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Cash Me Outside, Howbow Dah?—An Alternative to Wasteful Medical Spending In Terminally Ill Patients

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CASH ME OUTSIDE—AN ALTERNATIVE TO WASTEFUL
MEDICAL SPENDING IN TERMINALLY ILL PATIENTS

*Christopher Neal Loy, Jr.**

Abstract

The U.S. health care system is an inefficient machine that is burdened by overconsumption and wasteful spending. The system has long defaulted into maximizing the quantity of life over quality—a choice influenced by corporations that stand to profit with every additional procedure. To stymie health care spending and attempt to restore the true cost of treatment to patients, this Note proposes an alternative to how health insurers provide options to terminally ill cancer patients by offering a partial cash rebate to forgo any life-extending measures. The patient would be free to leave his or her legacy, the health insurer would save on expenses, the natural inclination to consume more health care would be lessened, and the reduction of wasteful medical spending would help lower the cost of health care.

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INTRODUCTION

The true cost and realities of undergoing aggressive cancer treatment are often ignored in favor of an intrinsic desire to maximize the patient's lifetime, maximizing quantity of life over quality of life in determining medical treatment. There are many motivations for the propensity to elect for care—a patient's fear of death, society's inclination to maximize the lives of the dying while discounting the suffering associated with undergoing chemotherapy and similar measures, and physicians' reluctance to have frank, honest discussions with patients about the realities of dying and the true costs and benefits associated with undergoing aggressive cancer treatment.

To more closely align a terminally ill patient's wishes with the course of treatment received, this Note proposes that health insurers give terminally ill patients a choice. This Note suggests that health insurers offer a "cash out" provision in health insurance policies that provides a terminally ill patient an option to receive a cash rebate to forgo end-of-life treatment. The amount of the rebate would be equal to a percentage of the amount the insurer would pay for the treatment of a similarly situated patient.

As this Note asserts, not only is a cash-rebate provision like the one proposed possible, but such a provision should be adopted and utilized by health insurers. Part I of this Note explores the realities of cancer and delves into the current political and economic state of the U.S. health care system. Part II of this Note confronts some of the legal hurdles a cash-rebate provision would encounter and distinguishes the provision from numerous analogies to other medical legal issues. Finally, this Note concludes with a full endorsement of the provision and suggests that states adopt such an idea in an effort to restore the cost-benefit balance and to fully align the patient's desire with the treatment provided.

I. AN EXPENSIVE EXIT

Cancer kills nearly one in four Americans, second only to heart disease.¹ A 2016 article predicted that in that year alone, approximately 1,685,210 new cases of cancer would be diagnosed and approximately 595,690 people would die of cancer—1,630 people per day.² The amount of money the United States spends in combatting cancer is equally as

1. AM. CANCER SOC'Y, CANCER FACTS & FIGURES 2016, at 1 (2016), <https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2016/cancer-facts-and-figures-2016.pdf>.

2. *Id.*

devastating as the sheer loss of human life cancer claims.³ This Part will delve into the reality of cancer and the economics at play in the health care market surrounding this problem.

A. *What Is Cancer?*

The idea of cancer strikes terror into the minds of many; however, people often misunderstand the condition. *Cancer* is a term that collectively refers to diseases that are characterized by a rapid and uncontrollable reproduction of the body's cells which spreads to the surrounding tissue.⁴ As our cells age, they break down, die, and are normally replaced by new cells.⁵ However, biological processes can go haywire, causing rogue cancer cells to reproduce uncontrollably and form growths called tumors.⁶ Cancerous tumors are often malignant⁷—the runaway cells can spread and not only invade nearby tissue, but can break off and travel through the blood to remote parts of the body to form additional tumors far away from the original location.⁸ Usually the body's immune system destroys rogue cells; however, cancer cells are able to dodge and even hijack the body's immune system to keep the system from destroying cancer cells.⁹ The spread of the cancerous cells to additional parts of the body is referred to as metastasis.¹⁰ Treatment of metastatic cancer may only help prolong the lives of some people, since it focuses on controlling the growth of the cells or relieving symptoms caused by it rather than curing it.¹¹ Treatment options for cancer can include radiation, chemotherapy, and targeted therapy, among others.¹² The decision to undergo treatment for terminal cancer is a complex

