The fragmented nature of the U.S. healthcare system is quite anomalous. A hilarious video on YouTube makes the point well, asking what it would be like if air travel worked like healthcare. In this alternative world, we see an unfortunate consumer trying to book a cross-country flight to Oregon. He discovers he needs to book separately with an East Coast specialist to get him to Chicago and a West Coast specialist to get him to Oregon, then book a separate baggage specialist and fuelist for each leg, all of whom bill separately and require their own paperwork, none of whom publicly post their rates, with the whole uncoordinated mess resulting in an astronomical cost to travel on a day different than when he wants to fly. You cannot watch the video without thinking “thank heavens we do not live in that world.”

But for U.S. healthcare, we do live in that world. Even the physicians who practice in a hospital are typically independent from each other and from the hospital and its nurses. If you are lucky, the hospital will have a case manager to try to coordinate all these actors, but the case manager will have a hard time getting the physicians to pay attention because they are paid separately and the hospital depends on the admitting physician for business. Outside of hospitals, the situation is even worse. The average Medicare patient sees seven doctors a year, ten if the patient has a chronic condition, and no one is paid to coordinate them.

The evidence indicates, as I show in Part I, that this fragmentation raises costs and worsens health outcomes. Further, as Part II explains, the eco-
nomic theory of the firm suggests that allowing greater integration should improve these results. The problem, Part III demonstrates, is that current law stands in the way. Regulatory laws restrict how hospitals and physicians can work together, while payment laws require disaggregated payments for specific services. This legal framework today prevents healthcare markets from reaching the optimal level of healthcare integration, instead favoring fragmentation of healthcare provision and payment.  

The good, and perhaps surprising, news is that Obamacare might well provide the solution to this problem. More formally known as the Patient Protection and Affordable Care Act, Obamacare contains a number of provisions that could, Part IV shows, lift current legal obstacles to efficient healthcare integration. All we need is appropriate implementing regulations. This approach is probably the least painful way to lower healthcare costs because it actually increases quality. It should also have bipartisan appeal, because it would use provisions of Obamacare to adopt the sort of deregulatory reforms that generally appeal to Republicans but should also appeal to Democrats because they will likely be necessary to make Obamacare a success. Best of all, it can be done through executive action, thus sparing us the agony of trying to pass another healthcare statute. 

How Fragmentation Raises Costs and Hurts Patients

*Fragmentation within hospitals.* Fragmentation at the level of a single illness can occur when there is a failure to coordinate among the various providers with whom a patient interacts during a single hospital visit. Attending physicians in a hospital are typically independent of each other and of the hospital. Further, hospital administrators have no direct control over physician decisions. Nor do they have much financial leverage because attending physicians typically bill separately. Indeed, the financial incentives tend to run the other way because physicians are usually the primary source of the hospital’s business. While a dedicated case manager (when provided by a hospital) can help prevent some failures of communication, case management does not give the hospital actual control, nor does it change the financial incentives of either the doctors or the hospital. 

To illustrate how fragmentation can impair healthcare even in a world-leading hospital, consider a recent article’s account of the organization of
surgical instruments at Stanford University Hospital. Surgeons at the hospital, each of whom was an independent contractor who gets a fee for each surgery, indicated the instruments they required by submitting preference cards. Technicians, who are hospital employees, were responsible for loading the requested supplies onto a cart to follow the varying physician specifications. Under this system, errors could occur in filling out the cards, loading the supplies, mislabeling bins, or a host of other possibilities. Physicians had no direct contact with these technicians, so they tended to blame the nurses when errors occurred even though the nurses had nothing to do with loading the instruments. These failures led to potentially unsafe practices, such as nurses keeping instruments in lockers, doctors taking instruments home with them, and flash sterilizations of instruments rather than the preferred six-hour sterilization process.

Neither this situation nor this article’s assessment of the problem is idiosyncratic. They are perfectly in line with reports by the Institute of Medicine, the highly influential medical branch of the National Academy of Sciences that offers independent evidence-based advice on health policy. The Institute has concluded that similar problems exist throughout the system because it is fragmented and focuses on “professional prerogatives and separate roles” rather than on “cooperation and teamwork.” As a result,

> [p]atients and families commonly report that caregivers appear not to coordinate their work, or even to know what others are doing. Suboptimization is seen, for example, in operating rooms that must maintain multiple different surgical tray setups for different doctors performing the same procedure. Each doctor gets what he or she wants, but at the cost of introducing enormous complexity and possible error into the system.”

