. Final rates will be established on the basis of increases in the general economy over 1973 derived from U.S. Bureau of Labor Statistics, National Survey of Professional Administrative Technical and Clerical Payrolls classified into 19 different areas.

For over a decade prior to 1974, the Massachusetts Blue Cross Plan disallowed on audit, individual hospital expenses in amounts averaging over a million dollars a year. After such adjustments, each hospital's payment rates were based on the lower of allowable cost or charges. In 1973, this resulted in 43 out of 132 hospitals receiving payments at rates lower than cost.

Michigan: Since 1958, the Blue Cross Plan has classified hospitals by size and geo-
have been evidenced in a number of those jurisdictions by lawsuits between the Blue Cross Plan and hospitals with respect to such limitations.\textsuperscript{19}

I make this point with some vigor since for the last 15 years as Secretary and Counsel of Greater New York's Blue Cross Plan (sometimes known as Associated Hospital Service, hereinafter referred to as "AHS"), I have spent a large portion of my time contesting hospital lawsuits and proceedings demanding additional reimbursement.\textsuperscript{20} During that period, hospital representatives have called me a Communist, a Bolshevik, and a destroyer of hospitals. After a bitter hearing on reimbursement rates, one attorney for a particularly prestigious hospital asked me how I could sleep at night after denying his client money needed to pay for the care it rendered its patients. I do not recite these occasions from any sense of grievance but merely to indicate that extremists, whether they want more money for hospitals or, like Ms. Law, less money, are equally capable of empty epithets.

Let us turn from epithets to the record—cases where AHS has fought to limit while hospitals strove to increase payment rates.

graphical area and imposed limitations on these groups as to the amount which the hospital's payment rate can increase from one year to the next, dependent on its average per diem cost compared to the average for its peer group. Approximately 15-20 hospitals each year have had their payment rates reduced below cost by this limitation.

Rhode Island: Since 1970, by Rhode Island statute, (R.I. GEN. LAWS ANN. §27-19-14 (Supp. 1973)) the state budget office has participated in line by line budget negotiations between the Blue Cross Plan and its member hospitals. Payment rates derive from these budgets to which the hospitals must correlate their expenditures or bear the consequences. See notes 19-20 infra, for cases concerning payment limitations in the other noted jurisdictions.


\textsuperscript{20}. The situation in New York State seems a proper subject for discussion since Ms. Law herself chose it as a primary arena. At the beginning of the book (pp. 14-16), she relies heavily on three pages of quotations and conclusions drawn from two New York State lawsuits; Thaler v. Stern, 44 Misc.2d 278, 253 N.Y.S.2d 622 (Sup. Ct. N.Y. County 1964) and Procaccino v. Stewart, 25 N.Y.2d 301, 251 N.E.2d 802, 304 N.Y.S.2d 433 (1969). Both of these New York cases were decided in favor of the Blue Cross Plan and will be examined in more detail later (see text accompanying notes 75-84 infra). Since Ms. Law cites them for the proposition that there is no examination "into the reasonableness and propriety of payments made to member hospitals by [Blue Cross]" (p. 15), she has a responsibility to her readers to at least refer to the many other proceedings in New York State where the Blue Cross Plans or the regulatory authorities or both have vigorously contested hospital demands for higher payment rates. See text accompanying notes 21-39 infra.
I. REIMBURSEMENT TO HOSPITALS


1. Prior to 1970

While the volume of controversy and litigation between the Greater New York Blue Cross Plan and its member hospitals has increased since the introduction of prospectively determined payment rates in 1970, the decade of the 1960's did see considerable litigation, focused on limitations on payment, between the Greater New York Blue Cross Plan and the hospitals in the metropolitan New York area. The results of the many court cases between hospitals and the Blue Cross Plan in this decade were almost entirely supportive of the New York Blue Cross Plan's efforts to limit or withhold payments to hospitals.

Of particular interest in this connection is Lefferts General Hospital, Inc. v. Associated Hospital Service of New York. At page 89 of her book, Ms. Law criticizes the American Hospital Association's "Principles of Payment" (which at page 66 she incorrectly attributes to the Blue Cross system), on the basis that "allowable" items are not questioned. Particularly, Ms. Law asserts that "if a salary is 'allowable' for a particular position, it is a reasonable cost whether the amount paid is $10,000 a year, $50,000 a year or $200,000 a year."

However, in the Lefferts case, Greater New York's Blue Cross Plan did question and disallow $91,500 of salaries paid by Lefferts General Hospital on the basis that the work done "was duplicative and not substantially productive," and successfully defended this limitation in court. Again, in another case, the New York Plan's refusal to include as "allowable," cost rent which it...


23. P. 89.

regarded as unreasonably large was upheld.\textsuperscript{25}

While the New York Blue Cross Plan was successful in these contests with hospitals in the courts, it had more difficulty with various administrative proceedings brought by other hospitals attacking the same and other limitations placed by the Blue Cross Plan upon their payment rates. In a proceeding brought by Madison Avenue Hospital with respect to 1965 payment rates, the New York State Commissioner of Health determined that the New York Blue Cross Plan had acted properly in disallowing certain salaries, but that its imposition of a ceiling on the maximum allowable percentage increase in per diem expense made the payment rate to the hospital inadequate.\textsuperscript{26} The limitation on the allowable percentage increase in per diem expense was again stricken down in a proceeding by Parsons Hospital, also with respect to its 1965 rates.\textsuperscript{27} In a proceeding by Medical Arts Sanatorium, Inc. with respect to 1963 and 1964 rates of payment, the Commissioner of Health determined that the Blue Cross Plan had improperly disallowed certain salary from reimbursable expense, but that its application of limitations reducing the hospital's reimbursement because of inefficiently low occupancy was appropriate.\textsuperscript{28} In a proceeding by Pearl River Hospital with respect to its 1965 payment rates, the Blue Cross Plan was ordered not to disallow certain salaries and further, not to apply a ceiling limitation which had been based on the average costs for a comparable group of hospitals.\textsuperscript{29}