3. See Hagop Kantarjian & S. Vincent Rajkumar, *Why Are Cancer Drugs so Expensive in the United States, and What Are the Solutions?*, 90 MAYO CLINIC PROC. 500, 500 (2015) (stating that the United States spends 18% of its gross domestic product on health care costs versus 5–9% in European nations).

4. *What Is Cancer?*, NAT'L CANCER INST., <https://www.cancer.gov/about-cancer/understanding/what-is-cancer> (last updated Feb. 9, 2015).

5. *Id.*

6. Cancers generally form solid tumors; however, cancers of the blood generally do not. *Id.*

7. *Id.*

8. *Id.*

9. *Id.* (“Although the immune system normally removes damaged or abnormal cells from the body, some cancer cells are able to ‘hide’ from the immune system.”).

10. *Id.*

11. *See id.*

12. AM. CANCER SOC'Y, *supra* note 1, at 1.

decision that consists of a web of factors, not the least of which is the impact on family and loved ones.¹³

B. *Cancer Diagnosis and Contributing Factors*

While many factors can contribute to the rate of cancer diagnosis,¹⁴ individuals with a lower socioeconomic status (SES) experience both a higher prevalence and more cancer deaths than those with a higher SES.¹⁵ In addition to a higher prevalence of cancer, those with a lower SES “are substantially more likely to be diagnosed with cancer at a later stage when treatment is more extensive, more costly, and less successful.”¹⁶ One study that examined the rate of colorectal cancer diagnosis found a striking relationship between SES and the stage at which colorectal cancer is diagnosed.¹⁷ On a broad basis, the study found that individuals living in the lowest SES areas were 45% more likely to be diagnosed at a later stage than persons in the highest SES area.¹⁸ More specifically, the study reported that within the poorest SES, Blacks were significantly more likely (68%) to be diagnosed with a late-stage disease than Whites (63.1%).¹⁹ Additional factors of an individual’s diagnosis and ultimate outcome are the individual’s “social context,”—housing condition, neighborhood poverty, and unemployment.²⁰

The relationship between lower SES and high rates of late-stage diagnosis is difficult to precisely define and explain. A factor that could contribute to the higher rates could be a lack of access and availability of early screening detection.²¹ Another contributing factor could be the attitudes to the culture of poverty that not only decrease the likelihood of those individuals utilizing early detection, but also cause a general unwillingness to seek care for manifesting symptoms.²² Other factors that can account for a heightened rate of cancer include a higher likelihood of

13. See, e.g., *EXTREMIS* (f8 Filmworks 2016) (depicting the stark reality of end-of-life care and how the decision whether to undergo care encompasses more than merely the effect on the patient themselves).

14. Jeanne Mandelblatt, *The Late-Stage Diagnosis of Colorectal Cancer: Demographic and Socioeconomic Factors*, 86 AM. J. PUB. HEALTH 1794, 1794–95 (1996) (citing age, race, socioeconomic status, and insurance status as factors that relate to cancer diagnosis).

15. AM. CANCER SOC’Y, *supra* note 1, at 50; see also Mandelblatt, *supra* note 14, at 1795 (suggesting poverty as the key through which other sociodemographic factors influence how severe a patient’s cancer has progressed at diagnosis).

