



## **OUR FRAGMENTED HEALTH CARE SYSTEM: CAUSES AND SOLUTIONS**



*The Petrie-Flom Center for Health Law Policy, Biotechnology and Bioethics  
Harvard Law School*

**Friday, June 13 – Saturday, June 14, 2008**

# Conference Schedule

**Friday, June 13, 2008**

Location: Langdell South, Harvard Law School

2:00 p.m. **Panel I Causes of Fragmentation**

*Mark Hall & Frank Pasquale moderating*

**Integrated Delivery Systems: What they do; why we need them; and how to get there from here?**

*Alain Enthoven*

**Competition Policy, Organizational Structures and Fragmentation**

*Thomas Greaney*

**Healthcare Fragmentation: We Get What We Pay For**

*David Hyman*

**The US Healthcare System: A Product of American History and Values**

*Nancy Kane & David Johnson*

**Defragmenting Health Care Delivery Through Quality Reporting**

*Kristin Madison*

**From Visible Harm to Relative Risk: Centralization and Fragmentation of Pharmacovigilance?**

*Arthur Daemmrch*

4:15 p.m. Break

4:30 p.m. **Panel II Consequences of Fragmentation**

*Kristin Madison & Kathryn Zeiler moderating*

**Fragmentation and Service Delivery: Explaining Who Owns What in Health Care**

*David Cutler & Jill Horwitz, Joseph Ladapo, Milton Weinstein, Scott Gazelle*

**Clinical Trials, the Market for Observations, and the Cost of Medical R&D**

*Anup Malani & Tomas Philipson*

**Markets for Infections: Mismatched Incentives for Hospitals, Patients and Drug Companies**

*Kevin Outterson*

**Organizational Fragmentation and Care Quality in the US Health Care System**

*Randal Cebul, James Rebitzer, Lowell J. Taylor, & Mark Votruba*

**How Does Fragmentation of Care Contribute to the Costs of Care?**

*Meredith Rosenthal, Hoangmai Pham & Eric Schneider*

**Mental Health Care Consumption and Outcomes: Considering Preventative Strategies  
Across Race and Class**

*Barak Richman et al*

6:45 p.m. **Close of First Day**

**Saturday, June 14, 2008**

Location: Langdell South, Harvard Law School

8:30 a.m. Continental Breakfast

9:00 a.m. **Panel III Developments in Fragmentation**

*Frances Miller & Kevin Outterson moderating*

**The Emergent Logic of Health Law**

*Gregg Bloche*

**Technology and Expenditure Growth in Healthcare**

*Amitabh Chandra & Jonathan Skinner*

**Beyond Coverage: Employer Based Health Related Services and  
Their Effects on Fragmentation**

*Dean Hashimoto*

**Fight or Flight: The Threat of Specialty Competition and the Service  
Offerings of General Hospitals**

*Robert Huckman & Jonathan Thompson Kolstad*

**Treating Niche Providers Fairly: Can CMS Calculate the Real Impact of Fragmented Health Delivery  
Systems?**

*Frank Pasquale*

11:00 a.m. Break

11:30 a.m. **Panel IV Possible Reforms**

*Einer Elhauge & Barak Richman moderating*

**Of Doctors and Hospitals: Setting the Analytical Framework for Managing and  
Regulating the Relationship**

*James Blumstein*

**Property, Privacy and the Pursuit of Integrated Electronic Medical Records**

*Mark A. Hall*

**Value Purchasing Opportunities in Traditional Medicare: A Proposal  
and Legal Evaluation**

*Lawrence Casalino & Timothy Jost*

**An Incentive Compatible Design for Public Health Insurance**

*Eric Helland & Jonathan Klick*

**Fragmentation: Is That Why American Health Care Reform Is So Hard?**

*Theodore Marmor*

1:30 p.m. **Close of Conference**

# PRESENTATION SUMMARIES

## *Causes of Fragmentation*

### **Integrated Delivery Systems: What they do; why we need them; and how to get there from here**

*Alain Enthoven*, Marriner S. Eccles Professor of Public and Private Management, Emeritus and Core Faculty Member of the Centers for Health Policy and Primary Care and Outcomes Research at Stanford University