The imposition of a limitation based on the average costs of similar hospitals was also called into question in a proceeding by the Long Island Jewish Medical Center.\textsuperscript{30} Attacking the application of this "Group Maximum," and dissatisfied with the allowances which the Blue Cross Plan had made for its skills and resources as a teaching center, the hospital demanded that no

\textsuperscript{25} Mid Island Hosp. v. Wyman, 25 App. Div.2d 765, 269 N.Y.S.2d 259 (2d Dep't 1966).

\textsuperscript{26} In re Madison Avenue Hospital, order dated July 17, 1970. A copy of this order is on file in the offices of the Hofstra Law Review. See p. 93 of the text of the book where Ms. Law speaks favorably of "a fixed limit on allowable increases in reimbursement," the type of control AHS sought to impose here.

\textsuperscript{27} In re Parsons Sanitarium, Inc., order signed July 17, 1970. A copy of this order is on file in the offices of the Hofstra Law Review.

\textsuperscript{28} In re Medical Arts Sanatorium, Inc., order signed November 23, 1970. A copy of this order is on file in the offices of the Hofstra Law Review.

\textsuperscript{29} In re Pearl River Corporation, order signed July 28, 1969. A copy of this order is on file in the offices of the Hofstra Law Review.

\textsuperscript{30} In re Long Island Jewish Medical Center, order signed April 20, 1973. A copy of this order is on file in the offices of the Hofstra Law Review.
Group Maximum whatsoever be applied and that the Plan make additional payments of $1,500,000 in connection with its payment rate for years 1965 through 1969. In his decision, the hearing officer found that the Blue Cross Plan had given insufficient recognition to the special circumstances at this institution and that the hospital should be paid an additional $583,000—an amount which the Health Department later reduced to $448,000.

2. Hospital payment disputes-1970 and after

With the 1970 introduction of prospectively determined reimbursement rates in New York State, there was a rapid increase in the tempo of hospital proceedings against this Blue Cross Plan. On July 15, 1970, 22 members of the Greater New York Hospital Association began the first proceedings under the internal review provisions of the state-approved Blue Cross Prospective Reimbursement Method, which proceedings were subsequently carried to the Department of Health. Since 1970, nine different hospitals have started separate proceedings before the Department of Health seeking sums aggregating in excess of $15,000,000. This does not include more than 100 appeals that did not reach or have not yet reached the Health Department, involving sums in excess of $150,000,000.

In May and June of 1973, three lawsuits, two of them in Supreme Court, New York County and one of them in Federal District Court were commenced by a total of 55 hospitals attack-
ing the Prospective Reimbursement Method and its implementation by Greater New York's Blue Cross Plan in the light of the economic environment produced by federal price controls for the year 1973. These lawsuits sought a total increase in 1973 payment rates in the approximate amount of $70,000,000.

In April of 1974, Justice Gellinoff of the New York Supreme Court rendered his decision upholding the prospectively determined reimbursement method of the Plan but overturning one aspect of its interaction with the federal price controls. Under this court determination, hospitals were found to be entitled to the lifting of Blue Cross Plan limitations in the amount of approximately $14,500,000.

In 1974, the Plan has already been served with papers in a hospital class action concerning 1974 rates of payment; additionally, Presbyterian Hospital has commenced an action for approximately $5,000,000 on the basis that the Blue Cross rates of payment for 1970 and 1971, as confirmed by the decision of the Health Department, were insufficient.

All books have publication deadlines. The developments in 1974, perhaps even 1973, probably came too late for inclusion in Ms. Law's book. They are only the most recent developments, however, in a consistent pattern of hospital reaction to AHS payment limitations. What happened in 1973 and 1974 was a continuation of the prior decade with its scores of lawsuits and administrative appeal proceedings by hospitals of all types.

Ms. Law could easily have discovered these New York proceedings by the most elementary legal research or the simplest inquiry. She instead chose utterly to ignore them and assert that only in Pennsylvania do Blue Cross Plans attempt to limit hospital payments.

B. New York State Hospital Cost Control Act.

While the book makes no mention of the reimbursement litigation between hospitals and Greater New York's Blue Cross

(S.D.N.Y., filed June 1, 1973). At the time this review went to press, this case was still pending.


Plan, it does comment on the New York State 1969 Cost Control Law. In so doing, it badly misstates and misconstrues the incentive reimbursement program established through prospectively determined rates. First of all, it is not true that “it does not apply to many of the most costly elements of hospital care” such as “capital costs, costs of schools of nursing, costs of interns and residents, and costs of ancillary services.” The truth of the matter is that items such as ancillary services are part of the predetermined rate within which the hospital must live. Thus Ms. Law’s subsequent statements “that as much as one-half of a hospital’s operating budget is excluded from controls” and “[a] hospital could shift routine costs to ancillary services and be assured of full reimbursement, plus the incentive guaranteed by the base rate” are equally incorrect.