All this would be less worrisome if medical errors in hospitals were not a serious problem, but they are. According to the Institute of Medicine, preventable medical errors in hospitals result annually in forty-four thousand to ninety-eight thousand deaths and cost between $17 billion and $29 billion. The Institute concludes that “[t]he decentralized and fragmented nature of the healthcare delivery system . . . contributes to unsafe conditions for patients, and serves as an impediment to efforts to improve safety.”

In short, medical errors in hospitals annually cause tens of thousands of deaths and billions of dollars in costs, and healthcare fragmentation causes many of these medical errors. The Institute adds:
A highly fragmented delivery system that largely lacks even rudimentary clinical information capabilities results in poorly designed care processes characterized by unnecessary duplication of services and long waiting times and delays. And there is substantial evidence documenting overuse of many services—services for which the potential risk of harm outweighs the potential benefits. . . . Patients tell stories of fragmented care in which relevant information is lost, overlooked, or ignored; of wasted resources; of frustrated efforts to obtain timely access to services; and of lost opportunities. When clinicians and their families and those steeped in health management become patients, they, too, find that there appears to be no one who can make the systems function safely and effectively.10

Fragmentation across providers. Fragmentation in the care provided to a single patient can also occur when there is a failure to coordinate between different providers treating different conditions or even different aspects of the same condition. The typical Medicare beneficiary sees two primary-care and five specialist physicians a year; those with a chronic disease such as coronary artery disease see ten physicians annually, on average.11 Worse, as Professor David Hyman notes, each physician is “focused on the discrete symptoms and/or body parts within their jurisdiction.”12 Medical histories from other providers are often unavailable or distrusted, leading to imaging studies or laboratory tests being unnecessarily repeated.13

Payment structures contribute to this disjointedness. Neither Medicare nor other insurers pay physicians to coordinate care.14 To the contrary, because providers are paid separately for the amount of care they provide, coordination that solves medical problems more effectively would reduce the need for provider services and thus reduce their revenue.15 The perverse result is that “providers can actually do better if their patients do worse.”16

These conclusions again comport with the assessment of the renowned Institute of Medicine, which concludes that “physician groups, hospitals, and other healthcare organizations operate as silos, often providing care without the benefit of complete information about the patient’s condition, medical history, services provided in other settings, or medications prescribed by other clinicians.”17 More generally, the Institute states: “Today’s health care system is not well designed to meet the needs of patients with common chronic conditions. . . . For too many . . . care for even a single condition is fragmented across many clinicians and settings.
with little coordination or communication, and some needs remain undetected and/or unmet.”

One striking empirical study directly addressed whether having more physicians worsens care. It studied the outcome differences for Medicare patients after a heart attack depending on whether they saw a relatively low number of physicians (4.8 physicians per patient) or a relatively high number (9.2 physicians per patient). It found that having more physicians involved not only increased patient costs by $3,331 (with a 99.9 percent statistical level of confidence), but also reduced their odds of surviving by 2.5 percent (with a 94.0 percent statistical level of confidence). So seeing more physicians not only increases costs, but contrary to common intuition worsens medical outcomes, here increasing the odds of death by 2.5 percent.

This sort of fragmentation also helps explain why, for a nation that spends so much money on healthcare, our overall metrics are so unimpressive. Of course, it is well known that measures of U.S. health are worse than developed nations that spend much less on healthcare. But because those sorts of statistics are subject to the objection that this difference may reflect our diet or lifestyle, consider a simpler metric: What percentage of us get medically recommended levels of preventive care, or when we have a chronic illness, receive the recommended treatments for it? It turns out that the answers are only 55 percent on the first question and only 56 percent on the second. That is remarkably low, and it seems likely that part of the explanation is that ensuring that recommended care is provided often falls through the cracks in our fragmented system, where lines of responsibility are unclear.