Our health care system is extremely fragmented, and, as the Institute of Medicine has pointed out, that is costing the lives and well being of many Americans, as well as contributing to the excessive level and unsustainable growth rate of expenditures on health care. Regrettably, few people in the public policy sphere seem to recognize that this is a fundamental problem needing remedy. Few Americans are aware of the benefits of or even the existence of integrated (the opposite of fragmented) delivery systems. In this paper, I propose to address the questions: What does fragmented mean? What does its opposite, “integrated” mean? How and why did our system become so fragmented? How can we transform our fragmented health care system into one that is integrated, striving to improve value for money through quality improvement, expenditure reduction, and better integration?

### **Competition Policy, Organizational Structures and Fragmentation**

*Thomas Greaney*, Chester A. Myers Professor of Law and Co-Director, Center for Health Law Studies at Saint Louis University School of Law

An analysis of the various ways antitrust enforcement and competition policy have sought to promote integration and counteract the fragmentation in health care markets. The effort has been only intermittently successful as changes in health care financing and the demise of managed care have proved to be powerful counterweights to these efforts. The paper will explore how competition policy interacts with (and often conflicts with) signals sent by other legal regimes including fraud and abuse law, the law governing exempt organizations. It will also describe and analyze how these legal cross currents influence organizational structures in health care.

### **Healthcare Fragmentation: We Get What We Pay For**

*David Hyman*, Richard W. and Marie L. Corman Professor and Director, Epstein Program in Health Law and Policy at the University of Illinois College of Law

Compared to other industries providing products of comparable sophistication and cost, health care delivery is extremely fragmented. This degree of fragmentation is not accidental, and it has numerous causes. Yet, the way in which health care providers are paid should be accorded prominent place – particularly when one adds in the effects of the regulatory framework necessary to administer and police the boundaries of the payment system. Our encounter-based, primarily fee-for-service payment system has a distinct tendency to reward unbundling and inefficiency. Even under the best of circumstances, the current payment system does not create systematic incentives to deliver efficient high quality care. The impact of these misaligned incentives is magnified by the civil and criminal penalties that await those foolish enough to try to rationalize (and/or) exploit these inefficiencies. If we want to address health care fragmentation, reform of the payment system should be high on the list of priorities. Yet, attempts to reform the payment system will create numerous opportunities for those who profit from the status quo to engage in symbolic blackmail. Furthermore, it remains to be seen how much fragmentation consumers actually want; the preferences of reformers may well differ from that of consumers. Aspiring reformers should be aware of these risks and frame their efforts accordingly.

## **The US Healthcare System: A Product of American History and Values**

*Nancy Kane*, Professor of Management, Associate Dean for Educational Programs in the Department of Health Policy and Management at Harvard School of Public Health & *David Johnson*, Managing Director, CitiCorp, Inc., Chicago, IL

The US healthcare system stands apart from those of other industrialized nations. It costs more, employs more technology, generates remarkable medical innovation, emphasizes specialty care, underserves over twenty percent of its people and avoids standardization. We suffer disconnections across the continuum of care, disparities in care across population subgroups; lack of information or care integration even within legally structured “systems” of care; disparities in insurance coverage and benefit structures; excess availability of some services and scarcity of others in communities throughout US. How can we explain American tolerance for these contradictory outcomes? And why is the American model for healthcare delivery so different from other developed nations? American exceptionalism has been a part of our national character from the country’s origin. It was on his way to America in 1630 that the Puritan John Winthrop gave his famous sermon outlining his vision for the Massachusetts Bay Colony in which he said “For we must consider that we shall be as a city upon a hill. The eyes of all people are upon us.” American ideology is unique in its reverence for the individual, its suspicion of authority, its broad optimism and belief in national destiny. While these American “virtues” give us our unique history and accomplishments, they also bring with them what Reinhold Niebuhr would call “ironies.” “Irony consists of apparently fortuitous incongruities in life which are discovered, upon closer examination, to be not merely fortuitous....If virtue becomes vice through some hidden defect in the virtue, if strength becomes weakness because of the vanity to which strength may prompt the might man or nation, i...in all such cases the situation is ironic<sup>1</sup>. The authors’ contention is that fragmentation is an ironic by-product of our virtues, and it is important to understand the hidden defects in our virtues in order to appreciate what it will take to correct them.

