2013

The Split Benefit: The Painless Way to Put Skin Back in the Health Care Game

Christopher Robertson

ESSAY

THE SPLIT BENEFIT: THE PAINLESS WAY TO PUT SKIN BACK IN THE HEALTH CARE GAME

Christopher Robertson†

This Essay proposes a solution to the growth of health care costs, focusing on the sector of expensive, and often unproven, treatments. Political, legal, and market limits prevent insurers and physicians from rationing care or putting downward pressure on prices. Because the insurer bears the cost, the patient is also not sensitive to price, and thus consumes even low-value but high-cost treatments.

The traditional cost-sharing solution is onerous for patients with limited wealth. When treatments can cost $25,000 or more, one cannot expect the median patient to pay a significant portion thereof. Instead, patients often enjoy supplemental insurance or exhaust their cost-sharing limits, and thus enjoy full insurance when making such a consumption decision. Raising the limits is a painful solution, since it would reduce access to care and cause medical bankruptcies.

A new solution emerges from the recognition that insurance currently provides only an "in-kind" benefit, paid to the provider rather than the beneficiary. Instead, under a "split benefit," for expensive treatments (costing, say, $100,000), the insurer should consider satisfying its coverage obligation by paying a portion (say, $10,000) directly to the patient. The patient then decides whether to spend that portion on the treatment. If so, the insurer pays the balance ($90,000) to the provider, thereby insuring access. If the patient instead declines the care, he or she can save or spend the money on anything else. The insurer saves the balance ($90,000).

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Because it is fungible, the split benefit creates an opportunity cost, causing some patients to decline the expensive treatment in lieu of medical and nonmedical alternatives that they value more highly. Strikingly, the split benefit is consistent with current insurance contracts and regulations, since it does not change coverage or the size of the benefit. That feature makes the split benefit practicable, unlike many other theoretical solutions. Moreover, the insurer can exercise the split benefit as a unilateral option whenever it is most likely to save money.

The split benefit is a better solution than traditional cost sharing or rationing by insurers or physicians, which all reduce access to care. The proposal serves patients' autonomy by giving them additional options and reduces the distortion in the larger economy caused by nonfungible insurance. This Essay considers objections, including the possibility of stimulating false demand and the need to protect patients who are unable to decide for themselves—both of which the appropriate legal mechanisms can address.

INTRODUCTION

U.S. health care spending has reached approximately $2.5 trillion or 17.6% of GDP.[1] We spend more on health care than on food, housing, transportation, or anything else.[2] Congressional Budget Office (CBO) leaders have argued that "our country's financial health will in fact be determined primarily by the growth rate of per capita

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1 CTRS. FOR MEDICARE & MEDICAID SERVS., OFFICE OF THE ACTUARY, NATIONAL HEALTH EXPENDITURE PROJECTIONS 2010–2020: FORECAST SUMMARY 4 tbl.1, *available at* https://www.cms.gov/nationalhealthexpenddata/downloads/proj2010.pdf.

2 *See* Timothy Stoltzfus Jost, *Our Broken Health Care System and How to Fix It: An Essay on Health Law and Policy*, 41 WAKE FOREST L. REV. 537, 537 (2006).

health care costs."[3] At the household level, health care spending leads to personal bankruptcies and home foreclosures.[4]

The states are also suffering from the health care cost burden. "Last year, Medicaid spending was estimated to account for nearly a quarter of total state spending—the largest portion of their budgets—and it's getting only more expensive."[5] These costs have assumed constitutional proportions, as the Supreme Court has recently taken up the allegations that the federal government mandates have commandeered the state budgets.[6]

It will only get worse. As shown in Figure 1, experts expect national health spending to comprise 20% of GDP by 2020, with health care costs inflation dramatically outpacing every other sector of the economy.[7] This would amount to nearly $13,500 for each American, nearly three times the cost in 1999.[8] The CBO projects that unless the system implements significant changes, health spending will grow to half of all U.S. spending.[9] One former secretary of health and human services called this the "health-care inflation monster" that is eating our economy.[10]

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3 Peter R. Orszag & Philip Ellis, *The Challenge of Rising Health Care Costs—A View from the Congressional Budget Office*, 357 NEW ENG. J. MED. 1793, 1793 (2007).

4 *See* David U. Himmelstein et al., *Medical Bankruptcy in the United States, 2007: Results of a National Study*, 122 AM. J. MED. 741, 741, 744–45 (2009); Christopher Tarver Robertson et al., *Get Sick, Get Out: The Medical Causes of Home Mortgage Foreclosures*, 18 HEALTH MATRIX 65, 90–94 (2008).

5 Ezekiel J. Emanuel, *What We Give Up for Health Care*, N.Y. TIMES (Jan. 21, 2012, 5:41 PM), http://opinionator.blogs.nytimes.com/2012/01/21/what-we-give-up-for-health-care/.

6 *See* Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566 (2012).

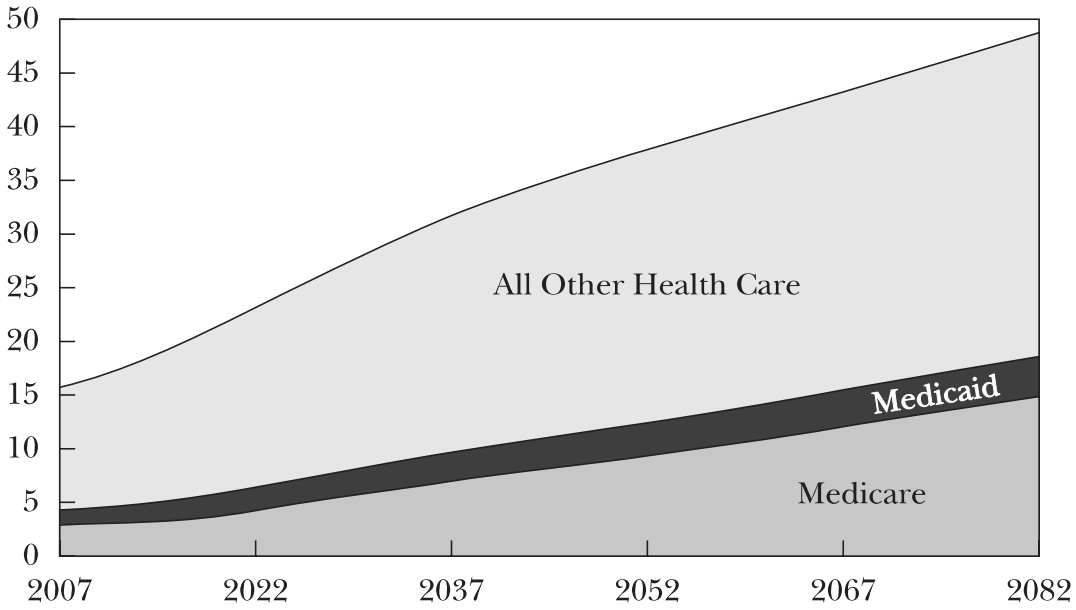
7 *See* CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 1, at 4 tbl.1.

8 *See id.*; *see also* Edward J. Larson, *Medical Rationing, Death Panels and the Rising Cost of Health Care: Whittier Law School Health Law Symposium Paper*, 33 WHITTIER L. REV. 13, 15 (2011) (reviewing this data).

9 *See* CONG. BUDGET OFFICE, TECHNOLOGICAL CHANGE AND THE GROWTH OF HEALTH CARE SPENDING 5 (2008) [hereinafter CONG. BUDGET OFFICE, TECHNOLOGICAL CHANGE], *available at* http://www.cbo.gov/ftpdocs/89xx/doc8947/01-31-TechHealth.pdf.

10 Robert Pear, *Reagan Has Achieved Many Goals, but Some Stir Opposition*, N.Y. TIMES, Aug. 20, 1984, at A18 (quoting Margaret Heckler).

FIGURE 1:
PROJECTED SPENDING ON HEALTH CARE AS A PERCENTAGE OF GROSS DOMESTIC PRODUCT (GDP)



Source: Congressional Budget Office

Note: Amounts for Medicare are net of beneficiaries' premiums. Amounts for Medicaid are federal spending only.

For both public and private health insurers, reform to address the cost conundrum seems inevitable. The question is how. The default rule will be the sorts of crude policies that also cut into access, choice, and health. For example, states are slashing their Medicaid budgets nationwide.[11] Arizona stopped paying for certain organ transplants.[12] Hawaii refuses to pay for hospital stays of more than ten days for most patients, regardless of whether the hospital can safely discharge the patient.[13] Other states are doing likewise.[14] These solutions are far from elegant. They are zero-sum games, which the patients lose.

A more elegant solution requires closer attention to the causes. It is tempting to suppose that demographic changes drive this growth. Yet, the United States spends 20 to 30 percent more per capita than countries with excellent health care systems and similarly aging populations, such as France and Germany.[15] As Ezekiel Emanuel writes, "The truth is, the United States is not getting 20 or 30 percent better

11 *See* Phil Galewitz, *More States Limiting Medicaid Hospital Stays*, USA TODAY, Oct. 31, 2011, at 1A.

12 *Id.*

13 *Id.*

14 *Id.*

15 *See* Ezekiel J. Emanuel, *How Much Does Health Care Cost?*, N.Y. TIMES, Oct. 30, 2011, at SR5.

health care or results than other countries."[16] And, even within the United States, from one region to another, there are large disparities in the amount spent on health care, which demographic and health factors cannot explain.[17] Areas with double, or even triple, the amount of spending per patient do not show better outcomes as a result.[18]

"[M]ost analysts have concluded that the bulk of the long-term rise resulted from the health care system's use of new medical services that were made possible by technological advances . . . ."[19] If this market were efficient—and if such spending were making us healthier and happier than alternative spending could—then we would count this trend as progress.[20] Closer analysis reveals, however, that this market is failing to align our health care consumption choices with our values, which is to say that much of this money is wasted. This failure results from a complex set of well-intentioned laws that mandate coverage of expensive, and often unproven, treatments but effectively prevent anyone from weighing the costs of those treatments.

First, public or private insurance covers most of the patients who make the majority of health care spending choices.[21] The recent health care reform legislation imposes a legal mandate on employers to cover their workers and on individuals to enroll themselves, and helps subsidize the costs of premiums.[22] Thus, as we approach universal coverage, insurers will handle nearly all health care spending decisions. Therefore, the question of how to control health care costs is

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16 *Id.*

17 *See id.*

18 *See id. But see* Richard A. Cooper, *States with More Health Care Spending Have Better-Quality Health Care: Lessons about Medicare*, 28 HEALTH AFF. w103, w112–13 (2009) (noting that quality "depends on total health care spending" and "relates to a broad array of sociodemographic characteristics," and that "Medicare spending is a poor proxy for overall health care spending.").

19 CONG. BUDGET OFFICE, TECHNOLOGICAL CHANGE, *supra* note 9, at 1; *see also* Mark A. Hall & Gerard F. Anderson, *Health Insurers' Assessment of Medical Necessity*, 140 U. PA. L. REV. 1637, 1664 (1992) ("According to most observers, a driving force behind the increase in health care spending is new technology.").

20 *See generally* Katherine Baicker & Amitabh Chandra, *Aspirin, Angioplasty, and Proton Beam Therapy: The Economics of Smarter Health Care Spending* 1, 3 (Sept. 9, 2011) (unpublished manuscript), *available at* http://www.kc.frb.org/publicat/sympos/2011/2011.BaickerandChandra.paper.pdf (discussing estimates as to whether it is optimal to spend as much as a third of the U.S. economy on health care, but arguing that the spending is likely less than optimal).

21 *See* CTRS. FOR MEDICARE & MEDICAID SERVS., NATIONAL HEALTH EXPENDITURES BY TYPE OF SERVICE AND SOURCE OF FUNDS, CY1960–2011, *available at* http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html (showing that public and private insurers pay over eighty-eight percent of health care costs).

22 *See* 26 U.S.C. § 5000A(a) (2006); *see also* Seven-Sky v. Holder, 661 F.3d 1, 4–20 (D.C. Cir. 2011) (discussing Congress's rationale for the mandate and upholding the mandate as constitutional).

largely a question of how to design public and private insurance policies so that insurers cover patients for the treatments they demand but also minimize wasteful spending.[23]

When deciding whether and how to cover the costs of health care treatments—including drugs, devices, surgeries, imaging, tests, and other procedures—a rational insurer will be primarily concerned about whether they are cost-effective and efficient. Some treatments—such as blood pressure and diabetes drugs—are known to be efficient for health insurers. Spending more money on these procedures actually saves the insurer money by preventing the need for expensive procedures later.[24] A recent wave of research has endorsed the idea of Value-Based Insurance Design (VBID), wherein insurers reduce or eliminate co-pays and deductibles for such treatments, and perhaps even create affirmative programs to encourage their adoption and adherence.[25]

At the other end of the cost-effectiveness spectrum is a vast domain of expensive treatments that have small or unproven effectiveness. The CBO has noted that "[a]lthough estimates vary, some experts believe that less than half of all medical care is based on or supported by adequate evidence about its effectiveness."[26] When Medicare Administrator Donald Berwick stepped down from his post in 2011, he argued that 20 to 30 percent of health care spending—more than $1 trillion a year—was waste.[27] "Much is done that does not help patients at all," Dr. Berwick said, "and many physicians know it."[28]

One might suppose that if the U.S. Food and Drug Administration (FDA) approves a drugs or device, then it is proven effective.

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23 *See generally* Robert H. Blank, *Regulatory Rationing: A Solution to Health Care Resource Allocation*, 140 U. PA. L. REV. 1573 (1992) (discussing a more fundamental approach to this question). Robert Blank's paper takes for granted the primary features of the American health care system circa 2012.

24 *See generally* Tammy O. Tengs et al., *Five-Hundred Life-Saving Interventions and Their Cost-Effectiveness*, 15 RISK ANALYSIS 369, 378, 381 (1995) (compiling studies of cost-effectiveness).

25 *See* Michael E. Chernew et al., *Value-Based Insurance Design*, 26 HEALTH AFF. w195, w195, w197 (2007).

26 CONG. BUDGET OFFICE, RESEARCH ON THE COMPARATIVE EFFECTIVENESS OF MEDICAL TREATMENTS: ISSUES AND OPTIONS FOR AN EXPANDED FEDERAL ROLE 11 (2007) [hereinafter CONG. BUDGET OFFICE, RESEARCH ON THE COMPARATIVE EFFECTIVENESS OF MEDICAL TREATMENTS], *available at* http://www.cbo.gov/ftpdocs/88xx/doc8891/MainText.3.1.shtml (citing LEIGHANNE OLSEN ET AL., INST. OF MED. OF THE NAT'L ACADS., LEARNING WHAT WORKS BEST: THE NATION'S NEED FOR EVIDENCE ON COMPARATIVE EFFECTIVENESS IN HEALTH CARE app. A, at 341 (2011), *available at* http://www.ncbi.nlm.nih.gov/books/NBK64787/pdf/TOC.pdf).