U.S. healthcare fragmentation also produces outsize administrative costs. As of 1999, healthcare administration cost $1,059 per person in the United States, which was not only a remarkable 31 percent of total U.S. healthcare costs but also more than triple the $307 per person administrative cost in Canada. Part of this reflects the fact that U.S. health insurers are far more fragmented than Canada’s nationalized health insurance system; insurance overhead costs $259 per person in the United States versus $47 per person in Canada. But much of the difference reflects the sort of fragmentation in healthcare provision at issue in this article. For hospitals, administrative costs per person are $315 in the United States versus $103 in Canada. For practitioners, administrative costs per person are $324 in the United States versus $107 in Canada. In short, the average administrative costs per U.S. patient, hospital, and doctor are each triple those of their Canadian counterparts.
The Theory of the Firm

Although our healthcare system clearly seems excessively fragmented, that does not mean all integration is good. Well-functioning markets always feature some mixture of integration and disintegration. After all, buying airplane tickets may allow travelers to avoid choosing and coordinating pilots, planes, flight attendants, ticket agents, baggage handlers, and mechanics, but airlines do not also provide our taxicab to the airport or our hotel when we arrive.

Moreover, the optimal level of integration often changes over time with changing technologies or economics. At one time, people bought cars without wipers or bumpers and selected those separately. Airlines themselves now often charge separately for food, leading many passengers to buy their food before boarding from other firms, thus suggesting that air travel is becoming disaggregated from airplane food. Of course, airplane food is so bad that it became a comedic cliche, but other airline services also might become disaggregated. For example, airlines now frequently charge for baggage, and some separate firms are beginning to offer the service of taking your baggage directly from your home to your destination. While the latter service currently seems priced more at luxury levels, one could easily imagine the economics changing so that the transport of humans and their baggage became efficiently disintegrated in the future.

Indeed, even now, some beneficial changes in healthcare organization may involve disintegration. For example, retail health clinics have separated some routine healthcare from other healthcare. But getting this routine care while shopping could be beneficial, especially if the lower costs, greater convenience, and decreased delay result in patients getting medically beneficial healthcare more regularly and on time.

The economic theory of the firm explains how markets efficiently determine what activities to integrate into firms rather than leave outside them. As Professor Ronald Coase first pointed out, a defining characteristic of business firms is that they use centralized control rather than internal markets to allocate and coordinate resources. They will find this profitable only when centralized control provides an efficiency advantage over decentralized market transactions. Professors Armen Alchian and Harold Demsetz then showed that the major efficiency advantage firms have is that centralized control can mitigate the incentives to shirk that characterize a market system when it is hard for the market...
to measure and reward each individual’s contribution to team production that requires joint effort. Firms solve these inefficiencies by having a single owner that can both “(1) select, direct, monitor, and reward or punish team members based on their contributions to the joint product and (2) have a residual claim to any profits on the sale of the joint product that are left after all the team members are paid.” A residual claim to profits, coupled with the ability to monitor and control the inputs, is important in giving the owner both the ability and incentives to coordinate most efficiently—minimizing shirking by individual team members and ensuring that the joint product is maximally profitable.

Team production may not have been as important in healthcare decades ago, but has become vital to modern healthcare. Physicians, hospitals, nurses, drugs, devices, tests, technicians, and other inputs must be combined to produce the joint result of health. Yet it is difficult to determine the contribution of each participant to the joint result without close observation.

In healthcare, “shirking” generally does not take the form of failing to work—people in healthcare tend to work remarkably hard. Instead, shirking usually consists of failing to coordinate with other providers who also affect the same patients’ health on strategy, timing, and information in a way that maximizes health benefits and minimize costs. Thus, where providers are able to shirk in this way, greater coordination would be beneficial. However, the right level of coordination will vary across different areas of healthcare, depending on where direct observation and shirking are more or less likely, and will likely change with changing technology.