## **Defragmenting Health Care Delivery Through Quality Reporting**

*Kristin Madison*, Professor of Law at the University of Pennsylvania Law School

One of the many factors that contribute to continued fragmentation in the delivery of health care services is the law. While laws hindering efforts to coordinate care take multiple forms, many share an aim of blunting problematic incentives in a world in which patients and payers are unable to assess the quality of care. Examples of such laws include licensure-related limits on the corporate practice of medicine, which may preclude direct employment of physicians, and the anti-kickback and self-referral statutes, which circumscribe potential relationships between hospitals and physicians. Private forms of regulating relationships among providers, such as hospital medical staff bylaws preserving physician independence, may also fit this mold. The recent movement to collect and disseminate information about provider quality, however, may make it reasonable to weaken these restrictions, allowing providers to engage in quality- and efficiency-enhancing integration. Payment tied to quality reporting may give them the incentive to do so.

## **From Visible Harm to Relative Risk: Centralization and Fragmentation of Pharmacovigilance?**

*Arthur Daemmrich*, Assistant Professor of Business Administration at Harvard Business School

Adverse drug reactions pose fundamentally different, but similarly disruptive risks to patients, industry, physicians and regulators. Between the early 1960s and the present, national systems were built to collect, standardize, and respond to reports of side effects provided by practicing physicians, with the Food and Drug Administration (FDA) playing the central role in the United States. Since about 2005, however, this centralized approach to the collection and analysis of case reports has been challenged by the emergence of new, but episodic meta-analyses of large

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<sup>1</sup> Reinhold Niebuhr, *The Irony of American History*, P. xxiv

databases that identify the probability of side effects on a population level. This paper advances a historical comparison of these two methods and draws attention to the growing complexity and fragmentation of assessing potential risks of pharmaceutical agents. Understanding the origins and evolution of techniques for adverse drug reaction identification and response suggests greater patient involvement in reporting adverse reactions is necessary to align methodological and regulatory shifts currently underway in the post-market drug safety arena.

## **Consequences of Fragmentation**

### **Fragmentation and Service Delivery: Explaining Who Owns What in Health Care**

*David Cutler*, Social Sciences Dean, Faculty of Arts and Sciences, Harvard University, and the Otto Eckstein Professor of Applied Economics at Harvard University & *Jill Horwitz*, Assistant Professor of Law at the University of Michigan Law School

One of the biggest drivers of health care costs is technology. In a fragmented health care system, haphazard technology adoption is often seen as a sign of waste and inefficiency. Why this occurs is the subject we analyze. New and expensive technology does not arrive instantaneously when it is invented. Organizations must decide whether and when to adopt it. We focus on the early adoption and diffusion of 64-slice computed tomography (CT), a technology with mixed evidence on its efficacy, risk, and efficiency. While 64-slice CT is able to accurately perform cardiac CT angiography, its ability to improve health outcomes is uncertain, particularly because it imposes risks such as radiation exposure. Using data for every U.S. urban hospital we analyze whether and why different hospitals adopt 64-slice CT, focusing on four theories of adoption: 1) technological arms races, 2) profit seeking, 3) quality enhancement, and 4) availability of capital. Our preliminary findings suggest that the drive to be the first to adopt may be a driver for hospitals which adopt 64-slice CT in the first year, but that quality of cardiac care may be a driver in the second year. Given the clinical uncertainty of the technology, these results suggest potential inefficient adoption.