Ms. Law has become confused because the New York State Medicaid reimbursement method, and that of the upstate Blue Cross Plans, exempt ancillary services from the application of limitations based on group averages. The feeling is that the justified differences in ancillary services, hospital by hospital, make them less amenable to averaging than more routine services such as bed, board and general nursing service. This approach may or may not be correct, but it certainly does not exempt these services from the prospectively determined rate and the consequent stimulus to the hospital not to spend more than the rate provides.

Furthermore, the Greater New York Blue Cross Plan has availed itself of the Health Department Regulations and their flexibility to apply the same limitations based on group averages to ancillary services as it does to routine services. Thus Ms. Law’s comment is not only inaccurate generally but utterly inapplicable to the Greater New York Blue Cross Plan, and evidences her ignorance as to the operation of prospectively determined reimbursement in New York State.

It is significant that the groupings under which the averages

40. Pp. 105-06.
41. N.Y. PUB. HEALTH LAW §2807 (McKinney 1971).
42. P. 105.
43. Id.
44. 10 N.Y.C.R.R. §86.2(b) (1970).
45. Associated Hospital Service of New York, Prospective Reimbursement Method, Chapter 2. The applicable provision is contained in the Method originally certified by the New York State Commissioner of Health and approved by the Superintendent of Insurance for reimbursement rates for the year 1970 and in each of the revised Methods approved for the succeeding years, copies of which are on file in the offices of the Hofstra Law Review.
and thus the limitations are established have been criticized not only by Ms. Law, but also by the hospitals to which they apply as being not too generous, but too restrictive. The Long Island Jewish Medical Center and Pearl River proceedings are only two examples of Blue Cross-Hospital disputes arising from group-derived limitations which Greater New York’s Blue Cross has imposed on hospitals since 1960.

There is some merit in Ms. Law’s criticisms that in the prospective reimbursement system, “the incentive provided is indiscriminate” and that it has not taken into account proper “allocation of resources” between hospitals, at least insofar as changes in those allocations are concerned. However, while she charges that “New York’s program assures that hospitals that spend most, and have spent most in the past, will receive most,” it is just those hospitals which have been the most militant in bringing legal proceedings against Greater New York’s Blue Cross on the basis that their payment rates are inadequate, thus indicating substantial Blue Cross limitations on these hospitals.

Ms. Law does admit that “[i]f the problem of rising hospital costs were primarily one of efficiency or incompetence, cost incentives and penalties would be a helpful reform.” However, she characterizes the most expensive teaching hospitals as “often highly structured, well organized, and staffed with efficient, highly motivated and intelligent people” and argues that incentives do not help with these institutions’ chief problem of being “oriented toward parochial professional prestige.”

I think that Ms. Law has made a good point in saying that many cost escalation problems arise largely from competitive rather than cooperative striving for excellence. Still, she should realize that a hospital spending beyond its payment rates because of such an endeavor is just as adversely affected by the monetary loss as a hospital overspending because of inefficiency. Thus Ms. Law underestimates the effectiveness of incentives.

However, prospectively determined reimbursement as an incentive for hospitals to use available funds wisely and efficiently is a recent innovation. Refinements and improvements are

46. P. 106.
47. See notes 29, 30 supra.
48. P. 106.
49. Id.
50. Id.
51. Id.
probably in order. Methods for setting rates of payment that will recognize and stimulate effective delivery of a health care service that is uniquely personal to each patient (and thus so difficult to measure) can always profit from improvement. We certainly are not ashamed of prospectively determined reimbursement thus far, but we also welcome suggestions from Ms. Law or anyone else who can point the way to specific and practical improvements.

C. Reimbursement for care rendered to Medicare over Age 65 Beneficiaries.

Chapter IV of this book is entitled "Blue Cross and the Cost of Hospital Services." Throughout it, Ms. Law vehemently criticizes the workings of the "reasonable cost" reimbursement plan under Medicare and further maintains that Blue Cross is to be held responsible for its inception. Actually, the basis of reimbursement was established in 1965 by Congress in the Medicare Act\textsuperscript{52} and by HEW in the Principles of Reimbursement and other regulations issued by the Social Security Administration.\textsuperscript{53} Despite the book's attempts to cast the Blue Cross Plans in the role of the patron and progenitor of the alleged faults in the Medicare reimbursement method, the fact is that they, and the New York Plan in particular, pointed out and sought correction of flaws in the reimbursement method.\textsuperscript{54}

The Blue Cross role in Medicare reimbursement was not in the design of the method but its implementation and application to individual hospitals. With respect to implementation, which is the Blue Cross Plans' function, decisions in 223 appeals by hospitals alleging inadequate reimbursement have been published from 1968 to May, 1974. In these appeals, 70% of the decisions supported the local Plan's position as to reimbursement, 22% resulted in a partial recovery and only 8% were decided in favor of the hospitals seeking added payment.\textsuperscript{55} This is scarcely a record which supports Ms. Law's characterization of incompetency and complacency toward hospitals.