Unfortunately, U.S. healthcare refuses to adopt centralized ownership structures to deal with this team-production problem. A single hospital stay requires treatment by multiple physicians, each of whom is independent of the others and the hospital. The hospital cannot direct or monitor the medical decisions of the physicians, and because the hospital does not pay the physicians, it cannot leverage payments to influence them. In any case, the hospital has insufficient incentive to coordinate because it is not a residual claimant that stands to gain profit by coordinating physicians. The medical staff, which can review the decisions of other physicians, similarly lacks the incentive that a residual claimant would have to control physician decision making. Beyond a single hospital stay, the problems multiply: each physician bills for her own services and no one receives payment to coordinate among the providers. The most obvious
choices to coordinate care, either the primary-care physician or the insurer, are not residual claimants and have little incentive to serve in such a coordinating function. In any case, both the primary-care physician and the insurer lack the power to direct the decisions of other providers, even if doing so would lower costs and improve care.

True, medical providers sometimes coordinate in heroic ways to ameliorate this problem. But even then the system fails because the payment system rewards each participant for the amount of care they provide. The system does not pay a residual claimant for the value of the care, which would create the normal firm profit incentive to increase value and minimize the costs of providing that value. For example, Duke University Hospital once adopted an integrated program to treat congestive heart failure. The program reduced costs by approximately 40 percent by improving outcomes and lowering hospital admissions. But while the program was a resounding medical success, it was a business failure. By reducing the health problems it could bill to treat, Duke actually lost money. It is admirable how often we see medical institutions attempt these sorts of Herculean efforts to coordinate in ways that improve medical outcomes, but we are unlikely to see widespread adoption of such efforts if our payment system continues to penalize them financially.

How Current Law Mandates Fragmentation

So we have strong evidence that fragmentation worsens medical outcomes and costs, as well as sound economic theory that greater integration could alleviate those problems. Why, then, have we not seen healthcare institutions actually integrate in ways that solve these fragmentation problems?

After all, calls to address healthcare fragmentation are not new, and efforts to institute organizational change have been made. They have just not been successful. The Institute of Medicine observes:

What is perhaps most disturbing is the absence of real progress toward restructuring health care systems to address both quality and cost concerns, or toward applying advances in information technology to improve administrative and clinical processes. . . . Mergers, acquisitions, and affiliations have been commonplace within the health plan, hospital, and physician practice sectors. Yet all this organizational turmoil has resulted in little change in the way health care is delivered.
Why has organizational consolidation produced so little improvement? Part of the problem is that organizations adopt the permissible forms of integration that are the most profitable, and our payment system rewards fragmentation rather than medical efficiency. As the Institute put it:

The current payment system often reinforces fragmentation by paying separately according to the setting of care and provider type, and by not giving providers the flexibility needed to customize care for individual patients. . . . Furthermore, the fragmentation of payment by service can make it difficult for care to be coordinated efficiently across multiple settings. There is a misalignment among what the patient needs, the services provided, and how needed services are paid for.32

The Institute thus recommends that “purchasers and health plans . . . should eliminate or modify payment practices that fragment the care system.”33 But that shifts the question to a new level: Why haven’t institutions changed payment practices to encourage more efficient medical organization?

The answer is simple. Current law gets in the way of private efforts to reform both organization and payment structure. This has stymied adoption of the Institute’s recommendations on both fronts.

On organization, the law inhibits the development of firms that control the provision of care and have the profit motive of a residual claimant. The law does so through various legal obstacles to prevent corporations from controlling physicians or charging for medical services. The “corporate practice of medicine” doctrine prohibits the employment of physicians by corporations (including hospitals) on the ground that corporations cannot hold a medical license and thus cannot practice medicine or charge for medical services.34 Even in states that create exceptions to this doctrine to allow hospitals to hire physicians as employees, the doctrine limits the ability of the hospital to control the decisions of the physician.35

Tort law provides a further disincentive by imposing liability on firms that interfere with the medical judgments of individual physicians.36 Accreditation standards and sometimes licensing laws mandate that hospitals adopt bylaws that leave the medical staff in charge of medical decisions.37 Medicare also reinforces physician autonomy by requiring physicians to certify the medical need for the services that they render.38
and by prohibiting federal officials from supervising the practice of medicine or selecting some providers over others.\textsuperscript{39}