### **Clinical Trials, the Market for Observations, and the Cost of Medical R&D**

*Anup Malani*, Professor of Law and Aaron Director Research Scholar at the University of Chicago Law School & *Tomas Philipson*, Professor, Harris School of Public Policy, Department of Economics and the Law School at the University of Chicago

This paper examines the effect of the FDA pre-marketing approval requirement on drug innovation via the trial subject recruitment channel. Clinical trials require subjects and subject recruitment is difficult. Indeed recruitment may be the most important source of delay in getting drugs to market, a delay longer than the 1-2 years it takes for FDA approval. The effect of the pre-market approval requirement is to make the demand for the ultimate product an input into innovation because it is the former that forms the pool of potential trial subjects. Thus we get the interesting economic feature that the input supply function is the same as the output demand function. Two immediate implications are (1) that there is a negative externality of one company's R&D on another company's costs (and this externality is non-pecuniary because subjects cannot be paid positive wages), and (2) that the standard rules for monopoly markups are different than in the usual case (and than assumed by the prior literature on the pharmaceutical industry). We hope to prove at least (1) with empirical data on the effect of NDA approvals on the time it takes other companies to complete clinical trials.

### **Markets for Infections: Mismatched Incentives for Hospitals, Patients and Drug Companies**

*Kevin Outterson*, Associate Professor of Law at Boston University School of Law

Hospitals are dangerous places. People die there every day. We collect our sickest people together and treat them in a complex, technological system fraught with clinical uncertainty, fragmented agents, and human error. No wonder some people get hurt in the process, through accidents, inappropriate treatments, prescription errors, surgical mistakes, and nosocomial infections. Many others die in hospitals despite the best of care and the absence of error.

We are mortal and many of us choose to spend our last days in a hospital. As the largest payer in the US, Medicare may be able to reduce the frequency and severity of preventable hospital errors. Medicare uses the term hospital acquired conditions (HACs). One major category of HACs is hospital-acquired infections. One approach might reimburse hospitals for infection control and pay bonuses for reducing infections. It is much more difficult to justify rewarding a hospital financially for nosocomial infections and for inducing antibiotic resistance, but this has been the predominant reimbursement practice. Medicare's new value-based purchasing (VPB) initiative is trying to realign these incentives, but faces many challenges.

## **Organizational Fragmentation and Care Quality in the US Health Care System**

*James Rebitzer*, John R. Mannix Medical Mutual Professor, and Chair of Economics Department at Case Western Reserve University's Weatherhead School of Management

From an organizational perspective, the US health care system is highly fragmented. Critical tasks in the financing and provision of health care are distributed across a variety of distinct, often competing, entities each with its own objectives, obligations and capabilities. The market mechanisms, contractual arrangements, governance structures and information technologies that enable coordination elsewhere in the economy often function poorly in the health care setting. As a result, organizational fragmentation is a serious and persistent impediment to improving health care quality. We illustrate our argument with examples taken from the insurance and the hospital industries, and discuss possible responses to the problems that arise as a consequence of organizational fragmentation.

## **How Does Fragmentation of Care Contribute to the Costs of Care?**

*Meredith Rosenthal*, Associate Professor of Health Economics and Policy in the Department of Health Policy and Management at the Harvard School of Public Health & *Eric Schneider*, Associate Professor in the Department of Health Policy and Management in the Department of Health Policy and Management at the Harvard School of Public Health

Fragmentation of care may contribute significantly to the high cost of care in the U.S., particularly in traditional, fee-for-service Medicare. As performance measures on the costs of care are introduced into pay-for-performance programs, physicians and others will need guidance on remediable sources of cost variation so they can intervene to reduce costs without sacrificing the quality of care. Reducing fragmentation of care may be an important target for these efforts. In this paper we develop and examine measures of care fragmentation. Combining Medicare claims data for 2005 and 2006 with innovative episode grouper software, we evaluate the relationships between these measures of the fragmentation of care and the costs and quality of care for Medicare beneficiaries. Conducting the analysis within episodes of care defining homogeneous clinical populations allows us to minimize the effects of patient factors that contribute both to high costs and patterns of care that might be characterized as fragmented.