16. AM. CANCER SOC’Y, *supra* note 1, at 9.

17. See Mandelblatt, *supra* note 14, at 1795.

18. See *id.*

19. See *id.*

20. See *id.* at 1796.

21. See *id.* at 1795.

22. See *id.*

engaging in behaviors that increase risk of cancer, such as workplace exposures or being overweight.²³ Further, the lion's share of cancer-care costs occur during the last year of life.²⁴

Treatment for cancer is wide-ranging, depending on a number of factors like the type and phase of cancer present.²⁵ Treatment could include surgery, radiation, chemotherapy, immunotherapy, and targeted therapy, among others.²⁶ Chemotherapy is designed to kill cancer cells and can be administered orally, by injection, or intravenously.²⁷ As chemotherapy kills rapidly dividing cancer cells, however, it also slows the growth of healthy cells or kills them, causing painful side effects.²⁸ Another effective type of cancer treatment is radiotherapy, which involves administering high doses of radiation to kill cancer cells and shrink tumors.²⁹ Unsurprisingly, radiotherapy can be very expensive as it involves complex machines and numerous health care providers.³⁰ For instance, the external beam radiotherapy involves treatment that lasts up to six weeks with individual treatments five days a week.³¹

Chemotherapy and radiation treat many types of cancer effectively; however, it is not without physical cost in the form of side effects. For instance, common side effects for chemotherapy include fatigue, pain, mouth and throat sores, nausea and vomiting, blood disorders like anemia and leukopenia, hair loss, and various nervous-system effects.³² Accordingly, a patient must consider a horde of factors other than the side effects when deciding whether to undergo treatment for cancer.

23. AM. CANCER SOC'Y, *supra* note 1, at 50.

24. See Angela Mariotto et al., *Projections for the Cost of Cancer in the United States: 2010–2020*, 103 J. NAT'L CANCER INST. 117, 121 (2011).

25. *Types of Treatment*, NAT'L CANCER INST., <https://www.cancer.gov/about-cancer/treatment/types> (last visited Dec. 2, 2017).

26. *Id.*

27. *Chemotherapy*, NAT'L CANCER INST., <https://www.cancer.gov/about-cancer/treatment/chemotherapy> (last visited Dec. 2, 2017).

28. For instance, chemotherapy can attack cells that line a person's mouth and intestine which could cause mouth sores and nausea. *Id.*

29. *Radiation Therapy*, NAT'L CANCER INST., <https://www.cancer.gov/about-cancer/treatment/radiation-therapy> (last visited Dec. 2, 2017).

30. *Id.*

31. *Id.*

32. *Side Effects of Chemotherapy*, CANCER.NET (Aug. 2018), <http://www.cancer.net/navigating-cancer-care/how-cancer-treated/chemotherapy/side-effects-chemotherapy>. Leukopenia is a condition defined by a lack of sufficient white blood cells. *Id.* Generally, chemotherapy destroys healthy cells like white blood cells in addition to the cancerous cells. *Id.* A low white blood cell level is dangerous because it leads to a higher risk of serious infection. *Id.* Anemia is characterized by a lack of sufficient red blood cells in the body and can lead to fatigue, dizziness, and shortness of breath. *Id.*

C. Market Economics

The U.S. health care market is unique mainly because it is largely a for-profit industry, unlike the markets in European and other similar, advanced nations.³³ This structure creates interesting and adverse dynamics within the U.S. market regarding incentives and pricing structures. Further, the for-profit approach appears to result in consequences that are at least partially driven by demands for higher profits and higher health care costs.³⁴ This misalignment from the supply side subsequently may lead to an imbalance in favor of profit-seeking behavior that discounts the lives of the individuals and patients on the demand side. Compare, for instance, that the health care costs in the United States account for 18% of the United States' gross domestic product, whereas in the European model those costs are only 5% to 9%.³⁵ In a true free market, prices are determined by what the market is willing to pay for a certain good or service.³⁶ However, the United States' health care system is anything but a free market. Patients who are deemed terminally ill find their "freedom to participate" in medical intervention substantially diluted because the patient's choice to become subject to a sickness is not a voluntary decision. More often than not, a patient's decision whether to undergo medical intervention is substantially offset for a number of reasons, lessening the leverage the "buyer" has in the market.