On payment structure, the law requires a separation of payments that effectively prohibits integrated payments to firms that can serve as a residual claimant that would orchestrate all the providers necessary to jointly produce some health outcome. The law does so by generally requiring separate payments for hospitalization, physician services, drugs, and outpatient services that must go directly to each provider. Medicare explicitly separates payments for hospitals (Part A) from those for physicians (Part B) and those for pharmaceuticals (Part D).\textsuperscript{40} Each of these programs is separate, focused only on services performed, often with Medicare paying different amounts for the same thing depending on who performed the service.\textsuperscript{41} Medicare thus bars a firm from charging for everything necessary to treat a specific illness. Further, Medicare does not reimburse for the coordination of care or case management.\textsuperscript{42}

Because Medicare is the biggest source of hospital revenue, typically providing 35–55 percent of the money hospitals receive, hospitals cannot afford to organize themselves in a way that does not comply with Medicare. And because hospital care is generally an important part of integrated care, other organizations cannot afford to do so either. Even if they wanted to do so, separate payments are generally required by fee-splitting statutes that prohibit splitting fees either to induce treatment (referral fees) or deter treatment (antireferral fees).\textsuperscript{43} Not only does Medicare have a general bar on both types of fees,\textsuperscript{44} but many states directly criminalize referral fees or specify that referral fees are grounds for the suspension or revocation of a physician’s license.\textsuperscript{45} Such bans on fee splitting not only constrain efforts to substitute incentive payments for direct control, but also effectively prevent firms from being the residual claimant on profits earned from medical services.

Thus, although healthcare has seen many mergers and organizational changes, these laws have constrained vertical mergers or consolidations that integrate complementary inputs into team production in a way that produces the kind of efficient integration we see in industries like airlines. Instead, the mergers and consolidations we have seen in healthcare have tended to involve horizontal combinations of competing services, because combining hospitals or physician practices does not violate the fragmenting role divisions required by these laws. To be sure, antitrust scrutiny remains available to check horizontal combinations, but the enforcement agencies have generally lost cases challenging hospital mergers,
in part because of the intuition that some integration would be helpful. The perverse upshot is that in healthcare the laws have posed a much greater barrier to vertical combinations that could efficiently reduce fragmentation than to horizontal combinations that increase market power in a way that worsens efficiency. This is precisely the opposite of what prevails in other industries, where antitrust is generally the operative constraint and imposes much tighter limits on horizontal combinations than on vertical ones.

Together, these regulatory and payment laws limit organizational and payment innovation to protect a form of individual physician autonomy that once made a great deal of sense, when medical care was largely provided by a single physician to the patient with minimal equipment. But protecting individual physician autonomy makes little sense in the modern world where many medical treatments require intricate teamwork and expensive equipment.

To be sure, sometimes laws allow a specific form of integration, like HMOs. But such laws do not allow corporations to pick whatever level of integration is most efficient to achieve a valuable result. Moreover, the forms of integration that are allowed have problems. HMOs, for example, are not paid for the value of the care they provide but rather receive a fixed annual fee per insured. This means that HMOs are not a residual claimant that receives payment for achieving a particular valued result and has incentives to pay team members to achieve that result with maximum efficiency. Instead, HMO profits are the difference between their flat fee and the cost of the care they provide, which provides an incentive to undercare, even if that worsens health outcomes. This incentive to undercare has limited their market appeal. Further, to offset this incentive to undercare, HMOs are subject to laws that restrict their ability to control their physicians. The result may be better than fee-for-service medicine, but the combination of flawed incentives with imperfect control is far from optimal, and it means that HMOs do not combine the control and incentive structure required by the theory of the firm.

Regardless of whether HMOs are better than the traditional fee-for-service model, they provide an important lesson. Instead of dictating a particular form of integration, the law should be neutral as to the appropriate level, without restricting forms of integration that may be efficient. The experience with HMOs demonstrates how mandating a specified type of integration may provide inappropriate incentives, which must then be tinkered with on an ad hoc basis. The law should instead allow
market forces to determine optimal levels of integration (much as the market does for air travel), and focus on fashioning payment and liability systems to give firms incentives to choose whatever method optimizes team production by medical professionals. Only in this way can the law encourage those in the market to innovate in a way that develops efficient systems that balance high-quality delivery with low-cost provision.

