to charge higher premiums. *NYSA-ILA Medical and Clinical Services Fund v. Axelrod*, 27 F.3d 823, 827 (2d Cir. 1994).

The decisive matter is how expansively and literally to read the "relates to" clause of section 514(a) of ERISA. *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 97 (1983), held that a state law "relates to" an ERISA plan "if it has a connection with or reference to such a plan." *Shaw* set a strong precedent in maintaining, through a careful analysis of the statute and its legislative history, that Congress intended the preemption clause to pertain even to state laws that were not specifically created to affect employee benefit plans.

In 1995, the Supreme Court reduced *Shaw*'s effect in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 514 U.S. 645 (1995). *Travelers* held that ERISA did not preempt a New York statute that collected surcharges from hospital patients covered by commercial insurers but not from Blue Cross/Blue Shield hospital patients. Focusing on the intent of the preemption clause—facilitating uniformity in interstate benefit plans—the Court held that the surcharges' "indirect economic effect" on benefit plans would not cause particular structural or administrative choices that would affect uniformity. *Id.* at 659. Such cost variations were a far cry from the "'conflicting directives' from which Congress meant to insulate ERISA plans." *Id.* at 661 (quoting *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990)).

After handing down the *Travelers* opinion, the Supreme Court remanded *DeBuono* to the court of appeals, with instructions to reconsider it in light of *Travelers*. On remand, the appellate court reinstated its original judgment. It distinguished *Travelers* on the ground that its surcharge was on insurers and thus only indirectly affected the decisions of ERISA plan administrators, while in *DeBuono* the HFA tax was direct: it was placed directly on ERISA services.

On appeal, the Supreme Court agreed that the HFA state tax was "related to" benefit plans in the broadest sense, by affecting the relative costs of various health insurance packages. However, the Supreme Court denied the appellate court's distinction between *Travelers* and *DeBuono*. It noted that although the level of coverage was affected here, simply because the Fund set up separate hospitals for ERISA-covered employees, any state tax that affects employee benefits will affect the level of coverage. On that basis, the Court ruled that the indirect/direct impact distinction cannot withstand scrutiny. The Court redefined what it meant by "indirect economic effect" in *Travelers* by emphasizing that it is the economic effect itself that is indirect.

DeBuono follows *Traveler*'s lead in limiting the Court's broad understanding of ERISA's preemption clause. It not only allows for nonsubstantial economic impacts that do not interfere with Congress's intent to facilitate uniform interstate benefit plans, but also looks further into protecting states' right to regulate health plans: "The historic police powers of the State include the regulation of matters of health and safety." *DeBuono*, 117 S. Ct. at 1751. The Court is radically moving away from its previous broad understanding under *Shaw* of "relates to" by holding that a state law of general applicability should not be presumed to be preempted even if it imposes a direct burden on the administration of ERISA plans.

Pamela Laufer

Correspondence

IVF Shared-Risk Programs

Letter to the Editor. In his commentary "Money-Back Guarantees for IVF," Professor Thomas Murray dismisses all arguments in favor of "shared-risk" programs, and insists "we should not embrace these plans."[1] He offers several practical and philosophical reasons for this conclusion, contending that (1) shared-risk programs will not actually broaden access to in vitro fertilization (IVF), because physicians will shun couples who have less than an excellent chance of success; (2) the strong financial pressures created by shared-risk programs will induce physicians to endanger their patients' health by using aggressive procedures to ensure pregnancy; (3) a couple's decision to abort an abnormal fetus (and the physician's counseling of the couple during that decision) should not be distorted by the financial pressures created by a shared-risk program; and (4) physicians will use money-back guarantees to entice couples into IVF when they would be better advised to decline such services. Murray also fears that shared-risk programs will destroy the physician-patient relationship and commodify children and the family.

These objections to shared-risk programs are unpersuasive. Because couples comparison-shop when choosing IVF clinics, doctors have always had strong incentives to keep IVF success rates high. The Fertility Clinic Success Rate and Laboratory Certification Act was enacted because clinics were making inflated claims about success rates *under the fee-for-service (FFS) system*. Doctors may decline to offer high-risk patients the option of entering into a shared-risk program, and they may refuse to treat some high-risk patients altogether, as they do now. But absent any empirical evidence to the contrary, we would expect any change in the rate of rejection of high-risk couples to be small.

Murray assumes that once *any* IVF clinic offers shared-risk programs to any patients, *all* will offer only shared-risk programs to *all* of their patients. This assumption is unwarranted. Physicians will remain free to charge for IVF on a FFS basis, and those who do not have a sufficient volume of patients to diversify the associated risk or who themselves are risk-averse will continue to do so. As

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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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1. T.H. Murray, "Money-Back Guarantees for IVF: An Ethical Critique," *Journal of Law, Medicine & Ethics*, 25 (1997): at 292.
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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