27 Editorial, *Candid Advice from a Health Care Visionary*, N.Y. TIMES, Dec. 14, 2011, at A34; Robert Pear, *Health Official Takes Parting Shot at 'Waste,'* N.Y. TIMES, Dec. 4, 2011, at A23.

28 Pear, *supra* note 27, at A23.

However, the FDA's statutory authority requires only that manufacturers prove minimal effectiveness compared to a placebo, which is to say that the product is better than nothing.[29] Physicians often still must guess about whether the new drug or device will prove more effective than standard treatments.[30] Even when a drug has FDA approval and proven effectiveness, this does not necessarily mean that the drug is cost-effective. Indeed, the FDA statute does not authorize it to consider costs—only medical risks and benefits.[31] Even more, the FDA statute also allows physicians to prescribe drugs and devices off-label for other unapproved diseases and conditions without any proof or FDA review of efficacy.[32] The law actually prevents the FDA from taking an active role in controlling costs in the American health care system.

Thus, there are many expensive drugs, devices, and other treatments that are arguably not worth their cost. Consider, for example, the $80,000 treatment for breast cancer called high-dose chemotherapy plus autologous bone marrow transplant (HDC-ABMT).[33] The HDC-ABMT treatment became very popular in the 1990s, even though clinical trials had not proven the treatment effective.[34] At first, insurers refused to pay.[35] "Their refusals led to an avalanche of

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29 *See* Jerry Avorn, *FDA Standards—Good Enough for Government Work?*, 353 NEW ENG. J. MED. 969, 969 (2005). *See generally* Riegel v. Medtronic, Inc., 552 U.S. 312, 316 (2008) (analyzing the preemptive effect of the U.S. Food and Drug Administration (FDA) statute for medical devices); United States v. Rutherford, 442 U.S. 544, 555 (1979) (discussing the purpose and function of the FDA approval process and upholding a ban on the sale of unapproved drugs).

30 *See generally* Agency Information Collection Activities; Proposed Collection; Comment Request; Experimental Study of Comparative Direct-to-Consumer Advertising, 76 Fed. Reg. 38663, 38664 (July 1, 2011) (noting that "few head-to-head clinical trials have been conducted"); Sanket S. Dhruva et al., *Strength of Study Evidence Examined by the FDA in Premarket Approval of Cardiovascular Devices*, 302 JAMA 2679, 2679 (concluding that "[p]remarket approval of cardiovascular devices by the FDA is often based on studies that lack adequate strength and may be prone to bias").

31 *See* Peter J. Neumann et al., *The FDA and Regulation of Cost-Effectiveness Claims*, 15 HEALTH AFF. 54, 55 (1996). Still, the insurers' actuaries may have developed such data internally, and recent public policy initiatives should expand our knowledge in this area. *See Recovery Act Allocates $1.1 Billion for Comparative Effectiveness Research*, U.S. DEPARTMENT HEALTH & HUM. SERVICES, http://www.hhs.gov/recovery/programs/os/cerbios.html (last visited Mar. 12, 2013).

32 *See* 21 U.S.C. § 396 (2006) ("Nothing in this [Act] shall be construed to limit or interfere with the authority of a health care practitioner to prescribe or administer any legally marketed device to a patient for any condition or disease within a legitimate health care practitioner-patient relationship."); Buckman Co. v. Plaintiffs' Legal Comm., 531 U.S. 341, 350–51 (2001) (discussing off-label use in the context of medical devices).

33 *See* Michelle M. Mello & Troyen A. Brennan, *The Controversy over High-Dose Chemotherapy with Autologous Bone Marrow Transplant for Breast Cancer*, 20 HEALTH AFF. 101, 101–02 (2011).

34 *See id.* at 103–05 (describing 1990s clinical trials' inability prove the efficacy of the treatment).

35 *Id.* at 103.

litigation, accompanied by intensive political lobbying by patient advocacy groups."[36] For example, the Minnesota legislature mandated that insurers cover it.[37]

"These legal and political pressures led most health plans to capitulate and pay for the treatment by the mid-1990s."[38] More than 41,000 patients consumed HDC-ABMT during the 1990s at an aggregate cost of about $3.28 billion.[39] By 2000, new research showed that the "insurers were correct" in their initial refusals to pay.[40] But, of course, the money could not be unspent. Nor can those patients reverse the serious risks and side effects that accompanied this ineffective treatment.[41] For hundreds of other expensive and novel treatments, we now find ourselves in the same situation of epistemic uncertainty where insurers must pay for unproven treatments.[42]

Likewise, consider Avastin, which, at $88,000 per treatment, is eleventh on a list of the fifteen most expensive drugs.[43] Genentech marketed Avastin for the treatment of breast cancer after the FDA granted accelerated approval for that use in 2008.[44] The FDA based its approval on two open-label studies that showed that the drug slowed the rate of tumor growth but showed "no evidence of an effect on overall survival or improved symptoms."[45] Still, oncologists readily prescribed Avastin to their desperate patients.[46]

Subsequent double-blinded studies failed to replicate the early findings.[47] In 2011, after an extensive process, the FDA commissioner exercised her statutory authority to revoke Avastin as a treatment for

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36 *Id.* at 102.

37 *See* Karen G. Gervais & Reinhard Priester, *Mandates for Unproven Health Care Interventions*, 79 MINN. MED. 52, 52 (1996).

38 Mello & Brennan, *supra* note 33, at 102.

39 *See id.* at 101–02. The aggregate cost is computed by multiplying the individual price by the number of patients, both of which Mello and Brennan provide in their article.

40 *See id.*

41 *See id.* at 110 ("Acute-onset toxicities (in addition to vomiting and diarrhea) include sepsis, pulmonary failure, veno-occlusive disease, cardiac failure, nephrotoxicity, hemorrhagic cystitis, and cardiac toxicity.").

42 *See* text accompanying notes 103–19 (discussing reasons why insurers feel so compelled to pay).

43 Merrill Goozner, *An Extra Month of Life: Is It Really Worth the Cost?*, FISCAL TIMES (June 30, 2011), http://www.thefiscaltimes.com/Articles/2011/06/30/An-Extra-Month-of-Life-Is-it-Really-Worth-the-Cost.aspx#page1.

44 *See* Proposal to Withdraw Approval for the Breast Cancer Indication for AVASTIN (Bevacizumab), Docket No. FDA-2010-N-0621, at 23 (Dep't of Health & Human Servs., Food & Drug Admin. Nov. 18, 2011) [hereinafter Decision of the Commissioner] (decision of the commissioner). *But cf.* Goozner, *supra* note 43 (describing how the FDA revoked approval in 2010 for the Genentech drug Avastin for the treatment of breast cancer).

45 Decision of the Commissioner, *supra* note 44, at 13. The studies submitted to obtain accelerated approval (the E2100 study and the AVF2119g study) considered tumor growth to constitute disease progression (PFS). *Id.* at 18.

46 *See* Goozner, *supra* note 43.

47 *See* Decision of the Commissioner, *supra* note 44, at 23–25.

breast cancer, noting that its side effects presented very real dangers to patients (including a risk of death) not balanced by a proven, real benefit.[48] Cancer patients protested the decision, calling it "nothing short of a death sentence" for those who rely upon the drug.[49]

The decision will likely be taken up in court, but, for now, FDA revocation prevents the drug manufacturer from marketing Avastin for the treatment of breast cancer. However, despite the FDA's revocation and because Avastin has at least one other FDA-approved indication on its label, oncologists can still freely prescribe Avastin for the treatment of breast cancer.[50] In turn, Medicare will continue to pay for such treatments.[51] Some private insurers will likely follow suit.[52]

Treatments may be cost-effective for certain patients in certain situations even while ineffective for others.[53] For example, clinical studies prove heart stents effective for use after a heart attack, and surgeons implant more than one million each year, costing up to $100,000 each.[54] But stents are often used prophylactically in a domain that is not FDA-approved.[55] A large randomized, controlled trial (the gold standard for medical research) demonstrated that patients who received stents prophylactically would have fared just as well on a much cheaper (and safer) regimen of drugs.[56]

Likewise, the United States is now rapidly dispensing artificial hips and knees to its aging population. In the United States, nearly

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48 *Id.* at 12, 40.

49 Andrew Pollack, *F.D.A. Revokes Approval of Avastin for Use as Breast Cancer Drug*, N.Y. TIMES, Nov. 19, 2011, at B7.

50 *See* 21 U.S.C. § 396 (2006).

51 *Medicare to Keep Paying for Controversial Cancer Drug Avastin*, NATIONALJOURNAL (June 30, 2011, 3:55 PM), http://www.nationaljournal.com/healthcare/medicare-to-keep-paying-for-controversial-cancer-drug-avastin-20110630.

52 *See* Meredith Melnick, *Medicare Will Continue to Pay for Avastin*, TIME (July 1, 2011), http://healthland.time.com/2011/07/01/medicare-will-continue-to-pay-for-avastin/#ixzz1ZY3VWGdc (noting that "[m]any private health insurance companies typically follow Medicare's lead"); *see also* Goozner, *supra* note 43 (quoting Lee Newcomer, Senior Vice President for Oncology at UnitedHealthcare, who stated that "regardless of what the FDA does, we wouldn't make any changes").

53 *See generally* Ezekiel J. Emanuel & Jeffrey B. Liebman, Op-Ed., *Cut Medicare, Help Patients*, N.Y. TIMES, Aug. 23, 2011, at A25 (describing inefficiencies in health care spending and the prophylactic use of stents in particular).

54 *See id.* While the cost of a stent can vary between $1,000 and $4,000, the average cost of a stent procedure can vary from $30,000 to $100,000. *See* David Rosenfeld, *Is American Medicine Too Stent Happy?*, PAC. STANDARD (Apr. 17, 2010), http://psmag.com/health/is-american-medicine-too-stent-happy-12861.

55 *See* Rosenfeld, *supra* note 54 ("An estimated 700,000 Americans will have a stent implanted [in 2012] . . . either after a heart attack or stroke, to prevent one from happening . . . ."); Htut K. Win et al., *Clinical Outcomes and Stent Thrombosis Following Off-Label Use of Drug-Eluting Stents*, 297 JAMA 2001, 2008 (2007) (finding that of the 3,323 patients enrolled in the study who had received stents, 54.7% had at least one off-label characteristic).

56 *See* William E. Boden et al., *Optimal Medical Therapy With or Without PCI for Stable Coronary Disease*, 356 NEW ENG. J. MED. 1503, 1503 (2007).

one in twenty persons over the age of fifty now have artificial knees, at a cost of about $40,000 each.[57] The device industry continues to roll out new models with higher and higher price tags that enthusiastic surgeons suggest and install.[58] Yet these newer devices often do not perform any better than older, less expensive designs.[59]

"The list of procedures Medicare pays for that are proven to have no benefit goes on and on."[60] Whether provided by public insurers or private health plans, this coverage likely exists because Americans demand access to such treatments.[61] And these big-ticket treatments, concentrated in a small portion of the population, consume a huge portion of our health care budgets. In 2009, as much as 22% of health care costs fell upon only 1 percent of the population, where each individual incurred more than $90,000 in costs.[62]

There can be little doubt that there is room for reform in this sector of expensive treatments that have little or no proven effectiveness. In this, the most heavily regulated industry in America, we have not yet found a way to provide access to high-end, cutting-edge treatments while being sensible about whether and when to actually consume them. Strikingly, the recent landmark health care reforms barely scratch the surface in this domain of cost control—the legal and political challenges make this issue just too difficult to resolve.[63] This Essay explains how we are left with a legal and policy regime that

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57 Lindsey Tanner, *Nearly 1 in 20 U.S. Adults over 50 Have Fake Knees*, WASH. TIMES (Feb. 10, 2010), http://www.washingtontimes.com/news/2012/feb/10/nearly-1-20-us-adults-over-50-have-fake-knees/?page=all.

58 *See* Rajan Anand et al., *What Is the Benefit of Introducing New Hip and Knee Prostheses?*, 93 J. BONE & JOINT SURGERY 51, 53 (2011) (arguing that newer prostheses are likely more expensive than older models); James G. Wright et al., *Physician Enthusiasm as an Explanation for Area Variation in the Utilization of Knee Replacement Surgery*, 37 MED. CARE 946, 953 (1999) (suggesting that "surgeons' opinions or enthusiasm for the procedure" is a dominant factor contributing to higher rates of knee replacement).

59 Anand et al., *supra* note 58, at 53; *see also* V. Wylde et al., *Total Knee Replacement: Is It Really an Effective Procedure for All?*, 14 KNEE 417, 421 (2007) ("From the literature, it is evident that there exists a substantial subsection of the TKR [total knee replacement] population who experience little or no benefit from the operation.").

60 Emanuel & Liebman, *supra* note 53.

61 *See* John A. Romley et al., *Survey Results Show that Adults Are Willing to Pay Higher Insurance Premiums for Generous Coverage of Specialty Drugs*, 31 HEALTH AFF. 683, 683 (2012) ("US adults were estimated to be willing to pay an extra $12.94 on average in insurance premiums per month for generous specialty-drug coverage—in effect, $2.58 for every dollar in out-of-pocket costs that they would expect to pay with a less generous insurance plan.").

62 *See* Steven B. Cohen & William Yu, *The Concentration and Persistence in the Level of Health Expenditures over Time: Estimates for the U.S. Population, 2008–2009*, MED. EXPENDITURE PANEL SURV. (Jan. 2012), http://meps.ahrq.gov/mepsweb/data_files/publications/st354/stat354.pdf.

63 *See* David Orentlicher, *Cost Containment and the Patient Protection and Affordable Care Act*, 6 FLA. INT'L U. L. REV. 67, 67–68 (2010) (arguing that, due to political pressures, "the Act does far more about increasing access than it does about cutting costs").

forces patients to pay in advance for coverage of treatments they think they may someday want, creating a sunk cost. But it turns out that, at the point of consumption, many patients would rationally prefer to spend their money otherwise but are not allowed to do so. We have created a systematic economic bias toward health care consumption. This need not be the case.

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This Essay proceeds as follows. Part I explains why and how the current legal regime fails to prevent the overconsumption of expensive yet often unproven treatments. There are various efforts to get physicians, insurers, and patients themselves all to ration care, but they fail to solve the problem. These mechanisms constrict access, create conflicts of interest, and impose onerous burdens on patients.

Part II elucidates the essential problem that health insurance is paid to health care providers rather than the beneficiaries. This Part lays out the alternative approach of a "split benefit," in which part is paid directly to patients and thereby creates an opportunity cost for the consumption of expensive treatments. A particularly attractive aspect of this proposal is that the health insurers can implement it right now under current contracts and laws, without need for an expansion of the health care regulatory bureaucracy. The split benefit is thus a unilateral option the insurer can exercise in situations where it is most likely to work.