**How Obamacare Can Help**

Can Obamacare help address the fragmentation problem? Surprisingly, yes. Although public attention has focused on other controversial aspects of Obamacare, it also contains a number of provisions that create regulatory authority to address fragmentation in healthcare.

For policy insiders, the most well-known of these are the provisions that allow for the creation of Accountable Care Organizations (ACOs), which can coordinate care, and, if they meet quality performance standards, receive a share of savings that they can in turn distribute among providers. These provisions allow groups of physicians and hospitals with “shared governance” to participate as ACOs. Such groups must “be willing to become accountable for the quality, cost, and overall care” of the patients that join the ACO. Further requirements specify, among other things, that ACOs must join the program for at least three years, must have a minimum size in terms of patients assigned to the ACO, and must meet quality and reporting thresholds. Obamacare then provides for a “shared savings program.” Should the ACO’s average per capita costs (including hospital and physician payments under Medicare Parts A and B) fall below a benchmark set by regulation, the ACO will be eligible to receive payments that equal a share of those savings, which they can distribute among the providers belonging to the ACO. Eligibility also depends on meeting quality benchmarks and not taking affirmative steps to avoid higher-risk patients.

Unfortunately, the regulations implementing the ACO provisions so far continue to separate Medicare payments to each hospital and provider. For reasons discussed above, such separate payments provide an incentive for hospitals and physicians to increase care. This incentive to overcare (and receive the full price for any services provided) can easily override the counterincentive created by shared savings payments, which
give ACOs only a fraction of the savings from cutting this care that they then have to split among the participating hospitals and physicians.

To be sure, we are not limited to these initial implementing regulations. The statutory provisions allow the future adoption of regulations that could change the separate payment model itself in a way that eliminates this obstacle to efficient integration. But it seems less likely that the ACO provisions would allow regulations that remove legal obstacles to firm control over physicians. Thus, the ACO provisions are unlikely to provide a complete solution to the fragmentation problem. Still, one has to walk before one can run, and the creation of ACOs seems likely to be an important first step in the evolution toward less fragmentation of healthcare. The ACOs will not be fully integrated firms like airlines, but will link providers in ways that could more easily morph into such integrated firms in the future.

In any event, although the ACO provisions have received the most attention from policy insiders, other provisions offer the promise of a more complete solution to our fragmentation problem. In particular, consider the provisions on the Center for Medicare and Medicaid Innovation (CMI) and the Independent Payment Advisory Board (IPAB).

The CMI provides a way to test new healthcare payment and delivery systems, including those that decrease fragmentation. Introducing the idea, the provisions state:

The purpose of the CMI is to test innovative payment and service delivery models to reduce program expenditures . . . while preserving or enhancing the quality of care furnished to individuals. . . . In selecting such models, the Secretary shall give preference to models that also improve the coordination, quality, and efficiency of health care services. . . .

The statute then sets out criteria to guide the selection of models to be tested, as well as particular payment and delivery models that might merit examination. Models tested should be those that “address[] a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures.” This language certainly encompasses models that address fragmentation, given the abundant evidence that the lack of coordination reduces quality and increases cost.

Further, several of the specific models mentioned in the CMI provisions address concerns that lead to fragmentation. One potential model
that can be tested is “Contracting directly with groups of providers of services and suppliers to promote innovative care delivery models, such as through risk-based comprehensive payment or salary-based payment.”

Another model would be “Establishing comprehensive payments to Healthcare Innovation Zones, consisting of groups of providers that include a teaching hospital, physicians, and other clinical entities, that, through their structure, operations, and joint activity deliver a full spectrum of integrated and comprehensive health care services.” These provisions would allow the CMI to adopt regulations that override the legal obstacles to integrated payments and control that cause undue fragmentation.

The CMI provisions tend to be overlooked because they seem to provide merely for experimentation rather than to authorize national regulation. But the provisions actually allow any successful experiment to be implemented on a national basis and thus to become national policy. The statute provides that

[T]he Secretary may, through rulemaking, expand (including implementation on a nationwide basis) the duration and the scope of a model that is being tested . . . if . . . the Secretary determines that such expansion is expected to—(A) reduce spending under applicable title without reducing the quality of care; or (B) improve the quality of care and reduce spending.