## **Mental Health Care Consumption and Outcomes: Considering Preventative Strategies Across Race and Class**

*Barak Richman*, Associate Professor of Law at Duke Law School

In previous work (Richman 2007), we found that even under conditions of equal insurance coverage and access to mental healthcare providers, whites and high-income individuals consume more outpatient mental health services than nonwhites and low-income individuals. We follow-up that study to determine (1) whether nonwhite and low-income individuals obtain medical substitutes to mental healthcare, and (2) whether disparate consumption leads to disparate health outcomes. We find that nonwhites and low-income individuals are more likely than their white and high-income counterparts to obtain mental health care from general practitioners over mental healthcare providers. We further are unable to find any evidence that this leads to adverse health outcomes. These findings echo concern expressed in Richman (2007) that low-income and nonwhite individuals might be paying for health services that primarily benefit their white and more affluent coworkers.

## **Developments in Fragmentation**

### **The Emergent Logic of Health Law**

*Gregg Bloche*, Co-Director, Georgetown-Johns Hopkins Joint Program in Law and Public Health and Professor of Law at Georgetown Law School

The American health care system is on a glide path toward ruin. Health spending has become the fiscal equivalent of global warming, and the number of uninsured Americans is approaching 50 million. Can law help to divert our country from this path? There are reasons for deep skepticism. Law governs the provision and financing of medical care in fragmented and incoherent fashion. Commentators from diverse perspectives bemoan this chaos, casting it as an obstacle to change. I contend in this article that pessimism about health law's prospects is unjustified, but that a new understanding of health law's disarray is urgently needed to guide the project of reform. My core proposition is that the law of health care provision is best understood as an emergent system. Its contradictions and dysfunctions are not the fault of some failed master designer. No one actor has a grand overview – or the power to impose a unifying vision. Countless market players, public planners, and legal and regulatory decision-makers interact in oft-chaotic ways, clashing with, reinforcing, and adjusting to each other. Out of these interactions, a larger scheme emerges – one that incorporates the health sphere's competing interests and values. Change in this system, for worse and for better, arises from the interplay between its myriad actors. By quitting the quest for a single, master design, we can better focus our efforts on emergent possibilities for legal and policy change. We can and should continuously survey the landscape of stakeholders and expectations with an eye toward potential launching points for evolutionary processes – processes that leverage current institutions and incentives. What we cannot do is to plan or predict these evolutionary pathways in precise detail; the complexity of interactions among market and government actors precludes fine-grained foresight of this sort. But we can determine the general direction of needed change, identify seemingly intractable obstacles, and envision ways to diminish or finesse them over time. Dysfunctional legal doctrines, interest group expectations, consumers' anxieties, and embedded institutional and cultural barriers can all be dealt with in this way, in iterative fashion. This article sets out a strategy for doing so. To illustrate this strategy, I suggest emergent approaches to the most urgent challenges in health care policy and law – the crises of access, value, and cost.

### **Technology and Expenditure Growth in Health Care**

*Amitabh Chandra*, Assistant Professor of Public Policy at the Kennedy School Government, Harvard University

We examine the parallel trends in technology growth and cost growth in health care. A theoretical model of growth and productivity leads to a typology of medical technology: highly effective and inexpensive innovations (antibiotics, or aspirin and beta blockers for cardiac care), more expensive yet effective treatments for appropriate patients (hip and knee replacements, surgical interventions for heart attack patients), and “gray area” treatments with uncertain clinical value (ICU days among chronically ill patients). We show that the average productivity of treatments depend critically on the heterogeneity of effects across patients, the precise shape of the health production function, as well as the cost structure of procedures such as MRIs with high fixed costs and low marginal costs. Future productivity growth of the current system will be limited by constraints on health care financing because of high tax burdens and the collapse of private health insurance markets. Nonetheless, there are tremendous potential productivity gains from better coordination of care and information technology.