Part III explores some of the practical and normative objections, including co-optation by providers, autonomy, welfare, and the specialness of health. The split benefit empowers individuals to decide for themselves how to best serve their own welfare.

This Essay concludes that the split benefit is a promising mechanism for reducing the financial burden of expensive and often ineffectual treatments, without reducing patient access to the care that they prefer. Ultimately, the split benefit can reform a fundamental distortion in our economy, allowing our spending decisions to more efficiently reflect our values.

I
The Limits of Current Rationing Mechanisms

There are three parties in any health care consumption decision: the physician, the payor, and the patient—and each of these could in principle veto the consumption of low-value treatments. This Part explains why current efforts to reduce the consumption of these treatments—whether relying on the discretion of physicians, insurers, or patients—fail to resolve the problem. One can understand all of these efforts as forms of "rationing," as they distribute scarce health

care funds.[64] The law, market, politics, and professional ethics all restrict the efficacy of these mechanisms for rationing and point toward a better way.

A. The Physician Rationer

Federal and state laws put the physician in the role of gatekeeper between patients and treatments.[65] The physician has the power to ration care. If the physician declines to write a prescription, the patient cannot consume the drug. With both veto power and clinical expertise, we might view the physician as an ideal rationer. This section explains why physicians have their own reasons for prescribing inefficient treatments and thus make poor rationers.

Bioethicists have criticized the suggestion that physicians should take on the insurer's perspective because it could drive a wedge between the physician and his or her patient-client.[66] Accordingly, federal law prohibits health care plans covering Medicare or Medicaid patients from making "specific" payments "directly or indirectly" to physicians "as an inducement to reduce or limit medically necessary services."[67]

There are contexts—such as managed care organizations (MCOs)—in which insurers have created incentives for physicians to ration care.[68] During the 1980s and 1990s, managed care became relatively popular. Soon thereafter, however, consumers became dissatisfied with limitations on their choices and challenged MCOs in a wave of class action litigation.[69] For various reasons, there was a widespread retreat from efforts to incentivize physicians to ration care.[70] More recently, there has been another move toward "pay-for-perform-

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64 *See* MARK A. HALL, MAKING MEDICAL SPENDING DECISIONS: THE LAW, ETHICS, AND ECONOMICS OF RATIONING MECHANISMS 3–6 (1997).

65 *See, e.g.*, Federal Food, Drug, and Cosmetic Act, Pub. L. 107-377, ch. 675, 52 Stat. 1040 (1938) (codified as amended at 21 U.S.C. §§ 301–399 (2006)) (defining prescription drugs and requiring a doctor's prescription for such drugs).

66 *See* William M. Sage, *Should the Patient Conquer?*, 45 WAKE FOREST L. REV. 1505, 1509 (2010). *But see* Lois Snyder, *American College of Physicians Ethics Manual*, 156 ANNALS INTERNAL MED. 73, 86 (6th ed. Supp. 2012) (holding for the first time that "physicians' considered judgments should reflect the best available evidence in the biomedical literature, including data on . . . cost-effectiveness").

67 42 U.S.C. § 1395mm(i)(8)(A)(i) (2006). *See generally* David Orentlicher, *Paying Physicians More to Do Less: Financial Incentives to Limit Care*, 30 U. RICH. L. REV. 155, 162 (1996) (discussing these provisions).

68 *See* Pegram v. Herdrich, 530 U.S. 211, 220–21 (2000) (holding that rationing is an essential function of health maintenance organizations).

69 *See* Ronald Lagoe et al., *Current and Future Developments in Managed Care in the United States and Implications for Europe*, HEALTH RES. POL'Y & SYS. (Mar. 17, 2005), http://www.health-policy-systems.com/content/3/1/4 ("[C]onsumer dissatisfaction with the business practices of plans, including apparent arbitrary denials of service and failure to pay claims promptly, added fuel to provider complaints about low payment rates.").

70 *Id.*

ance"[71] and "accountable care organizations" (ACOs),[72] which help to align the interests of payors and physicians. It remains an open question as to whether these reforms will solve the problem, especially when patients demand access to expensive, unproven treatments.[73]

For the foreseeable future, many physicians will remain in fee-for-service relationships.[74] As the president of the American Board of Internal Medicine has said,

> One of the clearest reasons [for wasteful care] is our fee-for-service payment system, where doctors get paid more for doing more. Very few doctors do things that they know are wasteful, but if there's a gray zone they could say, why not, it may help and it doesn't hurt the patient.[75]

There are several other reasons why physicians may be biased toward costly treatment. Sheer optimism may give physicians an irrational belief in the effectiveness of unproven treatments.[76] Alternatively, physicians may work under professional norms and personal ascriptions that encourage "heroic" treatments for desperate patients.[77] Money and relationships with the drug and device industries may also bias physicians.[78]

Physicians sometimes set themselves up in self-referral situations where they refer patients to their own offices for expensive treatments.[79] Commonly, for example, a cardiologist may suggest a stent

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71 *See* Christopher Robertson, Susannah Rose & Aaron S. Kesselheim, *Effect of Financial Relationships on the Behaviors of Health Care Professionals: A Review of the Evidence*, 40 J.L., MED. & ETHICS 452, 458 (2012).

72 Jenny Gold, *Accountable Care Organizations, Explained*, NPR (Jan. 18, 2011, 8:21 AM), http://www.npr.org/2011/04/01/132937232/accountable-care-organizations-explained.

73 *See* Lee N. Newcomer, *Changing Physician Incentives for Cancer Care to Reward Better Patient Outcomes Instead of Use of More Costly Drugs*, 31 HEALTH AFF. 780, 781 (2012) (arguing for reform of "buy and bill" practices and reviewing current reform efforts). *But see* Baicker & Chandra, *supra* note 20, at 22 (arguing that ACOs may fail to reduce the consumption of high cost treatments, "particularly if the latest shiny innovation increases market share").

74 *See* Mark G. Field, *The Doctor-Patient Relationship in the Perspective of "Fee-for-Service" and "Third-Party" Medicine*, 2 J. HEALTH & HUM. BEHAV. 252, 254 (1961).

75 Sarah Kliff, *In Health Care, Determining What's Unnecessary*, WASH. POST WONKBLOG (Jan. 19, 2012, 10:36 AM), http://www.washingtonpost.com/blogs/wonkblog/post/in-health-care-determining-whats-unnecessary/2012/01/19/gIQAGo2mAQ_blog.html.

76 *See generally* Christine Jolls, *Behavioral Economic Analysis of Redistributive Legal Rules*, 51 VAND. L. REV. 1653 *passim* (1998) (reviewing literature on "optimism bias").

77 Maureen Kwiecinski, *To Be or Not to Be, Should Doctors Decide? Ethical and Legal Aspects of Medical Futility Policies*, 7 MARQ. ELDER'S ADVISOR 313, 319, 320–21 & n.21 (2006) (finding that "differences in treatment recommendations may also be associated with a number of non-clinical factors").

78 I have reviewed this literature with coauthors. *See* Robertson, Rose & Kesselheim, *supra* note 71, at 462.

79 Federal law prohibits certain self-referral and kickback relationships. *See* 42 C.F.R. § 1001.952 (2011) (listing safe harbors). *See generally* Dayna Bowen Matthew, *Tainted Prosecution of Tainted Claims: The Law, Economics, and Ethics of Fighting Medical Fraud Under the*

and then offer to perform the implantation procedure.[80] One study that examined physicians who bought ownership stakes in specialty hospitals to which they could then refer patients found that the "introduction of financial incentives linked to ownership coincided with a significant change in the practice patterns of physician owners."[81] The authors observed a sixty-times increase in complex spinal fusion surgeries by the physicians that bought in.[82] In other fields, such as oncology, scholars have documented physicians following the money.[83] Since 1989, there have been three rounds of lawmaking to revise and tighten the Stark Law that regulates physician referral relationships,[84] but the target keeps moving.

Further, physicians rely upon industry-created scientific research.[85] Judge Jack Weinstein writes, "[t]he pervasive commercial bias found in today's research laboratories means studies are often lacking in essential objectivity, with the potential for misinformation, skewed results, or cover-ups."[86] Similarly, an Institute of Medicine report concluded that "[s]everal systematic reviews and other studies provide substantial evidence that clinical trials with industry ties are more likely to have results that favor industry."[87] Nonetheless, some physicians believe the science and are skewed in their prescribing decisions. Many other physicians appear to discount such science and must rely upon their own anecdotal experiences, which may be skewed in other ways.[88]

Civil False Claims Act, 76 IND. L.J. 525, 554 (2001) (discussing the differences between the self-referral law and the antikickback statute).

80 *See* David C. Levin et al., *The Changing Roles of Radiologists, Cardiologists, and Vascular Surgeons in Percutaneous Peripheral Arterial Interventions During a Recent Five-Year Interval*, 2 J. AM. C. RADIOLOGY 39, 41 (2005).

81 Jean M. Mitchell, *Do Financial Incentives Linked to Ownership of Specialty Hospitals Affect Physicians' Practice Patterns?*, 46 MED. CARE 732, 736 (2008).

82 *Id.* at 735.

83 *See generally* Mireille Jacobson et al., *How Medicare's Payment Cuts for Cancer Chemotherapy Drugs Changed Patterns of Treatment*, 29 HEALTH AFF. 1391, 1391 (2010) (assessing how "substantially reduced payment rates for chemotherapy drugs . . . affected the likelihood and setting of chemotherapy treatment for Medicare beneficiaries").

84 *See* sources cited *supra* note 79.

85 *See generally* Christopher T. Robertson, *The Money Blind: How to Stop Industry Bias in Biomedical Science, Without Violating the First Amendment*, 37 AM. J.L. & MED. 358, 362 (2011) (reviewing this literature).

86 *In re* Zyprexa Prods. Liab. Litig., 253 F.R.D. 69, 106 (E.D.N.Y. 2008), *rev'd sub nom.* UFCW Local 1776 v. Eli Lilly & Co., 620 F.3d 121, 133 (2d Cir. 2010) (reversing on the question of causation).

87 INST. OF MED., CONFLICT OF INTEREST IN MEDICAL RESEARCH, EDUCATION, AND PRACTICE 104 (Bernard Lo & Marilyn J. Field eds., 2009).

88 *See* Aaron S. Kesselheim et al., *A Randomized Study of How Physicians Interpret Research Funding Disclosures*, 367 NEW ENG. J. MED. 1119, 1124 (2012) (showing that physicians tend to discount the reliability of such research, even though industry funds most of the research testing the efficacy of drugs and devices).

Most physicians also accept money and industry perks.[89] Drug and device manufacturers actively promote their products through "detailing" visits to physicians' offices, providing physicians with a one-sided view of the scientific literature about safety and efficacy.[90] Many attribute changes in physicians' prescribing decisions to these relationships.[91]

Overall, the wide variation in health expenditures per patient suggests that some physicians are much more attentive to evidence-based medicine and cost.[92] The foregoing considerations simply show why physicians are not the complete solution to the problem addressed by this Essay: the consumption of expensive treatments with little or no proven efficacy.

B. The Insurer Rationer

Insurers could simply refuse to pay for high-cost, low-value treatments by saying that they are not "medically necessary"—the criterion under most insurance contracts.[93] One might suppose that insurers are the ideal rationers to make this assessment about the cost-benefit profile of a treatment given that they have the aggregate perspective of millions of insureds.

Abroad, it is more common for insurers to simply refuse to cover a treatment. For example, Britain's National Health System (NHS) is moving to cut Avastin's coverage for breast cancer, along with many other drugs, such as Erbitux, which costs $128,000 per treatment.[94] Given that the United Kingdom spends less than half as much of its GDP on health care but reports significantly higher life expectancy and health care quality, it may be tempting to adopt such an overt rationing policy in the United States.[95]

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89 *See* Eric G. Campbell et al., *Physician Professionalism and Changes in Physician-Industry Relationships from 2004 to 2009*, 170 ARCHIVES INTERNAL MED. 1820, 1820 (2010) (finding that of surveyed physicians, 63.8% received drug samples, 70.6% food and beverages, 18.3% reimbursements, and 14.1% payments for professional services).

90 *See generally* Robertson, Rose & Kesselheim, *supra* note 71, at 39 (reviewing the literature on the biasing impact of these detailing visits).

91 *Id.*

92 *See* sources cited *supra* notes 15–18.

93 *See generally* Hall & Anderson, *supra* note 19, at 1640–41 (discussing the varied use of the phrase "medical necessity" to extend or refuse insurance coverage for certain treatments); William M. Sage, *Managed Care's Crimea: Medical Necessity, Therapeutic Benefit, and the Goals of Administrative Process in Health Insurance*, 53 DUKE L.J. 597, 601 (2003) (same).

94 *See* Neil Lancefield, *Breast Cancer Drug Avastin 'Not Effective' Says Nice*, INDEPENDENT (Apr. 18, 2012), http://www.independent.co.uk/life-style/health-and-families/health-news/breast-cancer-drug-avastin-not-effective-says-nice-7657187.html; Roxanne Nelson, *Access to Expensive Cancer Drugs Limited in Both the US and UK*, MEDSCAPE (Jan. 14, 2010), http://www.medscape.com/viewarticle/715110.

95 *See* Larson, *supra* note 8, at 22; *UK Comes Top on End of Life Care*—Report, BBC NEWS (July 14, 2010, 7:11 PM), http://www.bbc.co.uk/news/health-10634371 (describing a re-

In America, public and private insurers do utilize this strategy of refusing to pay. Medicare generally excludes drugs that are not at all FDA-approved and excludes alternative treatments such as acupuncture.[96] And some insurers have indicated that they will not pay for Avastin for breast cancer.[97] Insurers also impose pre-utilization reviews and "fail first" policies that require patients to try inexpensive treatments before seeking reimbursement for more expensive treatments.[98]

Still, the insurer's ability to ration is, and should be, severely limited. There are three reasons. Insurers are at an epistemic disadvantage. Their rationing depends on questionable normative assumptions. And, they have conflicts of interest that may bias their assessments. Consider each problem in turn.

First, in cases where a physician recommends an expensive treatment, there may be a reasonable dispute between the physician and the insurer. The physician, unlike the insurer, has hands-on knowledge of the particular patient.

Second, economists have developed metrics for measuring health improvements, such as an increase in quality-adjusted life-years (QALYs), to which they then assign dollar values.[99] If the dollar value of the benefit is greater than the dollar value of the costs, then the treatment is arguably worthwhile. These efforts are notoriously controversial, in part because "objective criteria for determining the value patients receive from treatment are lacking."[100] As one commentator explains,

> QALY's also have their fierce opponents who argue that they are unjust and offensive, even if inevitable. They reject outright the idea of ranking treatments for medical rationing and they object to

port by the Economist Intelligence Unit that ranked the United Kingdom's system ahead of the United States' system).