While the incentive shift that occurs within the patient-insurer relationship contributes to the inaccurate cost within the market, physicians' active role in determining cancer treatment options can also play a role.³⁷ In one survey, oncologists required a "survival rate of 2–4 months to justify a hypothetical treatment expense of \$70,000."³⁸ Thus, presenting a "cost-effectiveness threshold of \$300,000 per quality-adjusted life year (QALY)³⁹ [to prescribe] hypothetical treatment," a threshold that exceeds most others in health care.⁴⁰ This implies that doctors are much more willing to utilize aggressive cancer treatment,

33. Kantarjian & Rajkumar, *supra* note 3, at 500.

34. *Id.*

35. *Id.*

36. *Id.*

37. See Adam Schickedanz, *Of Value: A Discussion of Cost, Communication, and Evidence to Improve Cancer Care*, 15 ONCOLOGIST 73, 75 (2010) (reporting that in one study 88% of oncologists thought that cost should not impact treatment decisions at all).

38. *Id.*

39. A quality-adjusted life year (QALY) is a method of evaluating health improvement by combining the length of life with quality of life to produce a single number used to guide health care resource allocation decisions. See Milton C. Weinstein et al., *QALYs: The Basics*, 12 VALUE IN HEALTH S5, S5 (2009). One QALY equates to one year lived in perfect health. *Id.*

40. Schickedanz, *supra* note 37, at 74–75.

regardless of the high cost, low return. Another study found that the prescription of overly aggressive radiation treatment that provided little, if any, benefit was also partially attributable to oncologists' propensity to prescribe radiation treatment in the final stages of a patient's life.⁴¹ The study found that, while patients opted to go ahead with the treatment that was suggested by their oncologist as a possible ray of hope as their eminent death approached, that decision could also be attributed to the difficulty of confronting the switch from fighting the cancer to providing symptomatic care.⁴² Rather than suggesting a change of focus, it would seem easier for oncologists to simply suggest a heroic last-ditch effort at one more round of chemotherapy regardless of the limited benefit.⁴³ Inefficiencies in over-prescribing end-of-life heroic measures can lead to a poor utilization of resources which leads to higher costs for limited benefit that may not even align with the patient's wishes. Changes to the health care system (and the health insurance market more specifically) that more accurately align patient incentives with the true wishes of the patient should be a top priority for providers, insurers, and lawmakers interested in improving health care in the United States.⁴⁴

Cancer is a significant driver of health care costs—the direct medical costs for cancer in the United States in 2014 were \$87.8 billion⁴⁵ and are projected to rise⁴⁶ partially due to more effective targeted treatments becoming the new standard of care.⁴⁷ A wide range of factors contribute to the high cost of providing care—the cost of follow-up care, the cost of expensive procedures, and the cost of cancer drugs are just a few. Generally, the cost of cancer can be broken down into direct medical costs and indirect medical costs.⁴⁸ Direct medical costs are the costs associated with care that the patient receives—for instance, hospitalizations, surgery, radiation, and chemotherapy—and are usually measured by adding insurance payments along with patient out-of-pocket

41. Craig C. Earle et al., *Aggressiveness of Cancer Care Near the End of Life: Is It a Quality-of-Care Issue?*, 26 J. CLINICAL ONCOLOGY 3860, 3862 (2008).

42. *Id.*

43. *Id.* As an aside, one must also question the incentives oncologists receive from drug companies and whether that monetary interest is not insignificant. *See id.*

44. *See* Schickedanz, *supra* note 37, at 74.

45. *Economic Impact of Cancer*, AM. CANCER SOC'Y, <https://www.cancer.org/cancer/cancer-basics/economic-impact-of-cancer.html> (last updated Apr. 15, 2017).

46. *See* Mariotto et al., *supra* note 24, at 124 (projecting the cost of providing cancer care in the United States to be \$157.77 billion by 2020).

