in the legal marketplace, where lawyers offer hourly rates, flat fees, contingent fees, or various combinations of the same, clinics will likely offer a menu of payment options. Patients who prefer to pay fixed fees will almost certainly have the option to do so.

Murray's fear that doctors will use overly aggressive procedures is also overstated. Because success rates are already important to couples, physicians already have the incentive to use aggressive procedures. Moreover, relative aggressiveness is not particularly significant. The important question is whether shared-risk programs will increase the frequency of mismatches between couples who are willing to incur only low risks to become pregnant and doctors who employ procedures that carry high risks. Murray offers no reason to believe the rate of such mismatches or their severity will increase if shared-risk programs are widely available.

It also seems unlikely that shared-risk programs will be structured in a way that gives rise to the abortion-related concerns Murray raised. We think it likely that both parties to a shared-risk program will favor terms that make each responsible for the issues under their control. We predict that if a couple decided on an abortion, the contract would require the payment of the standard IVF fee, and not count that cycle against the shared-risk program. This arrangement would create incentives identical to those that exist under FFS.

Murray's concern that couples participating in a shared-risk program will not know "when to say when" is also exaggerated. Although there may well be issues relating to the disclosure of information about shared-risk programs, false, deceptive, and misleading advertising is already unlawful. In other markets, such problems are addressed without resorting to an outright prohibition, to the general satisfaction of all concerned. Similarly, although financial considerations affect the decision of "how much" assisted reproduction is "too much," it is precisely those couples who do not end up pregnant after repeated cycles that benefit from shared-risk programs, and who will be worse off if such programs are not available.

Finally, Murray's arguments regarding commodification and the destruction of physician-patient relationships seem contrived. First, although he does not suggest that couples (or doctors) should be indifferent to the rate at which IVF succeeds, he objects to a payment system that recognizes the value couples place on becoming pregnant. But if it is permissible, and even good, that couples and doctors care about success rates, why must they pretend they do not care when it comes to payment plans? Second, no one is proposing the legalization of baby selling. The only issue is whether to allow couples to pay for an existing medical service in a new way. Because IVF services are already bought and sold in markets, they have already been commodified. We fail to see how a new payment option will make IVF services more commodified. Third, contingent compensation agreements are allowed in other settings that involve intimate or fiduciary relationships, without apparent damage to those involved. Indeed, contingent compensation is common within the family, such as where a child's allowance is contingent on chores being done, or college tuition is paid only if a specified grade point average is maintained.

In the future, analysis of these issues should focus on the real problem, which is arriving at compensation systems to encourage physicians to make good judgments and to act skillfully and cost effectively. Murray's response is that "we are better off when physicians remain focused on our welfare, rather than when they become entrepreneurs peddling insurance."[2] This is a good sound bite, but it is little more. One could say, with equal force, that we are better off when physicians remain focused on our welfare than when they get paid whether we live or die. Neither caricature can answer what is at bottom an empirical question: Do different incentive arrangements cause doctors to act in different ways with different consequences for their patients' well-being and health?

In some contexts, fixed fees may create better incentives than contingent fees; in other settings, doctors may perform equally well under both arrangements; and in still other situations, contingent fees (of which shared-risk programs are an example) may work best. The growth of alternatives to FFS and the markets which operate in all other service industries and professions suggest that Murray's belief in the necessary and inevitable superiority of FFS medicine is wrong. His unsubstantiated fears are too slim a basis on which to forbid the use of a market mechanism that may enable thousands of additional couples to afford IVF each year.

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2. *Id.* at 294.

Federal Privacy Legislation

To the editor. In his 1997 article "Medical Record Confidentiality Law, Scientific Research, and Data Collection in the Information Age,"[1] Richard Turkington analyzed several legislative proposals then circulating regarding medical record confidentiality. Since that article, a bill introduced in April 1998 by Senators Jim Jeffords (R. Vt.) and Christopher Dodd (D. Conn.) ap-

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pears to have become the front-runner among those being considered by Congress. This bill, Senate bill 1921,[2] is similar to previous medical record bills to which privacy advocates have strenuously objected.

Like its predecessors, the Jeffords-Dodd bill puts virtually no limits on the disclosure of personal medical information within a corporate health care entity (no matter how large and how numerous its employees and "agents"). It also permits widespread disclosure without patient consent to various outside parties such as public health agencies, law enforcement personnel, oversight agencies, and state health care data banks. Consequently, the requirement of patient consent applies only to a minority of the disclosures that are likely to take place. If enacted, the principal effect of the Jeffords-Dodd bill would be to license a high volume of personal medical information disclosure irrespective of patient wishes.

Jeffords-Dodd is even more deeply flawed than some earlier bills, because it contains provisions that would render meaningless a great many patient "authorizations" for disclosure. These provisions are found in section 202, which states that "a single authorization form must be secured for each individual in connection with treatment, payment and health care operations." No mention is made of a patient's right to modify these authorization forms. Each employer offering a health plan and each health plan must obtain such authorizations as a condition of enrollment in the plan. In addition, every health care provider must get such an authorization from any uninsured and self-pay patients who have not already signed a form of this kind. So, *all* patients are to sign these blanket authorizations. Although the authorizations are referred to in section 202 as "legal, informed" authorizations, they would in fact be *compelled* consents that do not meet the requirements of informed consent. (Although the bill permits patients to revoke consent, patients are not likely to do so, if that will result in a loss of insurance or treatment.)

A few other points should be noted:

- The bill fails to provide clear criteria for "nonidentifiable" information or to require its use in various settings.
- Access without consent is granted to a broad range of government and nongovernment "oversight" agencies. No requirement is in place to ensure that these records be deidentified or anonymized, or that they be destroyed once the oversight function is completed.
- Access without consent is granted to all public health agencies for use in "public health investigations." There is no requirement that these records be deidentified or anonymized. No limitation is placed on the kinds of medical information that public health agencies may collect.
- Medical records may be disclosed to law enforcement authorities in response to a request "authorized by Federal or state law," that is, without a subpoena or court order. Under this vague standard, law enforcement authorities would be able to use their general investigative powers to access medical records, including large medical data banks. Information found there may be used for prosecutorial purposes.
- The bill preempts state medical privacy laws, with a few exceptions. It does not preempt state laws that authorize the creation of state health care data bases. Such data bases have been a major concern of privacy advocates.

When the provisions of Senate bill 1921 are taken together with the provision for a unique patient identifier (already passed into law in the Health Insurance Portability and Accountability Act of 1996[3]), they will make it impossible for any patient in the United States, even a self-pay patient, to obtain confidential medical care.

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1. See R.C. Turkington, "Medical Record Confidentiality Law, Scientific Research, and Data Collection in the Information Age," *Journal of Law, Medicine & Ethics*, 25, (1997): 113–29.

2. See Health Care Personal Information Nondisclosure Act of 1998, S. 1921, 105th Cong. (1998).

3. See The Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (codified as amended in scattered sections of the U.S.C. and I.R.C.) (1996).

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