96 *See Your Medicare Coverage*, MEDICARE, http://www.medicare.gov/Coverage/Home.asp (last visited Mar. 13, 2013).

97 *See, e.g.*, Deborah Kotz, *Will Mass. Breast Cancer Patients Lose Coverage for Avastin?*, BOS. GLOBE (Oct. 5, 2011), http://www.boston.com/Boston/dailydose/2011/10/will-mass-breast-cancer-patients-lose-coverage-for-avastin/mufDuqsDUqYuteyli5yRAM/index.html.

98 *See* Hall & Anderson, *supra* note 19, at 1654 (describing precertification processes); Stephen B. Soumerai, *Benefits and Risks of Increasing Restrictions on Access to Costly Drugs in Medicaid*, 23 HEALTH AFF. 135, 136 (2004) (describing "fail first" policies that require patients to try a cheaper drug before escalating to the more expensive one).

99 *See Measuring Effectiveness and Cost Effectiveness: The QALY*, NAT'L INST. FOR HEALTH & CLINICAL EXCELLENCE, http://www.nice.org.uk/newsroom/features/measuringeffectivenessandcosteffectivenesstheqaly.jsp (last updated Apr. 20, 2010).

100 Seth A. Seabury et al., *Patients Value Metastatic Cancer Therapy More Highly than Is Typically Shown Through Traditional Estimates*, 31 HEALTH AFF. 691, 691 (2012).

> the QALY method, which relies on healthy people to determine the quality of life of those who are disabled or ill.[101]

Third, the insurer "stands to profit from not paying claims," a conflict of interest with the patient's health.[102] Still, insurers seek to maintain a reputation for paying claims.[103] "[I]nsurers are acutely aware that a well-publicized dispute over an inappropriately denied claim might cause them to lose the next renewal of their contract."[104] Public insurers face similar constraints because "we regard health insurance as a life raft for those in peril instead of a common-pool resource requiring stewardship. We reach desperately for any new technology that might help defeat death. Any preplanned limit seems like a death panel."[105] Commentators have long concluded that it is "highly unlikely that the American population would support the rationing of expensive high technology in the fashion characterizing England's National Health Service."[106]

Recognizing these problems, the law limits insurer rationing. Insurers face the threat of litigation when they deny coverage, and courts interpret insurer contracts in favor of the patient where ambiguous.[107] Traditionally, courts deferred to physician, rather than insurer, assessment of medical necessity.[108] "Courts continually fail to see beyond the heart-rending facts of the immediate case to the reality that the present strained ruling in favor of coverage will be applied by

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101 Gina Kolata, *Ethicists Struggle to Judge the 'Value' of Life*, N.Y. TIMES, Nov. 24, 1992, at C3.

102 *See* Hall & Anderson, *supra* note 19, at 1668. Mark Hall and Gerard Anderson explain, however, that the interests of insurer and insured may align where the insurer merely manages benefits for a self-insured employer. *See id.* *See generally* JAY M. FEINMAN, DELAY, DENY, DEFEND: WHY INSURANCE COMPANIES DON'T PAY CLAIMS AND WHAT YOU CAN DO ABOUT IT (2010) (discussing insurers' tactics of delaying or denying justified claims and forcing policyholders to litigate).

103 *See* Hall & Anderson, *supra* note 19, at 1672.

104 *Id.*

105 Sage, *supra* note 66, at 1510; *see also* Peter J. Neumann et al., *Medicare and Cost-Effectiveness Analysis*, 353 NEW ENG. J. MED. 1516, 1519 (2005) (discussing similar reasons for American distrust of a cost-effectiveness analysis for Medicare).

106 DAVID MECHANIC, FROM ADVOCACY TO ALLOCATION: THE EVOLVING AMERICAN HEALTH CARE SYSTEM 215 (1986).

107 *See* Van Vactor v. Blue Cross Ass'n, 365 N.E.2d 638, 645 (Ill. App. Ct. 1977); Mello & Brennan, *supra* note 33, at 107–10 (discussing the litigation against insurers over HDC-ABMT, including a $77 million punitive damages judgment).

108 *See* David D. Griner, *Paying the Piper: Third-Party Payor Liability for Medical Treatment Decisions*, 25 GA. L. REV. 861, 861–62 (1991) ("For nearly a century, it has been the 'settled rule' that it is impossible for anyone to exercise control over the medical acts of physicians."); s*ee also* Rollo v. Blue Cross/Blue Shield of N.J., Civ. A. No. 90-597, 1990 WL 312647, at *1, *3, *9 (D.N.J. Mar. 22, 1990) (enjoining insurer from denying coverage for HDC-AMBT, which it deemed "investigational or experimental," despite consensus that it was necessary to save the patient's life); *Van Vactor*, 365 N.E.2d at 645–46 (affirming the trial court's denial of defendant insurer's motion for summary judgment based on affidavits of doctors and patients stating that the procedure was medically necessary).

other courts even if the contract is revised in the suggested manner."[109] When patients challenge insurers' cost-effectiveness coverage decisions, the insurers "consistently lose in court."[110]

State and federal governments have imposed over two thousand mandates on insurance providers, requiring them to cover particular treatments.[111] Thirty-six of these mandates require coverage of off-label drugs in particular, precisely those that often have unproven efficacy.[112] Most states also allow patients who have been denied coverage based on medical necessity to appeal to an independent physician.[113] Such "external review" policies remove ultimate power from the hands of the insurer.[114]

For public insurers, the law further constrains their use of cost-effectiveness analyses to refuse coverage. As a part of the landmark health care reforms, Congress established an Independent Payment Advisory Board (IPAB), which will eventually have broad powers to reduce the cost of health care.[115] It was thought necessary to create an independent agency for this purpose because political forces had repeatedly prevented Congress from doing so itself. Peter Orszag has called IPAB "the largest yielding of sovereignty from the Congress since the creation of the Federal Reserve."[116] Still, even in this moment of possibility, Congress did not permit IPAB to make any policy reforms that would alter the benefits of Medicare beneficiaries or re-

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109 Hall & Anderson, *supra* note 19, at 1657.

110 *Id.* at 1660.

111 *See* VICTORIA CRAIG BUNCE & J.P. WIESKE, COUNCIL FOR AFFORDABLE HEALTH INS., HEALTH INSURANCE MANDATES IN THE STATES 2010, at 1 (2010), *available at* http://www.cahi.org/cahi_contents/resources/pdf/MandatesintheStates2010ExecSummary.pdf.

112 *See id.* at 5. For a discussion of FDA approval as a proxy for proven efficacy, see *supra* notes 30–33 and accompanying text.

113 *See* Aaron Seth Kesselheim, *What's the Appeal? Trying to Control Managed Care Medical Necessity Decisionmaking Through a System of External Appeals*, 149 U. PA. L. REV. 873, 877 (2001) ("[B]y 1999 thirty states and the District of Columbia had established rights to external review for private health plan enrollees.").

114 *See* Clark C. Havighurst, *How the Health Care Revolution Fell Short*, 65 LAW & CONTEMP. PROBS. 55, 93 (2002) ("External review essentially denies health plans any intermediary role in selecting treatments . . . . [S]uch regulation drastically curtail[s] opportunities for health plans to . . . achieve consistency in administering . . . benefits.").

115 *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §§ 3403, 10320, 124 Stat. 119, 489–507, 949–952 (2010).

116 Ezra Klein, *Can We Control Costs Without Congress?*, WASH. POST (Mar. 26, 2010, 2:46 PM), http://voices.washingtonpost.com/ezra-klein/2010/03/can_we_control_costs_without_c.html.

sult in "rationing."[117] Even with these limitations, IPAB has become a political lightning rod.[118]

This section has shown that the insurer's fiat is an incomplete solution to the problem of expensive but low-value treatments. The political, market, and legal limits are too great. Due to these pressures, "insurers have largely abandoned direct attempts to limit coverage for most medical procedures and instead have adopted a pass-through attitude toward medical spending."[119]

C. The Patient Rationer

In recent years, the idea of consumer-directed health care has dominated health care reform debates. "Consumers must decide whether a purchase is worth its price."[120] The problem is that insurance allows patients to be insensitive to price because patients do not bear the cost. This problem is known as "moral hazard."

"Cost sharing"—in the form of co-pays, deductibles, coinsurance, and caps on coverage—is the typical solution. As shown in Figure 2, this method of cost control splits the cost between the insurer and the patient, such that the insurance benefit becomes somewhat less than the cost of the procedure. For example, the patient may be required to pay a ten-dollar share of the costs to his health care provider, and the insurer will pay the provider the remainder, say, $500.[121]

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117 *See* Patient Protection and Affordable Care Act § 3403(a)(1) (enacting a provision, to be codified at 42 U.S.C. § 1899A(c)(2)(A)(ii), stating that proposals by IPAB "shall not include any recommendation to ration health care"); JACK EBELER ET AL., THE HENRY J. KAISER FAMILY FOUND., THE INDEPENDENT PAYMENT ADVISORY BOARD: A NEW APPROACH TO CONTROLLING MEDICARE SPENDING 3 (2011), *available at* http://www.kff.org/medicare/upload/8150.pdf.

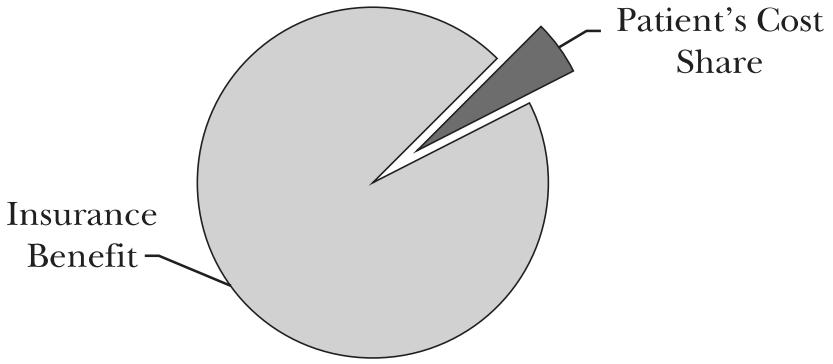
118 *See, e.g.*, Jason Kane, *Medicare Coverage of Pricey Cancer Drugs Sparks 'Rationing' Debate*, PBS (July 5, 2011, 3:27 PM), http://www.pbs.org/newshour/rundown/2011/07/pricey-cancer-drugs-spark-rationing-debate.html (describing the controversy following Medicare officials' decision to continue to pay for expensive cancer treatments of questionable effectiveness).

119 Mark A. Hall, *State Regulation of Medical Necessity: The Case of Weight-Reduction Surgery*, 53 DUKE L.J. 653, 655 (2003).

120 Mark A. Hall & Carl E. Schneider, *Patients as Consumers: Courts, Contracts, and the New Medical Marketplace*, 106 MICH. L. REV. 643, 659 (2008).

121 *See generally How to Spend Less on Copays and Coinsurance?*, MEDICARE.COM, http://www.medicare.com/medigap-insurance/how-to-spend-less-on-copays.html (last visited Feb. 16, 2013) (discussing the Medicare co-payment process).

FIGURE 2:
THE COST-SHARING STRATEGY



Cost sharing reduces insurance outlays in two ways. First, it reduces the burden on the insurer for each treatment consumed. Second, and more importantly, the cost share may reduce consumption by causing the patient to weigh that portion of the cost against the potential benefits of the procedure.[122] A rational patient will view the co-pay as an opportunity cost and consider whether she would prefer to spend her money on something other than treatment. Thus, a cost share partially aligns the interests of the insurer and the insured by causing the patient to internalize some of the cost of the treatment.

The well-known 1970s RAND Health Insurance Experiment demonstrated that cost sharing can decrease health care consumption.[123] In one condition, patients were required to make 95% co-pays and in another, they received full insurance. The latter was associated with a 45% increase in per capita spending.[124] Further, however, the RAND study "also found that people consume less necessary healthcare to the same extent as they consume less unnecessary healthcare, and that poorer people with chronic diseases suffered poorer health when faced with high cost sharing."[125] These adverse effects were noted even though the RAND study limited patients' exposure to cost to $1,000 per year,[126] far short of the cost necessary to

122 *See* Chernew et al., *supra* note 25, at w196 ("The motivation behind the use of cost sharing to allocate medical services and contain costs follows standard economic theory, which presumes that consumers will use only those services whose benefit exceeds the cost to them.").

123 *See* JOSEPH P. NEWHOUSE & THE INS. EXPERIMENT GRP., FREE FOR ALL? LESSONS FROM THE RAND HEALTH INSURANCE EXPERIMENT 338–39 (1993). The RAND study found that cost sharing had no adverse impact on mortality for the average person, but did for elevated-risk and low-income persons. *See id.* at 208–11.

124 *Id.* at 40.

125 Jost, *supra* note 2, at 584; *see also* M. Gregg Bloche, *Consumer-Directed Health Care and the Disadvantaged*, 26 HEALTH AFF. 1315, 1318 (2007) (describing the RAND experiment's finding "that high cost sharing reduced use of appropriate and inappropriate care in indiscriminate fashion").

126 *See* NEWHOUSE & THE INS. EXPERIMENT GRP., *supra* note 123, at 40.

have a sizeable impact on the highly expensive procedures that are the focus here.

Scholars have documented cost-sharing obligations imposing onerous burdens on patients. For example, insured patients who have cost concerns delay seeking emergency care for heart attacks.[127] Cancer patients do not fill prescriptions or take full doses of the prescriptions they did fill so as to preserve funds for cost-sharing obligations on other treatments.[128] Children with chronic health conditions forgo prescribed care.[129]

Scholars refer to this problem—where the insurance benefit is too small in proportion to the cost of care—as "underinsurance."[130] If patients decline care because the co-pay is just too high given their wealth, then the cost-sharing policy mechanism no longer achieves its purpose of sorting high-value care from low-value care.[131] Instead, the mechanism simply rations by wealth, which is to say that it discriminates against the poor.

It is not merely that cost-sharing obligations are large and can accumulate quickly. It is a pernicious cycle because illness and injury are often correlated with a loss of income, which further exacerbates the problem.[132] It is difficult to earn money to pay cost-sharing obligations when one is severely ill or when one must care for a sick child or elderly parent. The cost-sharing tactic imposes financial burdens on patients at a time when they may be least able to pay them.

Cost sharing also imposes negative externalities. Health care expenses lead to millions of bankruptcies and foreclosures, which impact other members of the family, other creditors, and neighborhoods.[133] Americans are already paying 15% to 22% of their

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127 *See* Kim G. Smolderen et al., *Health Care Insurance, Financial Concerns in Accessing Care, and Delays to Hospital Presentation in Acute Myocardial Infarction*, 303 JAMA 1392, 1397–99 (2010).