47. *Id.*

48. K. Robin Yabroff, *Economic Burden of Cancer in the United States: Estimates, Projections, and Future Research*, 20 CANCER EPIDEMIOLOGY BIOMARKERS & PREVENTION 2006, 2007 (2011).

copayments and deductibles.⁴⁹ Indirect costs are associated with “time spent receiving medical care, time lost from work or other usual activities (morbidity costs), and lost productivity due to premature death (mortality costs).”⁵⁰ Thus, the true cost of providing care is impossible to calculate looking only at direct medical expenditure. Rather, the true cost of cancer takes a toll on the entire economy, affecting productivity and an individual’s earnings and employment status.⁵¹ Additionally, not only is the cost associated solely with the individual suffering from the cancer, but costs are borne by caregivers and families.⁵²

The United States spends more on health care per capita than any other wealthy nation.⁵³ In 2013, the United States spent 17.1% of its gross domestic product on health care—nearly 50% more than the next highest spender globally, France.⁵⁴ Despite the amount of money poured into the system, the United States fares far worse in comparison to other similarly situated nations.⁵⁵ One study found that 68% of Americans aged 65 and older had at least two chronic health issues while international percentages ranged from 33% to 56%.⁵⁶ Additionally, in 2013 the United States had the lowest life expectancy (78.8 years) compared to the OECD median (81.2 years).⁵⁷ As a result, the high cost of health insurance paired with the lackluster results causes financial hardship for a number of U.S. citizens.⁵⁸ So much so that “[t]he burden of the cost of care is now

49. *Id.*

50. *Id.* at 2008.

51. See Gery P. Guy Jr. et al., *Economic Burden of Cancer Survivorship Among Adults in the United States*, 31 J. CLINICAL ONCOLOGY 3749, 3754 (“The plausible range of aggregate annual net productivity loss among cancer survivors was \$9.6-16.0 billion among those age 18-64 years and \$8.2-10.6 billion in cancer survivors age ≥ 65 years.”).

52. Yabroff, *supra* note 48, at 2008, 2012.

53. David U. Himmelstein & Steffie Woolhandler, *The Current and Projected Taxpayer Shares of US Health Costs*, 106 AM. J. PUB. HEALTH 449, 449 (2016); see also Florence K. Tangka et al., *Cancer Treatment Cost in the United States*, 116 CANCER 3477, 3477 (2010) (stating more specifically, the majority of cancer care cost is incurred in the last few months of life).

54. David Squires & Chloe Anderson, *U.S. Health Care from a Global Perspective: Spending, Use of Services, Prices, and Health in 13 Countries*, 15 COMMONWEALTH FUND 1, 2 (2015).

55. Olga Khazan, *U.S. Healthcare: Most Expensive and Worst Performing*, ATLANTIC (June 16, 2014), <https://www.theatlantic.com/health/archive/2014/06/us-healthcare-most-expensive-and-worst-performing/372828/>.

56. Squires & Anderson, *supra* note 54, at 7.

57. *Id.*

58. See Amy S. Kelley et al., *Out-of-Pocket Spending in the Last Five Years of Life*, 28 J. GEN. INTERNAL MED. 304, 304–09; see also M. Pisu et al., *Economic Hardship of Minority and Non-Minority Cancer Survivors 1 Year After Diagnosis: Another Long-Term Effect of Cancer?*, 121 CANCER 1257, 1261 (2015) (“[O]ur findings indicate almost 50% of survivors experienced economic hardship about 1 year after diagnosis.”).

considered an additional side effect of cancer and its treatment.”⁵⁹ A large portion of the costs that are attributable to financial hardship are not a result of undergoing the treatments, but rather the high costs that lead to the inability to afford the cancer drugs after receiving the treatments.⁶⁰ For instance, one study found that cancer survivors had higher mean annual expenditures compared to those who were not diagnosed with cancer.⁶¹ Further, “the annual excess economic burden of cancer survivorship among those recently diagnosed was \$16,213 per cancer survivor age 18–64 years and \$16,441 per cancer survivor aged over 65 years.”⁶² With the growing number of cancer survivors increasing substantially over time due to advances in treatment, early detection, and increased life expectancy, the cost of follow-up care becomes an important factor for patients diagnosed with cancer to consider.⁶³