\textsuperscript{52} 42 U.S.C. §1395f (b) (1970).
\textsuperscript{53} 20 C.F.R. §405.401 et seq. (1974).
\textsuperscript{54} See text accompanying notes 66-96 infra.
\textsuperscript{55} At the outset, digests of these decisions were published in the Commerce Clearing House Medicare and Medicaid Guide which subsequently discontinued, but more recently has resumed, such publication. A record of these materials is available from the author upon request.
II. **Blue Cross Boards of Directors, Particularly in New York State, are Not Hospital-Dominated**

There was a time when Blue Cross Plan boards were hospital dominated; but that time is long past in most jurisdictions, including New York State. Ms. Law cites the New York statute as one of the "enabling acts [which] require hospital representatives on the board."\(^5\) Reference to the statute indicates that the requirement would be satisfied for Greater New York's Plan by one hospital representative on its 44-man board, and further that the statute is very specific in its limitation of hospital and physician membership together on Blue Cross boards by requiring that "not more than one quarter of the directors . . . shall be persons who are licensed to practice medicine . . . or who are trustees, directors or employees of a corporation organized for hospital purposes."\(^5\)

As to the extent to which board membership is monitored by the New York State Insurance Department, Ms. Law errs in stating "... neither the BCA nor the Insurance Departments presently scrutinize board members for direct conflicts of interest . . . "\(^5\) The fact is that the New York State statute specifically requires such scrutiny. Compliance with the provisions of the law with respect to possible conflict of interest "shall be under the supervision of the [S]uperintendent [of Insurance]."\(^5\) The statute further directs that not more than ten days after the election of a director, the Superintendent shall be furnished in writing "the name and address of the person so elected; whether such person is . . . qualified to serve under the provisions of this subdivision; and a biographical statement concerning such person."\(^5\)

Naturally, the New York State Blue Cross Plans comply with both the requirements that board membership be submitted for Insurance Department scrutiny and that representatives of subscribers and the general public must make up 75% or more of Plan board membership. As a matter of fact, since its consolidation with the local Blue Shield Plan on June 1, 1974, the Greater New York Plan has had only five hospital representatives serving on its 44-man board.\(^5\)

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60. Id.
61. Bylaws of Blue Cross and Blue Shield of Greater New York, effective June 1, 1974
Aside from Ms. Law's errors as to New York State law, her charges of current hospital domination of Blue Cross boards of directors are not in accord with recent national statistics. Nor does she acknowledge that, "the needed increase in public and consumer representation on its [Blue Cross'] policy-making bodies," which Herman and Anne Somers called for sixteen years ago, has been taking place. Her only recognition of change is in footnote 150 where she characterizes as "a slight decrease" a decline of 13% in the proportion of hospital and doctor representatives from 1945 to 1969. The book is silent as to a further decrease of 17% in provider representation from 1969 to 1973, and the fact that by 1973 hospital representation on Blue Cross boards of directors across the country had fallen to 29%, even when one includes hospital trustees.

The characterization of hospital trustees (as well as full-time hospital administrators) as hospital representatives raises an interesting point as to Ms. Law's charge that "[i]t is unrealistic to expect" that such representatives will "challenge hospital policies on cost control." The fact is that hospital trustees often have as their full-time jobs employment by companies which spend millions of dollars on Blue Cross Plan premiums and therefore have millions of dollars at stake in controlling hospital costs. In such instances, the Blue Cross board member will have at least as much concern for his employer, whose interest is in keeping hospital payments down, as for the hospital of which he is a trustee. In any event, such a board member would have the benefit of viewing the problem from both points of view, a position that helps promote perspective.

following Hearing on Consolidation Before the New York State Dep't of Insurance (May 13, 1974). A copy is on file in the offices of the Hofstra Law Review.


64. Hospital and medical representation of 72% in 1945 had declined to 59% in 1969 and 42% in 1973. On a basis relative to the number of hospital and doctor representatives, these represent declines of 18.1% and 28.3%, respectively.

Further, the percentage of hospital and medical representatives is even lower if it is related to the number of subscribers covered. The figures given above related to total number of directors without reference to the size of the Plans where they serve. On the average, it is the smaller Plans which have a higher percentage of hospital and medical representatives and the larger Plans which have a lower percentage of hospital and medical representation on the board. Thus, public and subscriber control is the strongest where it counts the most—in the larger plans with the most subscribers covered.

65. P. 27.
One important point that Ms. Law rightly makes is the over-riding necessity that Blue Cross Plan boards be responsible to, and continually sensitive to the needs of, subscribers and the public. Some of the better passages in the book are the recitations in Chapter V of the unpleasantness and suffering which can occur when human needs run afool of rigid, albeit well-intentioned, rules and regulations. While the book still attributes to Blue Cross Plans responsibility not only for their own acts or decisions but also for decisions over which they have no control, the points it makes as to the conflict between tender loving care on the one hand and enforcement of good utilization practices on the other are valid and well presented.

Nobody can do a perfect job in resolving such paradoxes, but this is all the more reason that less than optimum performance in service to the subscriber should be identified, examined and corrected.

III. Supervision by State and Federal Regulatory Authorities

A. State Supervision.

In particularizing its charges as to "the massive failure of the public regulatory agencies to regulate either Blue Cross or the hospitals," the book reserves its most scathing comments for the New York State Insurance Department. When it states that the New York Department "has done a lackadaisical job regulating Blue Cross," the reader is likely to conclude that it is referring to New York in the statement on the same page that in "the majority of states there remains no opportunity for public participation in the rate making process." The fact is that the New York State Insurance Department has held scores of public hearings on the non-profit plans in the State, eleven of them covering a total of sixteen days on the Greater New York Plan alone. At these hearings, many hundreds of witnesses have had the opportunity to comment on the Blue Cross Plan program and performance.