128 *See* Yousuf Zafar et al., *Impact of Out-of-Pocket Expenses on Cancer Care*, 29 J. CLINICAL ONCOLOGY abstr. 6006 (Supp. 2011).

129 *See* Michael D. Kogan et al., *Association Between Underinsurance and Access to Care Among Children with Special Health Care Needs in the United States*, 116 PEDIATRICS 1162, 1162–63 (2005).

130 *See* Cathy Schoen et al., *How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007*, 27 HEALTH AFF. w298, w299 (2008) (classifying persons as "underinsured" if they experience "at least one of three indicators of financial exposure relative to income").

131 *See* JOHN A. NYMAN, THE THEORY OF DEMAND FOR HEALTH INSURANCE 144–51 (2003) (arguing that the imposition of cost sharing may harm aggregate welfare because it reduces access to both effective and ineffective care).

132 *See generally* JACOB S. HACKER, THE GREAT RISK SHIFT: THE NEW ECONOMIC INSECURITY AND THE DECLINE OF THE AMERICAN DREAM 137–43 (rev. & exp. ed. 2008) (discussing the economic insecurity that Americans face due to health care problems).

133 *See* sources cited *supra* note 4.

family income on health care, making further cost shifting toward patients unfeasible.[134]

Recognizing that cost sharing is impractical when costs are high in proportion to patient wealth, many public health insurance programs have minimal or no cost-sharing obligations. The beneficiaries of these programs are already destitute since that is the precondition for the public health insurance coverage.[135] More broadly, insurance plans often cap co-pays and deductibles by annual limits, beyond which the patient pays nothing out-of-pocket. "Roughly 77% of full-time employees of medium and large establishments enrolled in non-HMO plans have maximum out-of-pocket limits less than US$2000 per individual and the most common coinsurance rate is 20%. Thus, individuals with more than US$10,000 in total costs will face no cost sharing at the margin."[136] As Timothy Jost explains, "Once consumers reach the limits of the deductible, they have little reason to limit their consumption of health care or to pay attention to its price."[137]

Recent federal policy efforts have sought to increase these levels to about $6,000 for an individual, in conjunction with incentives for patients to save money in "health savings accounts."[138] Even assuming that a patient does have enough money set aside to then reach these higher limits, tests, office visits, and other treatments may quickly exhaust the higher limit, still long before a physician prescribes the patient an expensive treatment. And lawmakers in twenty states have introduced bills to prevent insurers from imposing higher co-pay obligations out of concern that big cost shares put expensive drugs out of reach.[139] Such high cost-sharing levels can undermine the purpose of insurance: guaranteed access to desired care.[140]

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134 *See* Patricia Ketsche et al., *Lower-Income Families Pay a Higher Share of Income Toward National Health Care Spending than Higher-Income Families Do*, 30 HEALTH AFF. 1637, 1640 (2011).

135 *See, e.g.*, Amy Finkelstein et al., *The Oregon Health Insurance Experiment: Evidence from the First Year* 5 (Nat'l Bureau of Econ. Research, Working Paper No. 17190, 2011), *available at* http://www.nber.org/papers/w17190.pdf?new_window=1 (explaining that Oregon's expanded Medicaid program does not include a cost-sharing obligation).

136 Michael E. Chernew et al., *Optimal Health Insurance: The Case of Observable, Severe Illness*, 19 J. HEALTH ECON. 585, 588 (2000) (citation omitted).

137 Jost, *supra* note 2, at 587.

138 *See, e.g.*, INTERNAL REVENUE SERV., DEP'T OF THE TREASURY, PUBLICATION 969: HEALTH SAVINGS ACCOUNTS AND OTHER TAX-FAVORED HEALTH PLANS 3 (2011), *available at* http://www.irs.gov/pub/irs-pdf/p969.pdf (noting the "high deductible" health plans that are eligible for use in conjunction with health savings accounts, which are capped at $5,950 per individual and $11,900 per family).

139 *See* Andrew Pollack, *States Seek Curb on Patient Bills for Costly Drugs*, N.Y. TIMES, April 13, 2012, at A1.

140 *See* Romley et al., *supra* note 61, at 683 ("Given the value that people assign to generous coverage of specialty drugs, having high cost sharing on these drugs seemingly runs contrary to what people value in their health insurance.").

Moreover, many patients have purchased supplemental insurance that covers the co-pay, thus preventing the patient from incurring any of the cost at all. That is the purpose of the extremely popular "Medi-Gap" policies used by Medicare enrollees.[141] "Catastrophic coverage" policies have a similar function of eliminating the patient's exposure to cost beyond a threshold.[142]

Thus, cost sharing is not a real solution where the cost of the treatment is large. In a world where the median annual income is $50,000[143] and a treatment can cost twice that, cost sharing simply cannot be our complete solution to the problem of high-cost but low-value treatments.

A more radical and crude notion of cost sharing has emerged in recent months—the Medicare voucher idea. Former Tennessee Governor Phil Bredesen and Republican House Budget Chair Paul Ryan have separately proposed to "[g]ive all Americans annual vouchers for a certain dollar amount of health care and if they exceed [the value of the voucher], they are on their own."[144] This proposal is a radical form of cost sharing because beyond the amount of the voucher, patients bear 100% of the cost for their care (if they can afford any care).[145] This proposal is crude because it severely hampers patients' access to necessary care, regardless of whether the care is cost-effective or efficient, and it fails to provide any insurance against the risk of needing higher-cost care.

II
THE SPLIT BENEFIT

This Essay presents an alternative mechanism for achieving a more rational expenditure of health insurance money in the set of cases where the physician prescribes a high-cost treatment that the insurer reasonably believes is inefficient. This mechanism seeks to

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141 Of Medicare beneficiaries, 89 percent had some form of supplemental health insurance policies in 2006. JULIETTE CUBANSKI ET AL., THE HENRY J. KAISER FAMILY FOUND., EXAMINING SOURCES OF COVERAGE AMONG MEDICARE BENEFICIARIES: SUPPLEMENTAL INSURANCE, MEDICARE ADVANTAGE, AND PRESCRIPTION DRUG COVERAGE 5 (2008), *available at* http://www.kff.org/medicare/upload/7801.pdf.

142 *See* Chernew et al., *supra* note 136, at 602 ("Catastrophic plans provide full coverage exactly when it should not exist (at the margin) and provide partial coverage precisely when cost sharing provides no benefit (at expenditures below the cost of the least expensive, medically appropriate treatment alternative).").

143 CARMEN DENAVAS-WALT ET AL., U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2011, at 6 (2012), *available at* http://www.census.gov/prod/2012pubs/p60-243.pdf.

144 Larson, *supra* note 8, at 19–20.

145 *See* Ezekiel J. Emanuel, *For Medicare, We Must Cut Costs, Not Shift Them*, N.Y. TIMES (Dec. 19, 2011, 9:15 PM), http://opinionator.blogs.nytimes.com/2011/12/19/for-medicare-we-must-cut-costs-not-shift-them (discussing voucher programs as an alternative to Medicare).

avoid the foregoing problems of co-pays and deductibles (which often must be too small to work) and insurers' refusals to cover (which tread on physician expertise, patient autonomy, and feasibility).

A. The Concept

Currently, insurers do not pay health insurance benefits to the beneficiary. Instead, insurance is an in-kind benefit paid to the provider on behalf of the patient.

The benefit does create an option for patients to consume care that might otherwise be unaffordable. That is the function and value of insurance.[146] But if a patient chooses to decline care for whatever reason, the insurance benefit disappears. The nonfungible benefit weighs only on one side of the rational patient's ledger, subsidizing the consumption of more, and more expensive, health care.[147] Thus, we should not be surprised to find that health care continuously grows to consume a larger share of our economy.

Instead of asking patients whether the health care consumption is better than nothing, we should ask patients if health consumption is better than whatever else they may prefer. As Figure 3 shows, the potential reform is simple:

1. Pay a small but substantial part of the insurance benefit as cash directly to the patient-beneficiary.
2. If the patient chooses to proceed with the treatment, the patient takes the cash payment to the provider (along with any required cost-share obligation), and the insurer matches it with the balance of the insurance benefit.

Thus, the total size of the insurance benefit is unchanged.

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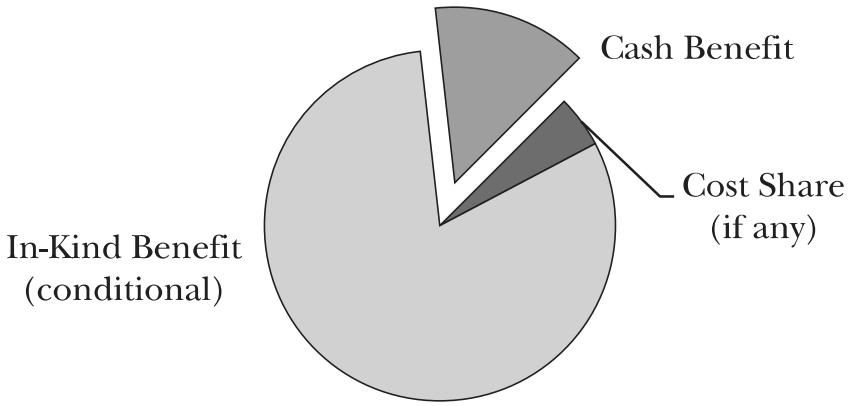
146 *See generally* NYMAN, *supra* note 131, at 136–41 (discussing some reasons why consumers do or do not purchase health insurance).

147 This problem of nonfungibility exists even for health savings accounts, which provide tax advantages for contributions and are designed to give patients skin in the game. These accounts limit spending from the account to health-related expenses, in order to preserve the tax advantages. *See* INTERNAL REVENUE SERV., *supra* note 138, at 3 ("Distributions may be tax free if you pay qualified medical expenses.").

FIGURE 3:
THE SPLIT BENEFIT MODEL



As such, the patient would receive both a cash benefit (the payment he or she receives) and an in-kind benefit (the payment to the provider), while still perhaps remaining exposed to some portion of the cost out-of-pocket. For patients that choose to spend the money in ways other than the treatment, the insurer saves the remainder of the cost of the procedure. For example, for each patient who would have taken Avastin under the status quo but declines upon receiving a $10,000 split benefit, the insurer saves $70,000. Although the size of the insurance benefit remains unchanged, the split benefit's rerouting of the flow of funds could alter patients' consumption decisions. Such a payment gives the patient additional options for using his or her insurance benefit, *viz*: an opportunity cost.

Patients who receive a split benefit may choose to proceed with the treatment or choose to promote health in some other way, such as consuming some other treatment not covered by the insurer (e.g., acupuncture, an alternative diet regimen, a concierge doctor, or visiting nursing services), paying money to a member of the family to stay home and provide care to the dying patient, or purchasing disability insurance to help cope with the symptoms of the illness. Or patients may use the money to serve other nonmedical values, such as enhancing housing, consuming more of some luxury good, paying off other debts that are causing disutility, paying for education (for themselves or others), contributing to a charity, or whatever else may appeal to the patient.

Logistically, the insurer would require the physician who recommends the expensive treatment to immediately notify the insurer. Insurers often already require physicians to submit plans for expensive treatments to the insurer for preauthorization. The insurer would then decide whether to pay a split benefit and, if so, deliver the split benefit payment to the patient rather quickly (within a day or two) so as to impact the patient's decision without causing undue delay. Insurers should not send merely a letter that offers a payment condi-

tional on the patient declining care. Instead, an actual payment in advance will create a default choice and an endowment effect that should further reduce consumption.[148]

The split benefit avoids the problems that traditional cost-sharing policies stumble over. Most importantly, it solves the wealth effect—the split benefit allows the cost-share proportion to grow with the cost of the procedure without being financially onerous on the patient. Other mechanisms of consumer-driven health care try to give patients "skin in the game" by increasing patients' deductibles and then *hoping* that patients will then have the wealth to compensate.[149] Such hopes often turn out to be false. The split benefit increases the patient's share to a substantial portion of the cost, but only by also increasing the patient's wealth by an equivalent amount. As a result, we can be confident that patients will select care when it has the highest value. Unlike a traditional cost-sharing obligation, the split benefit will not drive patients into bankruptcy or foreclosure.

The split benefit may also be politically feasible. Unlike increased cost sharing and rationing by insurers and physicians, the proposal does not constrain access to care or infringe on patient choice. The coverage and size of the insurance benefit remains unchanged. The patient makes the ultimate decision about whether to consume. Nonetheless, the split benefit may reduce health care spending and in turn make broad health insurance coverage sustainable.

B. The Insurer's Option

Private insurers could begin paying split benefits immediately, without changing their contracts. No patient could plausibly complain that she received a cash benefit rather than an in-kind benefit when her access to the given treatment remains unchanged.

Public insurance programs may require minor changes to the law to rectify situations where the authorizing statute has unnecessarily assumed that insurers would pay benefits to providers rather than beneficiaries.[150] Since the patient makes the ultimate consumption deci-

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148 *Cf.* RICHARD H. THALER & CASS R. SUNSTEIN, NUDGE: IMPROVING DECISIONS ABOUT HEALTH, WEALTH, AND HAPPINESS 207–14 (rev. & exp. ed. 2009) (discussing another situation—waiving the right to sue for malpractice—where patients may choose reduced rights in exchange for an economic benefit).

149 *See* Bloche, *supra* note 125, at 1319 ("Moreover, the least well-off are the least able to contribute to HSAs, and their lower marginal tax rates makes doing so less attractive. . . . [L]owwage workers are less likely than others to receive generous employment-based coverage, including substantial contributions toward their HSAs.").

150 The Medicare statute, 42 U.S.C. § 1395a (2006), is titled "Free choice by patient guaranteed" and provides that "[a]ny individual entitled to insurance benefits under this subchapter may obtain health services from any institution, agency, or person qualified to participate under this subchapter if such institution, agency, or person undertakes to provide him such services." Thus, the statute already contemplates that patients should be the

sion, the split benefit does not "ration care" within the meaning of federal law.[151] Similarly, since the split benefit covers the same benefits, just in a different way, the proposal does not interfere with state or federal laws that mandate minimum coverage of certain procedures.[152]

This feature of the split benefit proposal—that the health care industry can implement it immediately without a contentious political or legal battle—is a very significant advantage of the proposal over other ideas that may be worthwhile in theory, but stand much further from practicability. This feature also allows the insurer to view the split benefit as a unilateral option that it can deploy only when it is most likely to work. Insurers will find the split benefit most useful for procedures (whether drugs, devices, surgeries, or diagnostics) that meet four criteria: (1) the insurer must cover the procedure, (2) the procedure has not been proven to reduce health care expenditures on net, (3) the price of the procedure is disproportionate compared to the patient's wealth, and (4) the patient would otherwise be likely to consume the treatment. Consider each in turn.