### **Beyond Coverage: Employer Based Health Related Services and Their Effects on Fragmentation**

*Dean Hashimoto*, Associate Professor of Law at Boston College Law School

Generally, policy analysts view our current reliance on employer-based coverage as an unfortunate accident of history. Employer-based coverage may contribute to the fragmentation of healthcare delivery. For example, in

response to rising insurance premiums, employers may choose health plans that raise co-payments and deductibles. This approach may discourage employees from seeking appropriate care from primary care providers and may disrupt on-going treatment of chronic diseases. Current reform efforts have largely focused on using employer-based coverage as a way to improve access of the employee to the health care delivery system, rather than as a means for the employer to address directly problems of fragmentation. For example, the Massachusetts Health Care Reform Act requires employers to create plans that allow employees to pay for health insurance premiums with pre-tax dollars. It mandates employers to give their employees a choice between making a fair and reasonable premium contribution or paying the state a fee to subsidize uncompensated care. Another example is the movement for consumer-directed health care that shifts the cost to the employee as a consumer. Employees may use personal care accounts to support their choices of health care networks. These approaches rely on the employer-employee relationship as a structure to improve employee access to healthcare, but the employer is not involved in addressing issues of fragmentation. An alternative approach would be for employers to be more directly involved in addressing the problem of fragmentation as well as access. This approach is consistent with a market-driven trend known as “Health and Productivity Management”. Employers engage in a systematic approach designed to quantify, evaluate and optimize a company’s investment in its workforce. Investing in healthcare for employees is not just an expense, but also supports and enhances workforce productivity. The employer is actively involved in addressing the impact of employee health on absenteeism and “presenteeism” by improving both access to care and reducing the fragmentation of health care. Examples include providing primary care services onsite or close to the workplace and integrating employer-supported benefits such as health promotion and employee assistance programs with the healthcare provided by primary care doctors.

## **Fight or Flight: The Threat of Specialty Competition and the Service Offerings of General Hospitals**

*Robert Huckman*, Associate Professor of Business Administration Harvard Business School

The impact of specialty hospitals on the markets they enter has served as a source of significant recent debate. A central issue in this debate is whether specialty hospitals select the most-profitable cases in a market, thereby decreasing the ability of general hospitals to subsidize less-profitable (but socially beneficial) service lines. Despite interest in this question, few studies have been able to make causal assertions about the effect of specialty competition on hospital markets. We address this gap by studying whether an exogenous change in the threat of entry by specialty hospitals affected the services offered by competing general hospitals.

## **Treating Niche Providers Fairly: Can CMS Calculate the Real Impact of Fragmented Health Delivery Systems?**

*Frank Pasquale*, Associate Professor of Law at Seton Hall Law School

In my presentation, I will apply the theoretical model developed in my article on retainer care to specialty hospitals. States are becoming increasingly concerned with the tiering of health care. Innovations like specialty hospitals, retainer medicine, and cosmetic surgery may provide exciting new options for the wealthy. But they also threaten the delicate balance of cross-subsidization that has historically provided adequate health care to a broad swathe of Americans. For instance, specialty hospitals often don’t provide the type of emergency or charity care offered by competing general hospitals, which have supported such services with the types of profitable procedures that specialty hospitals “cream-skim” away. Defenders of cross-subsidization have used many tactics to stem the flow of entrepreneurial doctors to a wealthy clientele. After convincing Medicare to put a moratorium on specialty hospital participation in the program, general hospitals are using certificate of need laws to stymie the spread of these competitors. Though the moratorium expired, several forms of legal uncertainty cloud the prospects of specialty hospitals. Though they are often intended to protect access to care for the non-wealthy, these tactics have a cost. Specialty hospitals may pioneer some quality improvements even as they undermine the financial health of general hospitals. A better response to tiering would not entirely hamstring these developments, but would divert

some of the revenues specialty hospitals generate back to hospitals serving the rest of the population. Taxation might avoid the perverse incentives often created by regulation. After examining the regulatory battles over the emergence of specialty hospitals, this essay will examine laws in states that have pioneered the taxation of these entities. The key normative question to be addressed is whether taxation can make up for the loss of cross-subsidization that fragmentation accelerates.