As to other areas of regulation, while commercial insurance companies need only file their contracts, certificates, riders, en-

68. Id.

endorsements and application cards with the Insurance Department, the New York statute is very explicit as to the need for Insurance Department approval "of the contract or certificate and all applications, riders and endorsements as conforming to section two hundred fifty-three . . . ."70 Section 253 of the Insurance Law also goes into considerable detail as to the required provisions of the contract,71 and the Minimum Standards Regulations of the New York State Insurance Department cover exhaustively the benefits which hospital and medical coverage contracts must provide.72

The Minimum Standards Regulations are only a part of the regulations73 which the New York State Superintendent of Insurance has issued over the past few years with hundreds of pages establishing minimum benefit standards, claims practice requirements and other safeguards for the purchaser of health insurance. In its detailed supervision, the New York State Insurance Department reflects a similar intensity of interest on the part of the New York State Legislature, which since 1958 has enacted 52 chapter amendments to Article IX-c of the Insurance Law which governs Blue Cross and Blue Shield Plans.74

This brings us to the two New York cases which Ms. Law cites as being brought by "private citizens and city officials" and providing "insight into regulatory attitudes."75

The first of these,76 which AHS won, was brought in 1964 by New York State Senator Seymour Thaler. The allegations to which Ms. Law refers arose out of the certified financial statements which the Greater New York Plan had been requiring, and the audits which it had been conducting, of its member hospitals since 1960. By virtue of those audits and the limitations which had been incorporated in the 1960 Reimbursement Method, a number of hospital costs actually incurred were disallowed and

70. N.Y. INS. LAW §255.1 (McKinney 1966).
72. 11 N.Y.C.R.R. § §52.1 et seq. (1972).
payment rates to hospitals reduced in amounts of several million dollars each year.\textsuperscript{77} In almost all instances, the disallowances involved not questions of impropriety but only problems as to whether the costs were properly allocable to services rendered to Blue Cross subscribers. The Reimbursement Method limitations (mostly based on group averages) reduced many payments even below the amounts of properly allocable costs.

To these endeavors to safeguard subscriber funds, first Senator Thaler, and now Ms. Law, have ascribed the most sinister motives. The Blue Cross Plan was, in effect, accused of losing the money which actually it had saved! To excoriate a Blue Cross Plan for its method of recovering money instead of applauding its success in reducing the payments is scarcely calculated to motivate good Plan performance in this regard.

The 1969 lawsuit\textsuperscript{78} which Ms. Law cites in footnote 87 was really two proceedings\textsuperscript{79} brought separately (though almost simultaneously) by the two chief candidates competing in the 1969 mayoral election, both of whom made certain that their endeavors did not go unnoticed in the news media. Both petitioners pressed their causes vigorously before the second Tuesday in November, asserting that any rate increase should await an opportunity to review the reasonableness of the hospital reimbursement schedules\textsuperscript{80} which would be forthcoming by 1970 under the new Cost Control Law. Neither petitioner, however, evinced the slightest interest in these schedules when they did appear.

As to the merit of the two proceedings, the Court of Appeals, in upholding the subscriber rate increase, noted that the hospital payment schedules would not “be available until some time in 1970,”\textsuperscript{81} and the rate increase was necessary to avert Plan insolvency until such time as a determination could be made as to the effect of the new law upon hospital rates and the consequent impact upon subscribers.

The extent to which Ms. Law belittles the “expense and

\textsuperscript{77} Id.

\textsuperscript{79} The second proceeding was City of New York v. Stewart. It was later consolidated with Procaccino v. Stewart, Index No. 41709/69 (Sup. Ct. N.Y. County 1969).


inconvenience" to Blue Cross and its subscribers of a two-phase subscriber rate adjustment emphasizes her lack of understanding that it is the subscribers, not just the Plan, who are inconvenienced and must pay the expense.

Before leaving the subject of the degree to which the New York State Blue Cross Plans and the state regulatory authorities seek to control and limit hospital costs, it should be noted that sometimes their efforts in this regard are badly hampered by forces beyond their control. For instance, in 1974 the State Legislature passed a bill requiring third party payors to support each hospital's losses on ambulatory care. The impact of this law falls almost entirely on the Blue Cross Plans since it cannot be applied to Medicare and Medicaid reimbursement unless federal statutes and regulations are amended. As originally passed in April, 1974 by both houses of the State Legislature, it made no allowances for how well the hospital might be doing in other phases of its operations. Fortunately, it was revised by a Chapter amendment to offset net income from inpatient services against these ambulatory care losses. Even so, this Act of the Legislature will cost the Greater New York Blue Cross Plan and its subscribers about $7,000,000 in increased payment rates for the year 1975.

B. Federal supervision and programs

Before addressing the Medicare program for the aged, one comment on the Federal Employees Program is in order. The book deprecates, although recognizing as "probably inevitable," the adoption of experience rating. Since the Blue Cross system has "abandoned its commitment to community rating" whereby "low risk customers should subsidize the cost of the higher risk groups," the author questions "whether Blue Cross deserves its favored status under state and federal law."

82. P. 16. The extent to which Blue Cross seeks to minimize these administrative expenses so that more money will be available for benefits is shown by the testimony of Pennsylvania Insurance Commissioner Herbert Denenberg (see text accompanying notes 110-17 infra) before the Senate Judiciary Anti-trust Subcommittee:

Because of greater efficiencies and because of subsidies from group plans, the individual coverage written by Blue Cross may return even more than 97.3% in benefits.

Hearings on Commercial Health and Accident Insurance Industry Before the Subcomm. on Anti-trust and Monopoly of the Senate Comm. on the Judiciary, 92d Cong., 2d Sess., pt. 1, at 396 (1972) [hereinafter cited as 1972 Hearings].