First, for procedures that physicians already refuse to prescribe or which insurers already exclude, there is no benefit to split.[153] Altogether declining coverage is cheaper than covering a procedure through split benefit. An insurer might also use a fail-first policy to condition coverage on patients first trying cheaper and proven treatments, or getting a second opinion from an independent physician. The split benefit presumes that there will nonetheless be a sizeable domain of expensive treatments that remain covered by insurers.

The second criterion recognizes that a few health care expenditures, such as vaccines, are actually investments, such that spending on them will reduce future health care costs on net.[154] A rational insurer

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ones making decisions about whether and from whom to consume care. Nonetheless, many other parts of the U.S. Code currently contemplate payments directly to hospitals, which Congress may need to revise to allow for split benefit payments. *See, e.g.*, 42 U.S.C. § 1395ww ("Payments to hospitals for inpatient hospital services.").

151 *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 3403(a)(1), 124 Stat. 119, 490 (2010) (to be codified at 42 U.S.C. § 1899A(c)(2)(A)(ii)) ("The proposal shall not include any recommendation to ration health care, raise revenues . . . increase Medicare beneficiary cost-sharing . . . or otherwise restrict benefits or modify eligibility criteria.").

152 *See* BUNCE & WIESKE, *supra* note 111, at 1.

153 *See supra* Parts I.A, I.B (discussing those procedures which are already refused by physicians and insurers in the context of "rationing" by physicians and insurers, respectively).

154 *Cf.* Chernew et al., *supra* note 25, at w201 ("Offsetting the direct costs are the savings due to the improved health generated by the extra service use. For example, the direct costs of lower copayments for cholesterol-lowering medication would be offset, at least partially, by savings attributable to fewer heart attacks.").

would not utilize the split benefit where it wants to encourage, rather than discourage, consumption.

Even with this limitation, the split benefit proposal covers a broad swath of American health care. A 2006 study found that 21 percent of all prescriptions written in the United States are for off-label uses and that most of these had "little or no scientific support."[155] More broadly, "[al]though estimates vary, some experts believe that less than half of all medical care is based on or supported by adequate evidence about its effectiveness."[156] Even proof of effectiveness is far from proof that the treatment will save health care dollars on net since many expensive treatments have quite modest benefits. Hence, we can expect insurers to find a large domain that is ripe for the split benefit.

Although the split benefit could be utilized for any health care that is costly on net, individual insurers may select a narrower criterion. Public insurers, in particular, may succumb to political pressure from the providers of expensive health care treatments that would prefer that their goods and services not be subject to even this modest market-based scrutiny as to whether their product is worth the prices charged. Such an insurer could respond by narrowing the program to target drugs and devices that have unproven efficacy, especially those prescribed "off-label." This narrower scope would neutralize any paternalistic argument on behalf of patients and would incentivize drug manufacturers to prove the efficacy of their drugs. A narrowed domain for the split benefit may be better than no domain.

Insurers may, on the other hand, use the split benefit too often, given the mobility of patients between insurers during their lifespan and, in particular, the movement into Medicare for seniors. Since insurers will not themselves always reap the benefits of investments in health care spending that only pay off in the long term, they may use the split benefit to reduce consumption of some marginal treatments whose benefits a future insurer would have been borne. This is one reason that the Affordable Care Act mandated coverage of certain preventative care services that are socially optimal even if not rational investments for a single insurer.

Third, the split benefit will be most useful in those situations where a patient's limited wealth makes it impractical to impose on that patient a significant portion of the cost of a procedure. For wealthy patients or cheap procedures, the proposal is unmotivated,

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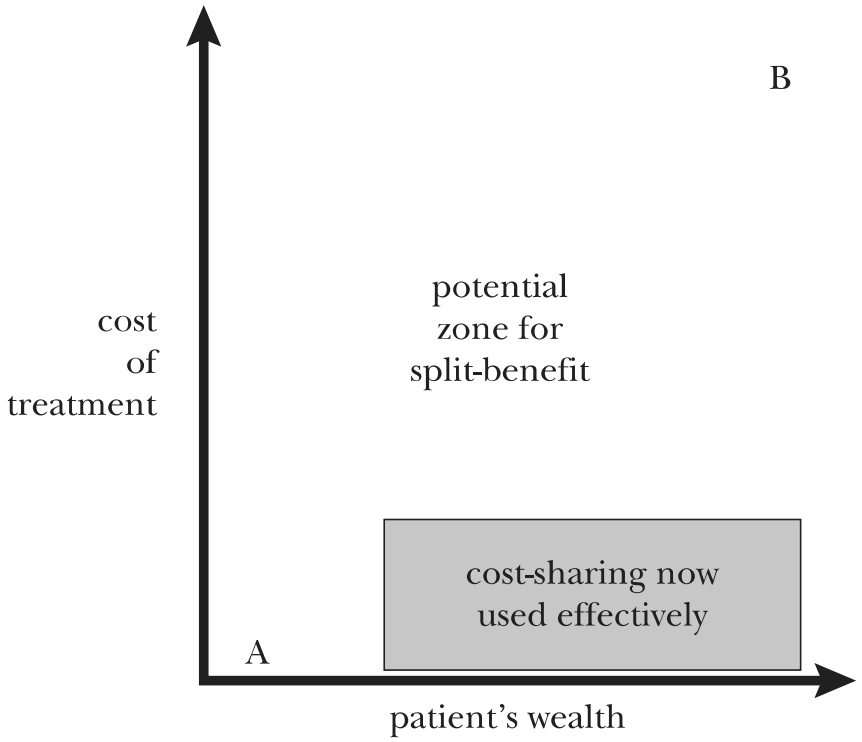
155 David C. Radley et al., *Off-Label Prescribing Among Office-Based Physicians*, 166 ARCHIVES INTERNAL MED. 1021, 1021 (2006).

156 CONG. BUDGET OFFICE, RESEARCH ON THE COMPARATIVE EFFECTIVENESS OF MEDICAL TREATMENTS, *supra* note 26, at 11.

since traditional cost-sharing mechanisms are cheaper to the insurer and may sufficiently deter overuse without reducing access.

This relationship is shown in Figure 4. The zone in which cost sharing is now used effectively has a relatively low limit for costly treatments because a patient's maximum cost share for individual procedures is often a few hundred dollars, while his or her maximum aggregate cost share over a year is a few thousand dollars.[157]

FIGURE 4:
OPPORTUNITY SPACE FOR SPLIT BENEFIT VERSUS COST SHARING AS A FUNCTION OF COST OF TREATMENT AND PATIENT WEALTH



As shown in Figure 4, a state Medicaid program that caps coverage eligibility at the federal poverty level may be unable to impose cost-sharing obligations at all and thus could use the split benefit even for inexpensive treatments.

Point B depicts the situation of the employer-sponsored health insurer for a company like Google, which has one of the highest-paid workforces in the world.[158] Although Google could impose higher cost-sharing limits for its richer employees (making that zone triangular rather than rectangular), insurers in fact tend to impose the same

157 *See* Romley et al., *supra* note 61, at 684 (identifying the ninety-fifth percentile of the patient cost-sharing scale at about $167 per month for the average user, as measured in 2010 dollars).

158 *See* Matt Lynley, *The 25 Highest-Paying Tech Companies*, BUS. INSIDER (July 12, 2012, 12:17 PM), http://www.businessinsider.com/the-25-highest-paying-companies-in-technology-2012-7?op=1.

cost-sharing obligations on the richest and poorest employees alike. This lack of sensitivity may exist because it is unseemly or impractical to discriminate based on patient wealth. Regardless, it creates an even larger potential for the split benefit.

Suppose that a drug that costs more than $12,000 for a course of treatment would be a good candidate for the split benefit, since a traditional cost-share obligation would need to be capped for median Americans long before it covered a substantial portion of the cost. The split benefit will still cover a huge portion of health care costs. Recall that in 2009, 1% of the population consumed 21.8% of aggregate health care costs; each individual in this 1% incurred more than $90,000 in costs in that year.[159] Although this proposal omits all sorts of lower-cost health care for middle income Americans—the cast on a broken bone or the migraine medicine—this proposal targets the rampant problem of expensive care that drives up health care costs and insurance premiums.

The insurer also has the discretion to select what level of split is optimal for each patient. The optimal size of the split benefit payment is an empirical question, one that is likely context-dependent. There will presumably be diminishing marginal returns, such that moving from a 1% to a 10% split may yield a very large reduction in the rate of consumption, but the equally costly step of moving from a 10% split to a 19% split may yield little additional benefit.[160] Patients may view a $1,000 payment much differently than a $10,000 payment if the first just seems like a supplement to income while the latter creates real opportunities.[161]

Fourth, the rational insurer will elect to pay a split benefit payment where the patient is most likely to consume the treatment otherwise. The insurer will decline to make a split benefit payment in cases where it suspects that patients may be seeking, and physicians may be providing, treatment recommendations merely for the sake of garnering a cash payout.

Given that the information necessary to make such predictions will be costly and imprecise, one can assume that split benefit payments will be made to some patients wastefully. We can roughly esti-

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159 *See* Cohen & Yu, *supra* note 62, at 1.

160 *See* Craig R. Fox & Russell A. Poldrack, *Prospect Theory and the Brain*, *in* NEUROECONOMICS: DECISION MAKING AND THE BRAIN 145, 146 (Paul W. Glimcher et al. eds., 2009).

161 *See* Claudia R. Sahm et al., *Check in the Mail or More in the Paycheck: Does the Effectiveness of Fiscal Stimulus Depend on How It Is Delivered?* 4–5 (Fin. & Econ. Discussion Series, Fed. Reserve Bd., Working Paper No. 2010-40, 2010), *available at* http://ssrn.com/abstract=1895524 (discussing the "mental accounting" framework of Richard Thaler and Cass Sunstein, and predictions of James Suroweicki).

mate whether over inclusiveness will be fatal to the split benefit proposal, such that rational insurers will never exercise their option.

As shown in Table 1, there will be three types of patients whose behaviors will be of interest to the rational insurer.[162] First are the "decliners"—those who would have received a prescription and consumed under the status quo, but upon receiving the split benefit decline to consume. In the foregoing Avastin example, we supposed that selected patients might each receive a $10,000 payment toward an $80,000 treatment. For each decliner, the insurer saves the difference between the insurance benefit and the split—here, $70,000. Second, the "riders" are those who receive split benefit payments but would not have consumed the treatment under the status quo anyway. For the riders, the split benefit is a windfall. Compared to the status quo, the insurer loses the amount of the split—here, $10,000. Finally there are the "seekers," who succeed in getting a prescription only for the purpose of getting a split benefit check, which they promptly cash. These patients also cost $10,000 each.

TABLE 1:
SCHEMATIC OF BEHAVIORS UNDER STATUS QUO AND SPLIT BENEFIT
(Assuming $80,000 Insurance Benefit and
$10,000 Split Benefit Payment)

		DECLINERS	RIDERS	SEEKERS
STATUS QUO	Prescribed?	Yes	Yes	No
	Consumed?	Yes	No	No
SPLIT BENEFIT	Prescribed?	Yes	Yes	Yes
	Consumed?	No	No	No
	Net Outcome	Saves $70,000	Costs $10,000	Costs $10,000

Roughly then, we can observe that the split benefit has a relatively high tolerance for riders and seekers, which one can group together. Even if there are six times as many riders and seekers as there are decliners, the split benefit is likely to save money on net.

Interestingly, the split benefit potentially saves money for the insurer even while providing a windfall to those innocent riders who are genuinely sick and probably could use the money, given that illness

162 This analysis excludes the patients who will consume under either the status quo or the split benefit, since they have no impact on cost (other than the nominal administrative expense of paying a split benefit, if that turned out to be higher than paying the provider in kind). In theory, there could be yet another type of patient who would have received a prescription under the status quo, and declined to consume, but the split benefit payment somehow caused the patient to consume the treatment.

and injury are also associated with loss of income.[163] The overinclusiveness of the split benefit may enhance social welfare incidentally.

Of course, the particular ratio depicted in Table 1 is peculiar to the Avastin example and its postulated values. It may be possible that an insurer could produce a significant number of decliners by paying only a $5,000 split, rather than a $10,000 split. That would then double its tolerance for riders and seekers. On the other hand, if the split benefit is applied to other drugs that are less expensive, say $40,000, but it is still necessary to pay $10,000 splits to get a significant number of decliners, then the tolerance for riders and seekers will be smaller. In that scenario, there is more of a risk that the split benefit will lose money on net.

One form of riding and seeking behavior would arise in contexts where there are multiple potential treatment alternatives. A patient could seek prescriptions for several different treatments in hopes of getting a split benefit payment, but then consume only one. Foreseeing this possibility, the rational insurer would pay a split benefit payment to the patient after the first such prescription, but tell the patient that she must pay the provider if she elects to pursue any of the courses of treatments that the insurer wishes to discourage. If clinical studies have proved some of the potential treatments more efficient than others, the insurer could have a tiered pricelist, just as they currently do with cost-sharing tiers, to discourage consumption of brand name drugs when generics are available.

In deciding whether to pay a split benefit, the insurer will analyze its claims data to observe that some diagnoses, procedures, physicians, and patients may have better yield rates than others. If a particular physician very frequently prescribes treatments that appear to be cost-ineffective but very few patients are actually electing the treatment over the cash payment, then the ratio can be lowered or that physician's patients can be excluded from eligibility for split payments.

Clearly, the split benefit should not be paid for ailments that are easy to fake or where the diagnosis is most subjective. For example, nonspecific back pain may be one such diagnosis that could be opportunistic for a higher percentage of patients than other diagnoses, such as breast cancer.[164]

In extreme cases, physicians and patients may commit outright fraud, providing sham diagnoses in order to secure an outlay from the

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163 *See generally* HACKER, *supra* note 132, at 138 ("Among *insured* Americans, 51 million spend more than 10 percent of their income on medical care.").

164 Even under the status quo, there are concerns about patients faking such diagnoses in order to procure prescriptions for narcotics. *See* Andrew D. Zechnich & Jerris R. Hedges, *Community-Wide Emergency Department Visits by Patients Suspected of Drug-Seeking Behavior*, 3 ACAD. EMERGENCY MED. 312 (1996). For recognition that "each illness has a different moral hazard profile," see NYMAN, *supra* note 131, at 154.

insurer for a procedure that was never truly indicated, or if indicated, not desired. These risks already exist to the extent that physicians can bill the insurer for procedures that they do not perform or that they perform even when not medically indicated.[165] An agreement between patient and physician to split the cash payment would seem to be a per se violation. Enforcement of the criminal prohibitions on health care fraud will be part of the solution just as it is now.