## **Possible Reforms**

### **Of Doctors and Hospitals: Setting the Analytical Framework for Managing and Regulating the Relationship**

*James Blumstein*, University Professor of Constitutional Law & Health Law & Policy, Director of the Health Policy Center at the Vanderbilt Institute for Public Policy Studies at Vanderbilt University Law School

The paper considers the movement toward integration of (i) physician services and (ii) the institutional and economic interests of hospitals. The paper uses that set of issues as a vehicle for addressing the problem of institutional fragmentation that arises from the existing regulatory structure for hospital governance. The paper considers how, and to what extent, economic considerations should factor into medical care decision making and what the appropriate regulatory structure is both to oversee the role of physicians and to govern the interrelationship of physicians and institutional providers such as hospitals. At one time, hospitals followed a “workshop” or what I have dubbed an “eBay” model, but this has changed. Hospitals now have their own institutional interests (and courts have begun to recognize those interests). These interests derive in part from hospitals’ independent duties to patients and their responsibility to assure quality of care and to manage costs. These new and evolving environmental realities call into question the traditional regulatory/governance structure of hospitals. The paper observes that integrated delivery networks (IDNs), which include physicians and hospitals, face a regulatory regime that is more flexible than the traditional hospital model (reflected in the accreditation standards of the Joint Commission on Accreditation of Health Care Organizations [JCAHCO]). It concludes (i) that the legal and regulatory environment should not have a large impact on how physician-hospital relationships should be developed – that public policy attention should be devoted to “creating a system of competition that incentivizes the provision of good quality care and appropriately incorporates economic considerations into the medical decision making process” but does not mandate or dictate the appropriate organizational form (which should sort itself out in accordance with pragmatic considerations of which forms perform best in any given circumstance); and (ii) that regulatory flexibility and “regulatory neutrality” should guide public policy in this arena.

### **Property, Privacy and the Pursuit of Integrated Electronic Medical Records**

*Mark A. Hall*, Fred D. & Elizabeth L. Turnage Professor of Law at Wake Forest University School of Law

[W]e have a twenty-first-century financial information infrastructure and a nineteenth-century health information infrastructure. Given what is at stake, health care should be the most IT-enabled of all our industries, not one of the least. Nonetheless, the “technologies” used to collect, manage, and distribute most of our medical information remain the pen, paper, telephone, fax, and Post-It note. Meanwhile, thousands of small organizations chew around the edges of the problem, spending hundreds of millions of dollars per year on proprietary clinical IT products that barely work and do not talk to each other. Health care organizations do not relish the problem, most vilify it, many are spending vast sums on proprietary products that do not coalesce into a systemwide solution, and the investment community has poured nearly a half-trillion dollars into failed HIT [“health information technology”] ventures that once claimed to be that solution. Nonetheless, no single health care organization or HIT venture has attained anything close to the critical mass necessary to effect such a fix. This is the textbook definition of a market failure.

## **Value Purchasing Opportunities in Traditional Medicare: A Proposal and Legal Evaluation**

*Timothy Jost*, Robert L. Willett Family Professor of Law and Alumni Faculty Fellow at the Washington and Lee University School of Law

The Medicare program spent over \$400 billion for health care services and supplies in 2006, accounting for over 19 percent of total national expenditures. Since its inception in 1965, traditional Medicare (which covers over 80 percent of beneficiaries) has taken a "silo" approach to paying for health care products and services. Medicare has separate prospective payment systems, participation requirements, and even cost sharing requirements for each discrete type of service it covers, including the recently added drug benefits. This approach to payment is largely emulated in the private sector, as well as by state Medicaid programs and even Medicare advantage plans. It has contributed significantly to the fragmentation of our health care system. This paper explores value purchasing models that could use Medicare's purchasing power to encourage greater coordination in the health care system. More specifically, it examines impediments posed by federal and state law to Medicare value purchasing, and proposes statutory and regulatory amendments that could remove these barriers.

## **An Incentive Compatible Design for Public Health Insurance**

*Eric Helland*, Professor of Economics at Claremont McKenna College & *Jonathan Klick*, Jeffrey A. Stoops Professor of Law at Florida State University College of Law