84. N.Y. PUB. HEALTH LAW §2807.4, L. 1974, ch. 1062.
85. P. 12.
Ms. Law ignores the fact that there are still community rated groups and that they are being subsidized by the low risk experience rated groups. She herself proves this, although she does not put it that way. When she inveighs against the rates charged for the Federal Employees Program she characterizes them as "profits" eleven times in three pages⁸⁷ and also as an "enormous gift to Blue Cross/Blue Shield."⁸⁸ And how does a nonprofit Plan use these "profits" and this "enormous gift"? That is right. They are used to support the high risk community-rated groups in just such a fashion as the book had previously eulogized!⁹⁰

Now for Medicare. The author makes the astounding statement that "the federal Social Security Administration has no means of monitoring plan performance"⁹⁰ as far as Medicare is concerned. The fact is that the Bureau of Health Insurance, through the Social Security Administration, conducts detailed and exhaustive surveys of individual Plan performance. Ironically, it is the author who demonstrates how erroneous are her charges of federal inattention by her references to "SSA study," "Contract Performance Review,"⁹¹ Annual Contract Reevaluation Reports,⁹² studies and audits by the General Accounting Office,⁹³ and by the HEW Audit Agency⁹⁴ and CSC audit.⁹⁵ Nationwide in 1973, the Blue Cross system was examined and tested in approximately 600 public audits.⁹⁶

The most recent such survey of the New York Plan, available for examination by anyone so desiring, covered 26 pages and rated the Plan's performance "satisfactory" in all eight areas. This audit took approximately one man-year of federal auditors' time. Other audits of the Greater New York Plan by federal agencies for the Federal Employees Program, the General Accounting Office and others totalled another man-year.

The New York State regulatory authorities spend an average of three to four man-years each year on the triennial examinations, the audits in connection with subscriber increases and other monitoring functions.

⁸⁷. Pp. 54-56.
⁸⁸. P. 56.
⁸⁹. P. 12.
⁹⁰. P. 23.
⁹². P. 46.
⁹⁴. P. 47.
⁹⁵. P. 53.
⁹⁶. Data on these figures are available from the author upon request.
IV. THE BOOK’S TECHNIQUES OF INNUENDO AND CONCEALMENT

Whether criticisms transgress the boundaries of propriety and good taste is a question of flavor and personal preference which each reader must determine for himself. However, the techniques of innuendo can be identified and demonstrated, although it is often tedious and time-consuming to do so. For that reason, this review will limit itself to a few obvious examples.

Blue Cross: What Went Wrong? offers the surmise that “[N]o one would be the wiser if a plan were to offer favorable group rates based not on experience but on political influence, representation on the plan board, or other extraneous factors.”

So it states; no example is offered. Then, on the next page, after charging lack of regulatory concern about conflict of interest,” it argues that such concern “would do much to curb the more flagrant abuses of Blue Cross power.”

No accusation has in fact been made. No charge has been explicitly levelled. However, the reader has definitely been left with the impression of widespread wrongdoing in this respect.

Again Ms. Law uses the “would be” technique to promote the inference that “it would be natural to expect that . . . costs would be loaded onto the public programs.” The anonymous observer of these two examples is joined by the unidentified male-factor in the allegation that “[t]hose institutions with some accounting sophistication or with a fiscal intermediary willing to assure the largest possible public reimbursement are provided large opportunities for loading costs onto the publicly financed programs.”

As a matter of fact, the book’s style of anonymous attribution is set at the very outset on page 1 when, without citation, it states that “it is widely acknowledged that the American health care crisis is primarily one of organization, administration, and accountability.”

Equally insidious is concealment by way of failure to give credit where credit is due. The book states with reference to Medicare reimbursement that “[s]ome more conscientious intermediaries questioned whether hospitals that were able to utilize the

97. P. 29 (emphasis added).
98. This is inaccurate. See text accompanying notes 61-82 supra.
99. P. 30. When the book cannot specify some alleged misdeed, it turns often to the phrase “flagrant abuses.”
100. P. 74.
departmental method should be allowed to claim more lucrative reimbursement under the combination method." Knowing that Greater New York's Blue Cross Plan was one of those "conscientious intermediaries," I was slightly sorrowful that the text did not so identify it but turned with anticipation to footnote 479 which was given to support the above statement. In its entirety that footnote reads:

In 1967 one intermediary wrote to BCA showing that a hospital would receive additional reimbursement of about $528,000 annually through the use of the combination method. The intermediary concluded that, "Because there is an apparent loophole in the Medicare method of reimbursement this matter is being called to your attention for whatever action you might wish to take." GAO Report to the Congress, supra n. 471, at page 23.

It was Mr. J. C. Ingram of the Greater New York Blue Cross Plan who reported this loophole in the Medicare method of reimbursement, but the book omits to so state.

When Mr. Ingram again attacked the flaws in the Medicare reimbursement method in an article in Hospitals, Journal of the American Hospital Association entitled "The Case against RCC," the book did not acknowledge this and instead accused AHS of having "disseminated information on techniques of cost loading." This charge by Ms. Law is just as if one accused Ms. Law of having "disseminated information on techniques" for the Blue Cross system to "go wrong" because her book describes, while it attacks, asserted wrongful acts on the part of Blue Cross.

