

## Targeted, Concise Treatments for the American Health Care System

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- David Orentlicher, *Controlling Health Care Spending: More Patient “Skin in the Game?”*, 13 **Indiana Health L. Rev.** 348 (2016), available at [SSRN](#).
- Barbara A. Noah, *The (Ir)rationality of (Un)informed Consent*, 34 **Quinnipiac L. Rev.** 691 (2016), available at [SSRN](#).

From a health law and policy perspective, the recent presidential election results have undoubtedly ushered in a new period of tremendous uncertainty. With President-elect Trump ascending to the office this year, it is likely that the health care delivery and financing system—to say nothing of the numerous health law syllabi in health care law courses across the country—will look radically different in the years to come. As I write, policymakers and prognosticators are debating which—and how many—pieces of the Affordable Care Act will survive. Nevertheless, no matter the makeup of American health care system in the future, many challenges the system currently faces will endure—and likely intensify. Chief among those concerns revolves around the strangling cost of American health care.

Examining the issue in two separate manifestations and focusing on patient decision-making in two separate contexts, [David Orentlicher](#) and [Barbara Noah](#) provide practical and succinct suggestions in well-written, recently-published essays, [Controlling Health Care Spending: More Patient “Skin in the Game?”](#) and [The \(Ir\)rationality of \(Un\)informed Consent](#), respectively. Both tackle problems that contribute to the nagging challenge of cost—Orentlicher largely with an eye on influencing patient decision-making through coverage incentives and penalties, and Noah with an eye on improving patient clinical decision-making at the end-of-life. As overutilization and cost are a focus of much of my scholarship, I was delighted to discover both pieces and to engage with their insights as we overlook a new period of yawning uncertainty in health law and policy.

First, in his insightful essay, Professor David Orentlicher paints a dark picture of American health care cost and quality before diving into a few suggested policy changes. Orentlicher focuses on two main solutions: (1) recalibrating patient cost-sharing, and (2) using employer wellness programs to address inefficiencies and incentives. On improving patient cost-sharing, Orentlicher rightly observes the main challenge: if the insurance’s cost-sharing amount is too high, patients are deterred from seeking care (especially those of lower economic means), and if the cost-sharing is too low, patients will seek too much health care and waste resources.

After identifying this challenge, Professor Orentlicher presents targeted solutions. First, he notes that aggressive cost-sharing must be reserved for lower-value care; this way, patients are appropriately steered to the doctor when it is most efficient for them to visit. Second, Orentlicher notes the importance of reference pricing to standardize the cost of a given procedure or product, pushing patients to lower-cost providers. And third, he highlights “scaled” cost-sharing, in which he suggests that deductibles and other cost-sharing mechanisms be scaled to one’s familial income, and not a raw dollar amount. This would address the problem of those without disposable income avoiding the doctor too much, and those with more disposable income visiting the doctor too often.

Finally, Professor Orentlicher highlights the upside of employer wellness programs in cutting the cost of health care. Within this section, after describing some of the limitations and threats facing wellness programs, he encourages program designers to think about three main features for incentives: first, programs should reward short-term progress; second, programs should structure incentives indefinitely; and finally, programs must carefully consider the benefits and downsides of a system with either built-in rewards or penalties (Professor Orentlicher seems to suggest that rewards may work better).

Second, in her artfully titled essay, Professor Barbara Noah tackles the inadequacies of informed consent. She starts by highlighting the size and scope of the problems raised by dying in America—most notably that we overutilize certain care and that we underutilize other types of care—and forecasts that it is likely to worsen due to shifts in population. Referencing everyone’s different conception of, and approaches to, end-of-life decision-making, Professor Noah notes that a substantial amount of end-of-life care provides no measurable benefit. She laments the “default model” that pushes doctors to continue to provide care unless the patient undertakes a burdensome effort to opt out of often needless treatment.

Professor Noah does a masterful job of describing the difficulty facing patients at the end-of-life. After highlighting a number of other complicating factors, including cultural challenges (both of physicians’ concerns about liability and of society’s conception of death) and payment incentives, Noah attacks as impossible the idea of a “perfect” decision at the end-of-life in the face of a number of unconquerable obstacles. To explain this complication, Professor Noah effectively relies on recent work by philosophers to observe that clinical decision-making at the end-of-life is characterized by “necessary fallibility,” and is defined by unknowable and unpredictable variables. Sneakily, “unknown unknowns” may impact the real likelihood of survival, but cannot be fully understood during the clinical decision-making process. As a result, Noah argues, there is no “best” approach or treatment for a patient who may be facing the end of his or her life. This uncertainty swamps the abilities of both the provider and patient to come to a rational “best” clinical decision.

Noah finishes by pointing out a number of pressures that impact the decision-making process—from optimism bias, to a false belief that patients can achieve a perfect and rational end-of-life decision, to an inability to convey the hard edges of what can be known. She notes that we must continue to strive for informed consent, but must recognize that the doctrine is limited and imperfect. In the end, it comes down to patients being able to face the situation with as much knowledge as possible while understanding this imperfection of the decision-making process, and, above all perhaps, the fragility of life.

Both Orentlicher and Noah provide clear and focused works geared toward improving the delivery of American health care with an eye toward building a more just and efficient system. Their pieces remind all Americans—during this time of remarkable uncertainty—that some of the same old challenges will remain in need of adequate legal and policy-based solutions.

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