The IPAB provisions create a new independent agency, the Independent Payment Advisory Board, that is required to produce proposals to lower Medicare spending in years in which payments are expected to exceed targets. An interesting feature of the IPAB is that it can make proposals that become law unless Congress enacts legislation to override the specific proposal. In meeting its duty to reduce Medicare costs, the IPAB cannot ration care, increase premiums or cost sharing, or restrict benefits or eligibility.

What distinguishes the IPAB from the CMI is that the IPAB must act if the statutory triggers are met: “The [IPAB] shall develop detailed and specific proposals related to the Medicare program. . . .” Moreover, the IPAB must make proposals that improve health or efficiency through greater integration or coordination if it can. “In developing and submitting each proposal . . . the [IPAB] shall, to the extent feasible . . . include recommendations that . . . improve the health care delivery system and health outcomes, including by promoting integrated care, care coordination, prevention and wellness, and quality and efficiency improvement.”

You are reading copyrighted material published by University of Chicago Press. Unauthorized posting, copying, or distributing of this work except as permitted under U.S. copyright law is illegal and injures the author and publisher.
Thus, the IPAB provisions provide a strong mechanism to defragment U.S. healthcare. Whenever Medicare spending is projected to exceed targets, which seems sadly inevitable, the IPAB must make proposals that include efforts to integrate care and improve care coordination if they would improve medical quality and efficiency. Given the evidence noted above, this arguably creates an affirmative duty for IPAB to adopt regulations that allow firms to defragment healthcare.

Under either the CMI or the IPAB, the federal government could and should promulgate several regulations that cut to the core of the fragmentation that exists in U.S. healthcare. Possible regulations could preempt state laws that prevent firms from controlling physician behavior, such as the corporate practice of medicine doctrine and various tort doctrines. Regulations could limit the scope of fee-splitting laws to allow financial coordination between hospitals and physicians. Payment systems could be changed to make integrated payments to a firm that orchestrates the providers necessary to achieve a health outcome.

Paying for the value of health outcomes may often be too difficult because it requires putting a financial value on those outcomes and determining the extent to which firms improved them. But an alternative payment system that could optimize the incentives of firms would be to give each firm both (1) an amount per enrollee attracted, which they could keep as profits; and (2) a separate risk-adjusted payment that must be spent on care for the group of enrollees, and thus cannot go to firm profits. Such a system would eliminate incentives to undercare because the payments for care cannot be kept if unspent, while creating a powerful incentive to spend those care payments efficiently to maximize health benefits because that will attract the most enrollees. It would thus give integrated firms the ability and incentives to optimize team production by the medical professionals within their control.

This proposed approach of separating profit payments from care payments has some similarity to the medical loss ratio requirements of Obamacare, which require that insurers spend 80–85 percent of their premiums on healthcare. But the proposal differs in various key ways. First, it would extend beyond insurers to integrated providers, thus providing a solution to the integration problem rather than merely an effort to reduce insurer profiteering. Second, it would give a profit payment per enrollee that is not set as a percentage of spending, thus eliminating the incentive to spend more on care to get more. Third, it would separate profits from spending rather than try to micromanage the allo-
cational of money between administration and medical care, which may be counterproductive when better administration would lead to more efficient care. Nonetheless, the proposal has enough of a family resemblance to the medical loss ratio rules that it would not require a great leap in regulatory strategy, which might smooth the transition to such a system.

**Conclusion**

The fragmentation of U.S. healthcare increases costs and decreases quality. The main reason such fragmentation persists is a combination of regulatory and payment laws that entrench physician autonomy and prevent the development of integrated firms that have the incentives and control necessary to achieve the team coordination needed in modern medicine. In an era when the biggest question facing the country may be the long-term trend in healthcare costs, the Obamacare provisions that enable the federal government to remove legal barriers to efficient healthcare integration offer a critical and useful tool. Used effectively, regulations under these provisions could improve healthcare, potentially saving tens of thousands of lives, avoiding hundreds of thousands of injuries, and saving hundreds of billions of dollars in medical costs. Given the persisting objections to the costs of Obamacare, adopting regulations like this that can save huge sums of money while improving quality may indeed be necessary to make it a success and fend off efforts to undermine it. These regulatory tools also have the clear benefit of allowing progress to be made without requiring another round of politically volatile federal healthcare lawmaking.