Another sample of insincerity on the author's part involves the timing of Medicare payments to hospitals. It criticized the Principles of Reimbursement for "permitting hospitals to be paid one month in advance for services to be rendered to Medicare beneficiaries"); it charges Blue Cross with failure because "[u]nder Medicare, interim payments are made, 'on the most expeditious basis administratively feasible . . . ’"); and it expresses outrage that "hospitals are paid in advance." Further on its criticism is the complete opposite, namely, that "Blue

102. P. 85.
103. P. 203 n. 479.
104. Ingram, The Case Against RCC, 41 HOSPITALS 38, April 16, 1967.
105. P. 81.
106. P. 64.
107. P. 94.
108. P. 96.
Cross has paid hospitals more for Medicare and Medicaid Services but paid more slowly and inefficiently.\textsuperscript{109}

The last example I will give of the book’s penchant for misleading the reader concerns former Insurance Commissioner Herbert Denenberg of Pennsylvania. Ms. Law is vociferous and consistent in her praise of the Pennsylvania Insurance Department under Dr. Denenberg’s leadership. She states it “is an outstanding example” of a department which has instituted “measures for the protection of the subscriber by taking a more rigorous, adversary attitude toward Blue Cross”\textsuperscript{110} and that it “has been uniquely effective in regulating costs and supervising Blue Cross operations.”\textsuperscript{111} Linked with Ms. Law’s praises for Dr. Denenberg are her citations of Denenberg as an authority to demonstrate Blue Cross Plan failure. For instance, she notes that in 1971 - 1972 “Insurance Commissioner Herbert Denenberg criticized the Plan for failure to hold down hospital costs”\textsuperscript{112} and again that “Pennsylvania’s Insurance Commissioner Herbert Denenberg noted that [e]vidence at the Blue Cross hearing indicated hospitals may buy . . . at many times the cost of identical equipment through conventional channels.”\textsuperscript{113}

Ms. Law completely neglects to note the many words of praise that Dr. Denenberg has had for the Blue Cross system. For instance, early in 1972 he stated “the public should not lose sight of the fact that compared to the commercial insurance industry, Blue Cross is an angel of mercy.”\textsuperscript{114} Again, in his testimony before the Senate Judiciary Anti-Trust Subcommittee on May 11, 1972, Commissioner Denenberg singled the Blue Cross system out for particular praise, noting its efforts in attempting “to serve the entire community,”\textsuperscript{115} and further suggesting that “the public would be better served if commercial insurers were immediately

\textsuperscript{109} P. 102 (emphasis added).
\textsuperscript{110} P. 16.
\textsuperscript{111} P. 18. See also pp.98-100, 112, 113.
\textsuperscript{112} P. 28.
\textsuperscript{113} Pp. 89-90. See also pp. 14, 16-17, 98, 112.
\textsuperscript{114} McFARLANE, Denenberg Uses Travelers-Blue Cross Decision to Blast Private Insurers, THE NAT’L UNDERWRITER, Jan. 22, 1972, at 1, 4. In the same article Dr. Denenberg is quoted as saying that:

in terms of the huge segments of the community it insures, the type of people it insures, the contracts it writes and in terms of sums paid out in benefits which represent 95 cents out of every dollar taken in, there is no substitute for Blue Cross.

Id. at 4.

\textsuperscript{115} 1972 Hearings, supra note 82, at 397.
removed from the market for individual coverage, leaving Blue Cross and Blue Shield and similar organizations with a monopoly." In the November 13, 1972 issue of Moneysworth, Dr. Denenberg is quoted as saying that "with the quality and efficiency of coverage offered in the health plans of the non-profit organizations, he has no quibble. The Blue Cross system pays back in benefits an average of 97 cents for every premium dollar it takes in . . . ."

Finally, since Ms. Law devoted so much of her energy to attacking the performance of the Blue Cross system under the Federal Employees Program and Medicare, it is worth noting what Commissioner Denenberg has to say in this regard. In his appearance before the Senate Subcommittee on May 11, 1972 he testified that Congress should “consider [giving] greater incentives and responsibilities to those who show promise of performance,” and thus should “consider giving greater responsibility for the Federal employees' health benefits program . . . [and] for the administration of medicare and medicaid . . . to approved Blue Cross Plans rather than commercial health insurance companies.” Not one of these words of praise for Blue Cross by Dr. Denenberg are mentioned by Ms. Law.

These examples of the book's techniques and tactics, together with the omissions and inaccuracies described at earlier points, do more than cast doubt upon the credibility of any of its assertions. They also impugn its integrity. The book is not bad merely because it is partisan. Many good books are partisan, for it is a virtue to be incensed at selfishness and outraged at injustice. Nor need there be balance and perspective in every writing. One cannot expect Demosthenes to point out the good qualities of Philip of Macedon or Shakespeare those of Richard III or Joan of Arc. We are not surprised when Charles Dickens, Sinclair Lewis, or A. J. Cronin depict the legal profession, the American businessman, organized medicine or hypocritical evangelism with emphasis on the warts and very scanty praise.

However, the license that is permitted to polemics, poetry and fiction does not extend to works of scholarship. Of course they can be partisan in their arguments and conclusions, for many of the wrongs that bedevil the world can only be righted through

116. Id. at 393.
118. 1972 Hearings, supra note 82, at 401.
careful study and scholarship. However, the work of scholarship is accountable to its readers to present the relevant facts and present them accurately. If, through some rationalization that the ends justify the means, it permits bias to becloud its veracity, it does the cause of truth and clear thinking a double disservice. First, it misinforms and misleads the reader. Worse than that, on the larger scale, its untruths and the need to refute them lead the reader to mistrust all studies and analyses as self serving and untrustworthy.