The foregoing analysis suggests that there is a wide domain of potential for rational insurers to exercise the option to pay a split benefit to satisfy their coverage obligations, rather than providing an in-kind nonfungible benefit as they currently do. Because the split benefit complies with current law and contracts, it creates a unilateral option that insurers can use to reduce inefficient health care consumption.

C. The Precedents

Research has failed to uncover a prior split benefit proposal in the scholarly and policy literature.[166] There are, however, various interesting analogues and precedents.

In the life insurance sector, there has been a practice of people exchanging their future life insurance benefit for a payment to be received during life, called a "viatical."[167] In this way, the life insurance benefit is made more fungible, better reflecting the consumption preferences of the policyholders.

Scholars have also previously noted the problem that health insurance is a nonfungible benefit.[168] Some have suggested an "indemnity" system where health insurers pay a cash benefit to patients rather than to providers.[169] Some automobile collision insurers likewise al-

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165 *See generally* Joan H. Krause, Skilling *and the Pursuit of Healthcare Fraud*, 66 U. MIAMI L. REV. 363, 365–68 (2012) (discussing concerns about physicians committing health care fraud).

166 John Nyman has suggested a related concept as a thought experiment. *See* NYMAN, *supra* note 131, at 40–41 (describing "the consumer's income payoff test" as defining the cost-effectiveness of care, predicated on the idea that the patient be given the insurance as a fungible benefit "that she could have spent on anything else" (emphasis omitted)).

167 *See* VIATICAL SETTLEMENTS MODEL ACT (Nat'l Ass'n of Ins. Comm'rs 2009), *reprinted in* NAT'L ASS'N OF INS. COMM'RS, 5 MODEL LAWS, REGULATIONS AND GUIDELINES 697-1, 697-1 to -40 (2012); *see also* Jessica Maria Perez, Note, *You Can Bet Your Life on It! Regulating Senior Settlements to Be a Financial Alternative for the Elderly*, 10 ELDER L.J. 425, 428 (2002) (discussing the mechanics of a typical viatical settlement transaction).

168 *See, e.g.*, Barry S. Coller, Commentary, *Realigning Incentives to Achieve Health Care Reform*, 306 JAMA 204, 204 (2011) ("The current health care system does not derive the benefit of market forces because the recipient of the services (the patient) does not directly pay the physician or hospital. Instead, a third party (the insurer) pays, and a fourth party (the employer) often chooses the third party.").

169 *See* Frank D Gianfrancesco, *A Proposal for Improving the Efficiency of Medical Insurance*, 2 J. HEALTH ECON. 176, 176 (1983); Robert F. Graboyes, *Our Money or Your Life: Indemnities*

low car owners to decide whether, when, and how to repair their car—and, notably, to keep any balance that they decline to spend.[170]

In the health insurance context, a 100% cash payment of the insurance benefit would more dramatically correct the distortion of nonfungible health insurance. Such a system would likely slow, or even reverse, the growth of health spending as a portion of our economy, as people choose higher-value options. However, a pure indemnity would not save money for the insurer or reduce insurance premiums for the employers and patients ex ante. Suppose that each Avastin prescription would invoke a full payment of the $80,000 insurance benefit to the patient rather than the provider. Patients would consume less Avastin if they valued other things more, but insurers would spend just as much money. Indeed, a pure indemnity would likely increase net costs because it would pay benefits to riders and seekers, who would not have consumed anyway. Even now, some patients receive prescriptions but do not consume the care, and under a pure indemnity, more patients would seek prescriptions that they could convert to cash. Unlike the split benefit, a pure indemnity proposal has no savings to offset this risk of over inclusiveness.

Of course, a pure indemnity proposal could save money if it also reduced the size of the insurance benefit.[171] That is, however, just another form of cost sharing, with all its problems. Instead, this Essay proposes to split the benefit in a way that reduces costs for public and private insurers, making health care insurance more sustainable and less expensive for the same amount of insurance coverage. Insurance can provide the same access to care and protection from risk at less cost.

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vs. Deductibles in Health Insurance 1–2 (Fed. Reserve Bank of Richmond, Working Paper No. 00-04, 2000), *available at* http://www.richmondfed.org/publications/research/working_papers/2000/pdf/wp00-4.pdf.

170 *See* Susan Feigenbaum, *"Body shop" Economics: What's Good for Our Cars May Be Good for Our Health*, *in* 15 REGULATION: CATO REV. BUS. & GOV'T 25, 27 (1992).

171 *See, e.g.*, Joseph P. Newhouse & Vincent Taylor, The RAND Corp., A New Approach to Hospital Insurance 3–4 (Jan. 1969) (unpublished manuscript), *available at* http://www.rand.org/content/dam/rand/pubs/papers/2008/P4016.pdf (developing a proposal for "Variable Cost Insurance," which sets the illness indemnity at a base level, and imposing 100% cost sharing above that level); Mark V. Pauly, *Indemnity Insurance for Health Care Efficiency*, 24 ECON. & BUS. BULL. 53, 57 (1971) [hereinafter Pauly, *Indemnity Insurance*] (explaining that under such policies "[t]he insured has no protection against the contingency that his out-of-pocket payments will be very large," and proposing a base-level indemnity and proportional cost sharing above that level); *see also* Joseph P. Newhouse & Vincent Taylor, *The Subsidy Problem in Hospital Insurance: A Proposal*, 43 J. BUS. 452, 453–54 (1970) (arguing that individuals would choose lower cost options if available); Mark V. Pauly, *Taxation, Health Insurance, and Market Failure in the Medical Economy*, 24 J. ECON. LITERATURE 629, 630 (1986) (arguing that "excessively" rising health care costs are tied to the health insurance scheme).

There are other indemnity reform proposals that bundle all potential treatments for defined categories of illness, not unlike the system Medicare now uses.[172] Patients are coded into one of several thousand "diagnosis related groups" (DRGs), each of which results in a specified payment that represents the "average" cost of treating the condition.[173] The DRG system transfers to the hospital the risk that within a DRG, a particular patient will get unusually expensive care; in turn, the hospital tries to spread that risk across its patients.[174] Accordingly, the DRG system creates an incentive for hospitals to select the easiest patients, code patients into the most lucrative DRGs, and provide the cheapest care within those DRGs.[175] Other public and private insurers adopted this DRG payment model, and it now serves as the norm for inpatient hospital services.[176]

Under the DRG system, insurers could make payments to patients, rather than in kind to providers. Under such a system, a patient with a given diagnosis would receive a one-time payment representing the average amount of care for the diagnosis, and then the patient can pay the provider on a fee-for-service basis. Insurance would simply not cover access to care beyond the average level. Unlike a hospital, an individual patient cannot spread the risk that she will want or need above-average care for her disease. This system cuts the size of the insurance benefit and thus fails to maintain access.

Alternatively, some scholars have proposed that insurers pay rebates to patients who select less expensive treatments and require a payment from the patient for the more expensive treatment.[177] Indeed, some innovative programs have begun where insurers are paying small incentives to patients who choose less expensive health care providers for the same treatments.[178] These are initial steps toward

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172 *See, e.g.*, Pauly, *Indemnity Insurance*, *supra* note 171, at 55 (proposing "[a] pure indemnity insurance for health-related losses . . . which specified a particular dollar payment for an individual with a given physical condition").

173 *See* Eleanor D. Kinney, *Making Hard Choices Under the Medicare Prospective Payment System: One Administrative Model for Allocating Medical Resources Under a Government Health Insurance Program*, 19 IND. L. REV. 1151, 1176 (1986). Even in the prospective payment system, hospitals can sometimes secure additional payments for "outlier" patients that require unusually expensive care. *See id.* at 1180. *See generally* RICK MAYES & ROBERT A BERENSON, MEDICARE PROSPECTIVE PAYMENT AND THE SHAPING OF U.S. HEALTH CARE 70 (2006) (discussing how hospitals turned to privately insured patients to recoup losses incurred from Medicare patients).

174 *See* Paul A. Taheri et al., *How DRGs Hurt Academic Health Systems*, 193 J. AM. C. SURGEONS 1, 1 (2001).

175 *See* MAYES & BERENSON, *supra* note 173, at 72–73.

176 *See* Kinney, *supra* note 173, at 1151.

177 *See* Chernew et al., *supra* note 136, at 601–02 (suggesting the concept but not "advocating for any particular insurance policy design").

178 *See* Michelle Andrews, *Some Insurers Paying Patients Who Agree to Get Cheaper Care*, KAISER HEALTH NEWS (Mar. 26, 2012), http://www.kaiserhealthnews.org/Features/

the fundamental reconceptualization of the insurance benefit proposed herein.

The closest analogue to the split benefit proposal is a German disability insurance program limited to those needing home care.[179] The German program offers patients an option to receive an in-kind benefit consisting of health care workers visiting their homes or a smaller cash payment instead.[180] Unlike the split benefit, the German program's cash payments are not designed to give the patient skin in the game when deciding whether to consume the in-kind services. Instead, the cash payment is the complete alternative benefit, one that a patient can use to support home care that he or she arranges, perhaps through family or informal support relationships.[181] The German patients elect which sort of benefit to receive; there does not appear to be a default rule.[182] The German program suggests that the split benefit payments might lead to a significant reduction in consumption. Based on data from the 1990s, "more than 75% of home care beneficiaries chose cash rather than services."[183]

III
Practical and Normative Challenges

This Part explores challenges to the split benefit concept, including both a practical challenge by the providers of expensive treatments, and normative challenges—some paternalistic and some teleological.[184] Ultimately, the split benefit arguably improves patient autonomy and welfare. But even if the split benefit were neutral on those points, it would still be worthwhile if only for the sake of cost control.

Insuring-Your-Health/2012/Cash-Rewards-For-Cheaper-Care-Michelle-Andrews-032712.aspx.

179 *See* Joshua M. Wiener & Alison Evans Cuellar, *Public and Private Responsibilities: Home- and Community-Based Services in the United Kingdom and Germany*, 11 J. Aging & Health 417, 437–38 (1999). In another German program, patients receive insurance premium rebates if they receive no care for a given period. *See* Peter Zweifel, *Premium Rebates for No Claims: The West German Experience*, *in* Health Care in America: The Political Economy of Hospitals and Health Insurance 323, 324 (H.E. Frech III ed., 1988).

180 *See* Wiener & Cuellar, *supra* note 179, at 437–38 ("For those in the most disabled category—needing activities of daily living care during the day and night—the cash level is $750 per month, as opposed to $1,400 in services.").

181 *Id.* at 439.

182 *See id.* at 437 ("For home care, the new insurance plan offers a choice: services, cash equivalent to about half the cost of services, or a combination of the two.").

183 *Id.* at 438.

184 I explored other practical challenges, including fraud and over inclusiveness, when I specified the criteria for paying a split benefit. *See supra* Part II.B.

A. Co-optation by Producers

Those who stand to benefit from spending on expensive treatments (the producers and providers of these drugs, devices, and procedures) may attempt to co-opt the split benefit by making side payments. For example, suppose a patient receives a physician's recommendation for Avastin and a $10,000 split benefit payment from the insurer. The drug manufacturer, the oncologist, or both could then send the patient a $10,000 coupon, telling the patient that he or she can take that, rather than the $10,000 cash, to the oncologist to initiate treatment. The split benefit proposal would thus fail to reduce consumption.

This objection is not peculiar to the split benefit; drug manufacturers already use such coupon strategies to defeat traditional cost-sharing strategies, at great cost to insurers.[185] For patients covered by federal health insurance programs and for all patients in Massachusetts, such kickbacks are illegal.[186] Congress could, and likely should, expand these prohibitions through state or federal legislation.

Insurers can also use their insurance contracts with patients to prohibit the use of coupons and can condition payments to providers on assurance that the provider did not accept a coupon. Finally, it would appear that insurers could use the Health Insurance Portability and Accountability Act (HIPAA) to litigate against those who pay coupons, since federal law elsewhere defines these as kickbacks.[187]

B. Access and Autonomy

If a physician refuses to write a prescription because of cost, if an insurer refuses to cover such a prescription, or if an onerous cost share exceeds a patient's ability to pay—the health care system has denied the patient the choice. In contrast, the split benefit keeps the decision in the hands of the patient.

As Bill Sage explains, "nearly all progressive impulses among American health lawyers and policy makers over the past half century have sought to liberate and empower the patient. Phrases used to express this desire include 'patient autonomy,' 'patients' rights,' 'patient

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185 *See* Jonathan D. Rockoff, *Drug Makers Criticized for Co-Pay Subsidies*, WALL ST. J., July 20, 2009, at B1; Chana Joffe-Walt, *Drug Coupons Hide True Costs from Consumers*, NPR (Oct. 20, 2009, 1:05 PM), http://www.npr.org/templates/story/story.php?storyId=113969968.

186 *See* Visante, HOW COPAY COUPONS COULD RAISE PRESCRIPTION DRUG COSTS BY $32 BILLION OVER THE NEXT DECADE 3 (2011), *available at* http://www.masspirg.org/uploads/bf/95/bf95f22db81052a7acb378a366b73a6c/visante-copay-coupon-study.pdf.

187 *See* Krause, *supra* note 165, at 363–64, 388–89; Linda A. Johnson, *Consumer Group Sues 8 Drugmakers over Drug Coupons*, USA TODAY (Mar. 7, 2012, 3:05 PM), http://usatoday30.usatoday.com/money/industries/health/drugs/story/2012-03-07/drug-coupons-lawsuit/53400686/1.

self-determination,' [and] 'patient preferences.'"[188] The autonomy agenda has, however, been cramped because insurance views the patient as merely a patient. He or she gets a walled garden of medical choices. The split benefit instead embraces a value pluralism, respecting the patient's weighing of medical and nonmedical values.

One might object that the split benefit payment seems coercive or bribe-like, perhaps an "undue influence."[189] The worry is that the split benefit payment will unduly push patients away from consuming health care. To the contrary, the entire insurance relationship on net, even including a split benefit payment, still induces patients toward consuming health care. The insurer tells the patient that he or she can spend the money on anything, but if the patient wants to consume health care, then the insurer will provide a nine-times subsidy (assuming a ten percent split). Merely allowing the patient to decide how she wants to spend one-tenth of her insurance benefit does not constitute an "undue influence."[190]

Still, the additional options created by the split benefit may cause subjective disutility to the patient tasked with deciding.[191] Prior behavioral research documents that, when given more options, people are sometimes less satisfied.[192] On the other hand, there is heterogeneity—some enjoy tasks that require effortful thinking and may savor the opportunities created by the new wealth.[193]

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188 Sage, *supra* note 66, at 1505 (footnotes omitted). Still, Sage worries that "the patient's conquest" will run up costs so much that it "risk[s] the collapse of the health care system that he or she would dominate." *Id.* at 1508.