**Notes**

I am grateful for summer research support from Harvard Law School and the Petrie-Flom Center, for research assistance from Jordan Wish, and for comments from Scott Altman, Nicholas Bagley, Amitabh Chandra, Nancy-Ann DeParle, Alain Enthoven, Julia Feldman, Allison Hoffman, Mark Hall, Joe Newhouse, Frank Pasquale, James Rebitzer, Barak Richman, Chris Robertson, Bill Rubenstein, Jonathan Schenker, Alan Stone, and Patrick Taylor, and participants at workshops at the University of Chicago and Harvard Law Schools.

2. For a comprehensive set of essays that address causes, effects, and remedies for fragmentation in the U.S. healthcare system, see generally The Fragmentation of U.S. Healthcare (Einer R. Elhauge ed., 2010).

3. Pub. L. No. 111-148, 124 Stat. 119 (codified as amended in scattered sections of 26 and 42 U.S.C.). Although the term “Obamacare” was originally a mocking Republican characterization designed for political effect, even President Obama now embraces it on the grounds that saying that Obama cares is not exactly an insult. I thus use the term because it is certainly shorter and more memorable, and I think it has lost the political spin it once had.

4. See Einer Elhauge, Why We Should Care About Health Care Fragmentation and How to Fix It, in The Fragmentation of U.S. Healthcare, supra note 3, at 1, 1–6.


7. Id.

8. Comm. on Quality of Health Care in Am., Inst. of Med., To Err Is Human 1–2 (2001). The Institute of Medicine estimates that healthcare costs represent approximately half of the $17–29 billion cost; the other half represents lost income and production. Id.

9. Id. at 3.

10. IOM, Chasm, supra note 7, at 3, 43.


13. Id.

14. Id. at 26.

15. Id. at 26–27.

16. Id. at 27.

17. IOM, Chasm, supra note 7, at 4.

18. IOM, Chasm, supra note 7, at 90.


20. Id.


23. Id. at 771 tbl.1.

24. Id.


26. See Elhauge, supra note 5, at 2; Hyman, supra note 13, at 34.


29. Elhauge, supra note 5, at 6.


31. IOM, CHASM, supra note 7, at 3.

32. Id. at 101, 202.

33. Id. at 13.


35. Elhauge, supra note 5, at 12.


37. Elhauge, supra note 5, at 12.


40. Elhauge, supra note 5, at 11. These names for the various Medicare programs come from the codification of Medicare in 42 U.S.C., chapter 7, subchapter XVIII.

41. See Hyman, supra note 13, at 26.

42. Elhauge, supra note 5, at 11.

43. Hall, supra note 35, at 488.

44. See 42 U.S.C. § 1320a-7a(b) (2006 & Supp. V 2011); id. § 1395nn(a).


46. See Elhauge, supra note 5, at 9.

47. See Einer Elhauge, OBAMACARE ON TRIAL (2012).
49. Id. § 1395jjj(b)(2)(A).
50. Id. § 1395jjj(b)(2)(B); id. § 1395jjj(b)(2)(D); id. § 1395jjj(b)(3).
52. Id. § 1395jjj(d)(1)(B)(i).
53. Id. § 1395jjj(d)(3)–(4).
55. See 42 U.S.C. § 1395jjj(i).
56. Id. § 1315a(a)(1) (emphasis added).
57. Id. § 1315a(b)(2)(A).
58. See Part I, supra.
60. Id. § 1315a(b)(2)(B)(viii) (emphasis added).
61. Id. § 1315a(c) (emphasis added).
63. 42 U.S.C. § 1395kkk(b)(3). The ACA also contains expedited procedures for Congress to consider proposals by the IPAB. See id. § 1395kkk(d).
64. 42 U.S.C. § 1395kkk(c)(2)(A)(ii); see also id. § 1395kkk(c)(2)(A)(iii) (prohibiting IPAB proposals before 2020 that would lower provider reimbursements).
65. Id. § 1395kkk(c)(1)(A).
66. Id. § 1395kkk(c)(2)(B)(ii)(I).