The world's problems are not simple. To solve them will require clear thinking and a dependable data base. Any treatise which trespasses against truth cripples the credibility of all scholarship, the good as well as the bad. The results are uncertainty and cynicism, and the loss of both the way and the will to improve our society.

V. THE BOOK'S PURPOSE: DOES ITS METHOD SERVE ITS GOAL?

One can assume, I think, that Ms. Law and the other participants in the Health Law Project had as their long range objective the improvement of health care in the United States. They feel that the present system serves that purpose poorly and that it must be radically changed to bring good care to the community.

With their long range goal, no one can quarrel. By the same token, such changes as may be necessary to achieve it should be made. The book itself is ambivalent as to whether such necessary changes include the abolition of Blue Cross, or the substitution for it of some other agency, governmental or private. It states, "[i]t is possible that the present Blue Cross organization could be transformed, so that the resource it represents could be used to administer a national health program primarily responsive to the needs of consumers of health services rather than to the research and professional needs of providers."119 However, it expresses doubt that "Blue Cross is interested in reforming itself in response to consumer discontent" or "that Blue Cross will move toward greater consumer control and accountability in the absence of hard and specific requirements to do so."120

The book's emphasis on "hard and specific requirements" are of course keyed to its concern for the administration of a national health program. It is likely that a national health insur-

120. P. 159. Contra, 1972 Hearings, supra note 82, at 386. "Blue Cross is clearly on the move toward greater consumer control and participation."
The insurance bill will pass in the near future, and now is a crucial time for designing its administration to provide the most effective health care for each dollar spent.

I certainly would join in the hope that any national health insurance program would bring as much (or preferably more) financial protection and sense of security against the inroads of ill health for the majority of the population as Medicare did for the aged. I would also hope that it would be designed with the lessons learned from Medicare, such as the inflationary effects of open-ended cost reimbursement, in mind. The significant questions are, what design gives the most promise of effective delivery and what entity or entities should participate?

In her censure of the present system Ms. Law focuses primarily on the Blue Cross Plans and the hospitals. Other candidates for future administrative responsibility, however, are not spared her criticism. She comments acidly upon state regulatory authorities,121 the Social Security Administration,122 the Civil Service Commission,123 Congress,124 and even labor.125 No one organization can be trusted for, to revert to the theme she expressed at page 2 of the book, “any organization or bureaucracy would attempt to maximize institutional autonomy and stability, particularly financial stability.” As Juvenal said 1900 years ago “sed quis custodiet ipsos custodes?”126 The best way to “guard the guardians” is to design a system where checks and balances improve rather than impede performance, where the scrutiny and critique of such performance is likely to be serious rather than self-serving and where the interests of the patient, the provider and third-party payor run as much as possible in concert.

This certainly does not recommend a single, monolithic, governmental system of administration. Government is just as vulnerable as any other organization, to use the book’s own terminology, to succumb to the temptations of “parochial professional prestige,”127 to cater to “political influence”128 and to itself gener-

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123. Pp. 51, 53-58, 114. At page 114 Ms. Law asserts that “[t]here are no good models.”
126. JUVENAL, Satire VI, line 347.
127. P. 106. See e.g., the enormous per diem costs and low occupancy at Downstate Medical Center in Brooklyn, New York. In 1968, its cost per patient day was $200.06, far higher than any other hospital in the area.
128. P. 29. See the track record of the Veterans Administration Hospitals. Media
ate situations where “[p]recise measurement of the fair costs of the services was impossible because of the unwillingness or inability of hospitals to make available actual costs of service and because of the lack of uniformity in hospital accounting.”¹²⁹

This does not mean that an all-voluntary non-governmental system is a panacea, but only that whatever system is chosen must be designed to recognize and guard against the natural and all too easily rationalized tendency of individuals and organizations to give pride of place to their own participation and performance. The best milieu for minimizing the evils of self-esteem is one where government carefully monitors and compares for effectiveness the performance of independent voluntary agencies in carrying out coverage, benefit administration, and cost control functions under programs which encourage the most cost-effective performance on the part of the actual providers of care.

I am not going to try to outline here such a system or its proper programs. I would suggest, however, that whatever system is chosen has a better chance of working if there is mutual respect and courtesy among the participants as well as reciprocal analysis and criticism. Intemperate and inaccurate tirades foster neither the independent judgment nor the realistic cost-effective approach which are necessary to run even the smallest health care facility. Hatchet jobs do not engender in the victim much appetite to analyze and be analyzed in that dispassionate detail which is necessary to weigh all of the complicated factors involved in most health care financing decisions.

The tasks to which Blue Cross: What Went Wrong? could better have addressed itself are the very real problems of organizational design; incentives to correlate provider predilections to patient needs; adjustment (within an incentive framework) of institutions to their changing communities and responsibilities; use and availability of hospital beds and other health care resources and how patient attitude and provider attitude can best interact beneficially rather than detrimentally. These are the areas of need to which Ms. Law and the rest of us should be

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¹²⁹. P. 59. For the 15 years in which New York’s Blue Cross has been auditing its member hospitals, the Municipal Hospital System of New York City has been unable to submit certified cost reports susceptible to meaningful verification through audit in the same fashion as Blue Cross has demanded of and received from the non-governmental hospitals in the greater New York area.

materials illustrating the recent public uproar over inadequate facilities in V.A. hospitals are on file in the offices of the Hofstra Law Review.
devoting our attention, rather than spending time in casting blame broadcast or in refuting the treatises in which such indiscriminate censure is published.