The problem of adverse selection bedevils health care reform. Any effort to increase coverage of the uninsured has the ancillary effect of inducing many consumers who were previously purchasing private insurance and who meet the income criteria for the expanded program to switch from private to public health insurance. While the relative benefits of government versus private health insurance is a subject of considerable debate, it is clear that the increased financial burden on the government resulting from this adverse selection is a serious impediment to increasing coverage to the uninsured. Private health insurers, however, will always have an incentive to avoid covering individuals who are expected to have relatively high health care expenditures in the future. Any private insurance company will have an incentive to prevent high cost individuals from joining their insurance pool while simultaneously trying to remove individuals from the pool who are revealed to be high cost. Moreover under the current system in the United States, in which health insurance is tied to employment, this provides employers an incentive to avoid hiring workers who have potentially high health care costs. As genetic testing reveals ever more about an individual's risk profile, this tension is expected to grow more acute. In this paper we propose a solution to these problems that attempts to preserve private insurance for the majority of consumers while providing a mechanism for moving only high cost individuals into the government run program. Our proposal begins with removing the tax subsidy for private insurance. The current system both encourages excessive health care spending, since any expenditure from private health insurance are paid with pre-tax dollars while out of pocket expenses are paid with after-tax dollars. The system is also regressive. For our purposes the most important feature of removing the tax subsidy is that it would break the link between insurance and employment and allow consumers to compare prices on different health insurance policies much as car insurance is sold today. The second feature of our proposal is an insurance mandate similar to the recent mandate passed in Massachusetts. This would require everyone to purchase basic health insurance and all health insurers to offer coverage to anyone who requests it. It is important to note that while we would require all providers to offer coverage they can do so at a price that is unregulated so that the offer from health insurance providers reflects the true cost of insuring the individual. We then propose instituting an income adjusted price that would be charged to the individual to enter the government insurance program. Before an individual can join the government health insurance pool, however, he or she must have three quotes above the set price. The basic logic is that if no company finds it profitable to insure the individual at a price deemed to be affordable on an income adjusted basis, the individual must enter into the government run policy. We propose to fund the difference between the true cost of insuring the individual and the income adjusted maximum price with a tax on private health insurance. The logic is to share the burden of the "uninsurable" across all

consumers. We also discuss the potential problems that might arise when individuals attempt to game the system as well as solutions to this problem.

## **American Health Care Policy and Politics: Is Fragmentation a Helpful Category for Understanding Health Reform Experience and Prospects?**

*Theodore Marmor*, Professor Emeritus of Public Policy and Management & Professor Emeritus of Political Science at the Yale School of Management

The continuities of American medical politics, despite the surges of reform enthusiasm, are impressive. As the presidential election of 2008 draws closer, all the candidates feel compelled to offer plans for universal health insurance. That was the case in the buildup to the presidential election of 1992, and what followed was the birth and death of the Clinton reform plan. Now, as then, huge majorities of Americans claim they want reform – universal insurance coverage – and disagree about what that would be. Then, as now, interest groups mobilize for battle, trading sound bites and horror stories attacking and defending particular reforms. At the same time, the more quiet politics in health care continue to unfold off the front page and the evening television news: the moral disputes over abortion, euthanasia, and stem-cell research, the distributive, intense local politics of hospital closures and clinic openings, the Washington and state capital fights in hearing rooms over the rules governing the practices of nurses, chiropractors, and physicians, let alone the armies of lobbyists struggling to start or stop health insurance reforms in the states. The cost of health insurance – public and private – dominates the surface of discussion, but the distributive realities of who bears those costs (and should) continue to agitate or bewilder many commentators. To make sense of these diverse topics on the American medical political agenda, it is essential to use categories that separate the fundamental from the incidental. One approach is to work with the ordinary categories of policy and political conflict, which will be my approach. But, throughout, I will ask whether and how the notion of fragmentation—the proposed focus of this conference—helps or hinders. In short, what follows is a running commentary on American health care politics over the past four decades interpreted with and without the focus on fragmentation. The essay proceeds in parts. The first reviews—in broad brush—the highlights of health policy disputes, changes and continuity from the 1970s to the present. The second elaborates on the contemporary scene, placing the United States in some comparative perspective. Part III discusses the regulation versus competition debate that has been so much a part of the American medical care dialogue since the 1970s. Part IV uses the issues surrounding the reform of Medicare—its affordability, its fairness, and the claimed need for modernization—as an illustration of an important policy dispute that the conception of fragmentation, if useful, should illuminate. Part V returns to the theme of contemporary health reform with my conclusions.