189 Critics have raised a similar concern with regard to payments made to human subjects as compensation for their participation in research. *See generally* Ari VanderWalde & Seth Kurzban, *Paying Human Subjects in Research: Where Are We, How Did We Get Here, and Now What?*, 39 J.L. MED. & ETHICS 543, 544 (2011) (reviewing the literature surrounding these objections). There are good reasons to doubt this entire line of critique. *See* John Lawrence Hill, *Exploitation*, 79 CORNELL L. REV. 631, 662 (1994) ("An offer of benefits can never be coercive . . . .").

190 *See* Christopher Tarver Robertson, *From Free Riders to Fairness: A Cooperative System for Organ Transplantation*, 48 JURIMETRICS 1, 36–38 (2007) (arguing against the idea that autonomy somehow entails a right to ignore the consequences of one's decisions).

191 *Cf.* Chernew et al., *supra* note 136, at 602 (discussing the concern of "whether being confronted with financial considerations lowers utility beyond the inherent disutility associated with paying"); Wendy Levinson et al., *Not All Patients Want to Participate in Decision Making: A National Study of Public Preferences*, 20 J. GEN. INTERNAL MED. 531, 531 (2005) ("[H]alf of the respondents (52%) preferred to leave final decisions to their physicians . . . ."). *But see* Lesley F. Degner & Catherine Aquino Russell, *Preferences for Treatment Control Among Adults with Cancer*, 11 RES. NURSING & HEALTH 367, 372 (1988) (pointing out that most patients preferred to share decision-making control with their doctor).

192 *See generally* BARRY SCHWARTZ, THE PARADOX OF CHOICE: WHY MORE IS LESS (2004) (using contemporary psychological studies to argue that eliminating choices may reduce consumer anxiety).

193 There is robust psychological literature on this point. *See, e.g.*, John T. Cacioppo & Richard E. Petty, *The Need for Cognition*, 42 J. PERSONALITY & SOC. PSYCHOL. 116, 116–17 (1982).

Perhaps some prefer the luxury of deciding under conditions of moral hazard, which the split benefit undermines. In principle, those people could pay extra for health insurance policies that reduced their range of choices by keeping benefits nonfungible. If there is market and political demand for that service, the health care industry can provide it.

Still, there may be situations where the patient cannot decide whether to consume a treatment and where someone else, such as a parent or next of kin, decides on the patient's behalf. The split benefit proposal may create a conflict of interest if that substituted decision maker receives the benefit of the cash payment (either through expropriation or inheritance), while the patient receives any benefit of the treatment.[194] It may be best to limit the split benefit program to only those situations where the patient is competent to make treatment decisions. Still, traditional cost-sharing obligations already impose these sorts of dilemmas on substituted decision makers who would rather keep the money. Even worse, traditional cost-sharing obligations, unlike the split benefit, may be so onerous that they deny access to the expensive care altogether.

C. Welfare and Health Exceptionalism

Ezekiel Emanuel put the proposition simply: "The more we spend on health care, the less we can spend on other things we value."[195] By simply making a cash transfer, the split benefit facilitates our trades to higher value and thereby makes us better off.

Some patients have preferences for aggressive care, which the split benefit and the status quo equally satisfy. The split benefit payment also satisfies other patient preferences.[196] The split benefit provides a way "to reduce spending while improving the quality of end-of-life care by ensuring that patient preferences are followed more closely."[197]

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194 A similar problem arises in the social security context. *See* SOC. SEC. ADMIN., PUB. NO. 05-10076, A GUIDE FOR REPRESENTATIVE PAYEES 6 (2009), *available at* http://ssa.gov/pubs/10076.html (describing restrictions on the use of benefits by "representative payees"). *See generally* Kurt C. Kleinschmidt, *Elder Abuse: A Review*, 30 ANNALS EMERGING MED. 463, 464 (1997) (describing financial abuse through the improper use of government benefits as a modern form of elder abuse). Public and private insurers should be required to disclose such payments, just as banks and individuals are currently required to disclose the receipt of cash payments of over $10,000. *See* 31 U.S.C. § 5313 (2006) (placing a disclosure mandate on banks); 26 U.S.C. § 6050I (2006) (placing a similar mandate on individuals).

195 Emanuel, *supra* note 5.

196 *See* Pauly, *Indemnity Insurance*, *supra* note 171, at 53 ("The market, in its own way, provides information about individual preferences. When people decide to buy or not to buy, or to offer for sale or not offer for sale, they indicate what things are worth to them.").

197 GOODMAN ET AL., THE DARTMOUTH INST. FOR HEALTH POLICY & CLINICAL PRACTICE, TRENDS AND VARIATION IN END-OF-LIFE CARE FOR MEDICARE BENEFICIARIES WITH SEVERE

Still, medical literacy will remain a problem. We know, for example, that most patients undergoing chemotherapy overestimate its potential benefits, supposing that it is curative when it is not.[198] Even with a split benefit, patients will continue to make bad choices—sometimes consuming a drug or device that they would be better off declining and sometimes declining a drug or device that they would be better off consuming. The split benefit may change the relative shares of these two types of errors.[199] Regardless of the split benefit, physicians, insurers, and policymakers should create a "choice architecture," consisting of second opinions, counseling services, and consumer information to assist patients with the decision-making process.[200]

More particularly, one might worry that the particular form of the split benefit payment—a $10,000 check—may bias patients away from treatments with benefits that are likely to accrue more gradually.[201] Policymakers could require that splits be paid as annuities with payments spread over the same period of benefit that would be provided by treatment. It bears emphasis, however, that the rational insurer will pay splits that are small relative to the total cost of the procedure, which allows patients to irrationally double or even quintuple the subjective value of the cash while still erring on the side of the treatment.

The poorest patients also present a particular concern. The poor patient's alternative consumption choices for food or housing are more pressing than those of the median patient. This makes the poor patient more likely to decline care in order to pursue those alternatives. Insurers could scale split benefit payments according to patient wealth, but that may appear unfair. With same-size splits, the benefits of a fungible payment will be greatest for the poor, precisely because those alternative consumption options—such as food or housing—

CHRONIC ILLNESS 2 (Bronner ed., 2011) [hereinafter DARTMOUTH INST.], *available at* http://www.dartmouthatlas.org/downloads/reports/EOL_Trend_Report_0411.pdf.

198 *See* Jane C. Weeks et al., *Patients' Expectations About Effects of Chemotherapy for Advanced Cancer*, 367 N. ENG. J. MED 1616, 1620 (2012).

199 For an example of such a criticism of consumer directed health care generally, see Bloche, *supra* note 125, at 1320 ("The consumer-directed model pushes back against this quality improvement strategy by calling on patients to plan their own care. Its cost-sharing requirements discourage patients from compliance with coordinated care based on best practices.").

200 *See* Chernew et al., *supra* note 136, at 603 ("Frequently, patients are provided with literature that describes treatment options. More recently, researchers have begun to produce sophisticated decision assistance tools in media such as interactive video to facilitate patient input into the decision-making process."). *See generally* THALER & SUNSTEIN, *supra* note 148, at 81 (discussing choice architecture).

201 *See generally* George Ainslie & Nick Haslam, *Hyperbolic Discounting*, *in* CHOICE OVER TIME 57, 57–62 (George Loewenstein & Jon Elster eds., 1992) (discussing the tendency to devalue future benefits).

will actually be better for the poor patient than expensive health care. Even if we focused exclusively on health outcomes, evidence suggests that investments in housing, diet, and education may prove more effective than investments in expensive medical interventions.[202] If the choice is hard, it is because the alternatives are attractive.

It would be difficult to motivate a broader paternalistic critique of the split benefit based on a worry about patients foregoing needed treatments. First, even if one allows the paternalist to ignore cost, the paternalist lacks proof of efficacy for many of these expensive treatments or proof of improved efficacy over the standard of care. As such, the paternalist cannot say that the drug or device is on net more helpful to the patient.[203] Even for those treatments that are proven to be more effective, given a pluralism about ultimate values, it may not be irrational for a patient to prefer a treatment plan that is less invasive and less expensive.[204] There is already wide heterogeneity in decisions about how to treat and cope with severe illness, and the split benefit will just move the median patient marginally across that spectrum.[205]

More fundamentally, this sort of paternalistic objection, if merited, would undermine traditional cost-sharing policies, which utilize the same opportunity cost mechanism but are stymied by the wealth effects discussed above. Implicitly, the paternalist would have to maintain that all health care decisions, or perhaps all consumption decisions, be made under conditions of absolute moral hazard. Such a theory ignores scarcity and the practical need for someone to weigh the benefits against the costs.[206]

A related objection would invoke the specialness of health. One might argue, as Amartya Sen has, that "health is among the most im-

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202 *See* Clare Bambra et al., *Tackling the Wider Social Determinants of Health and Health Inequalities: Evidence from Systematic Reviews*, 64 J. EPIDEMIOLOGY & COMMUNITY HEALTH 284, 285–89 (2010).

203 *See supra* note 30 and accompanying text.

204 *See* Ken Murray, *How Doctors Die: It's Not Like the Rest of Us, But It Should Be*, ZÓCALO (Nov. 30, 2011), http://zocalopublicsquare.org/thepublicsquare/2011/11/30/how-doctors-die/read/nexus/ ("Hospice care, which focuses on providing terminally ill patients with comfort and dignity rather than on futile cures, provides most people with much better final days. Amazingly, studies have found that people placed in hospice care often live longer than people with the same disease who are seeking active cures.").

205 *See generally* DARTMOUTH INST., *supra* note 197, at 1–3 (finding that changes in end-of-life treatment for Medicare beneficiaries with severe chronic illnesses between 2000 and 2007 varied significantly between regions and hospitals).

206 For a discussion of the move toward a population-based bioethics, see Dan W. Brock, *Considerations of Equity in Relation to Prioritization and Allocation of Health Care Resources*, *in* ETHICS, EQUITY AND THE RENEWAL OF WHO'S HEALTH-FOR-ALL STRATEGY 60, 60 (Z. Bankowski, J.H. Bryant & J. Gallagher eds., 1997) (arguing for an analysis of equity and utility that incorporates "the full ethical complexity of achieving equity in the prioritization and distribution of health-care resources").

portant conditions of human life and a critically significant constituent of human capabilities which we have reason to value."[207] Thus, it may seem perverse for the split benefit policy to facilitate patients trading health care in favor of other goods, such as housing or even jewelry. As a scholar in a related context has said, "the money is given for certain purposes and not others, and it would be considered an abuse to use it for something else, even if that were preferred."[208]

This critique does not bear scrutiny. People buy insurance to ensure future access to care that they otherwise could not afford.[209] Ex ante, consumers need not know whether they will actually want to consume a given drug for a given disease that they may someday suffer. But rational consumers want the option to consume such drugs when they become better informed by their actual experience of the situation.[210] Ex post, having secured the option, a rational consumer may nonetheless prefer to spend that benefit on other things.[211] The split benefit is perfectly congruent with the option-buying purpose of insurance. It has the side benefits of increasing patient wealth and reducing insurance costs along the way.

As Sen himself recognizes, "[w]hat is particularly serious as an injustice is the lack of *opportunity* that some may have to achieve good health because of inadequate social arrangements, as opposed to, say, a personal decision not to worry about health in particular."[212] Likewise, courts and commentators have recognized that Congress created Medicare "to insure that adequate medical care is *available* to the aged throughout this country."[213] Even if the purpose of health insurance were much narrower, it is not necessarily true that the means to that

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207 Amartya Sen, *Why Health Equity?*, 11 HEALTH ECON. 659, 660 (2002); *see also* Norman Daniels, *Justice, Health, and Healthcare*, 1 AM. J. BIOETHICS 2, 3 (2001) (arguing that health care allows people to fully participate in all spheres of their social lives).

208 Jonathan Wolff, *Cognitive Disability in a Society of Equals*, *in* COGNITIVE DISABILITY AND ITS CHALLENGE TO MORAL PHILOSOPHY 147, 150 (Eva Feder Kittay & Licia Carlson eds., 2010); s*ee also* Ronald Dworkin, *What Is Equality? Part 1: Equality of Welfare*, 10 PHIL. & PUB. AFF. 185, 243 (1981) (developing the thought experiment of a paraplegic violinist who prefers a violin over health care).

209 *See generally* NYMAN, *supra* note 131, at 2 (describing the purchase of health care as a transfer of income); Allison K. Hoffman, *Oil and Water: Mixing Individual Mandates, Fragmented Markets, and Health Reform*, 36 AM. J.L. & MED. 7, 11 (2010) (developing the concept of "health redistribution").

210 *See* Romley et al., *supra* note 61, at 683.

211 *See* Jost, *supra* note 2, at 582 (discussing such changes in perspective).

212 Sen, *supra* note 207, at 660 (emphasis added).

213 Hultzman v. Weinberger, 495 F.2d 1276, 1281 (3d Cir. 1974) (emphasis added); *see also* James M. Peterson, Massachusetts Medical Society v. Dukakis*: Are Medicare Beneficiaries Better Off?*, 14 J. CONTEMP. L. 151, 155 (1988) (recognizing a similar purpose of the Medicare Act).

end must be so narrowly circumscribed.[214] If the split benefit reduces health insurance costs, it may facilitate broader, more robust, and more sustainable health coverage over the long run.

CONCLUSIONS

The split benefit is a way to reduce the cost of health insurance, or could be a way to increase access and coverage at the same cost. We can save money without impinging on the advisory role of physicians, the autonomous choices of patients, or patients' access to care. In some instances, we should replace onerous traditional cost-sharing obligations with split benefit payments, which are instead painless for patients. In other instances, we should supplement traditional cost sharing with split benefit payments, which will increase the opportunity cost-signal beyond the level of traditional cost sharing.

The split benefit presents an opportunity to improve the efficiency of the larger economy. As Bill Sage has argued, "we seem finally to have reached the point at which spending more on health care means denying our other material needs. Stagnant wages for many middle-class Americans, for example, may in part reflect the rising cost of employer-sponsored health coverage crowding out cash raises in workplaces."[215] The split benefit reduces that distortion and returns some of the wages to the workers. It does so ex ante, by reducing insurance premiums for the same coverage, and ex post, by allowing people to choose for themselves how they wish to spend some of their insurance benefits.

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214 *See* Betsey A. Kuhn et al., *Policy Watch: The Food Stamp Program and Welfare Reform*, 10 J. ECON. PERSP. 189, 192 ("While all of the food stamps are spent on food, funds previously spent on food are reallocated to other needs, such as rent, clothing or medical care.").

215 Sage, *supra* note 66, at 103 (footnote omitted); *see also* Baicker & Chandra, *supra* note 20, at 17 (discussing evidence "suggesting that we may be spending too much on health relative to other goods."); Emanuel, *supra* note 5 ("Over the past 30 years, health care inflation has been a major reason average wages have remained stagnant.").