Another negative consequence of high cost of care manifests itself in medication nonadherence.⁶⁴ “It has been estimated that nearly half of prescription medications for chronic disease are not taken as properly described.”⁶⁵ Medication nonadherence accounts for more than \$100 billion a year in the form of increased health services utilization, hospital admission, and adverse drug events associated with nonadherence.⁶⁶ One study suggested that “[n]onadherence may have a substantial impact on the [outcome] of oral regimens for the prevention or treatment of malignancies.”⁶⁷ While it may seem like those suffering from cancer would “have more to lose” and subsequently incentivize them to strictly adhere to medication regimens, studies have suggested otherwise.⁶⁸ To

59. See Pisu et al., *supra* note 58. Some studies have termed the economic burden of receiving medical care “financial toxicity.” See Julie McNulty & Nandita Khera, *Financial Hardship—an Unwanted Consequence of Cancer Treatment*, 10 HEALTH ECON. 205, 206 (2015). Financial toxicity can lead to treatment nonadherence and lifestyle changes that impact the patient’s quality of life and affect the treatment’s efficacy. *Id.*; see also Jennifer L. Malin et al., *Wrestling with the High Price of Cancer Care: Should We Control Costs by Individuals’ Ability to Pay or Society’s Willingness to Pay?*, 28 J. CLINICAL ONCOLOGY 3212, 3212 (2010) (stating that 62% of personal bankruptcies are estimated to be a result of medical expenses).

60. See Pisu et al., *supra* note 58, at 1262.

61. Guy et al., *supra* note 51, at 3754.

62. *Id.*

63. *Id.*

64. Walid F. Gellad, Center for Health Equity Research and Promotion, *Targeted Cancer Therapy: From Bench to Bedside to Patient*, 32 J. CLINICAL ONCOLOGY 268, 268 (2014).

65. *Id.*

66. *Id.*

67. Ann H. Partridge et al., *Adherence to Therapy with Oral Antineoplastic Agents*, 94 J. NAT’L CANCER INST. 652, 659 (2002).

68. Theodore Darkow et al., *Treatment Interruptions and Non-Adherence with Imatinib and Associated Healthcare Costs*, 25 PHARMACOECONOMICS 481, 483 (2007) (citing a study that documented a low rate of medication adherence in individuals despite infection of HIV).

illustrate the need for strict adherence, one study documented that even a low rate of nonadherence of 85% was associated with the medication failure and spawning of cellular cancer clones.⁶⁹ Nonadherence is increasingly becoming a problem for patients suffering from cancer because traditionally, anticancer therapies have been administered in hospitals and physicians' offices which led to health care providers ensuring a full chemotherapy regime.⁷⁰ However, a growing number of anticancer therapies are administered orally, outside the formal health care setting, and therefore depend on the patient's rate of medication adherence.⁷¹

Further, anxiety over the cost of receiving treatment is not relegated to the traditionally poor patient.⁷² Rather, one study found that the direct and indirect costs of care were factors that were considered by a wide swath of privately insured patients, regardless of income.⁷³ Accordingly, the financial costs associated with immediate and long-term cancer care should be more of a factor in determining cancer treatment and health policy, especially in decisions that affect individuals in a lower SES.⁷⁴

One of the most significant factors driving a higher cost of care is the cost of cancer drugs. The price of pharmaceuticals in the United States is markedly higher than the price of the same pharmaceuticals in similar nations.⁷⁵ The cost of drugs associated with cancer care is growing at a rate of 15%—twice the rate of the overall market.⁷⁶ As of 2010, there were at least 100 new molecules for cancer treatment in phase III trials; however, there was no indication that any of these drugs would lead to cheaper alternatives to the currently available cancer drugs.⁷⁷ In the United States, the average for a single patient's annual cost of cancer drugs ballooned from the \$5,000 to \$10,000 range to more than \$100,000 in less than fifteen years.⁷⁸ However, the price of cancer drugs is not the only concerning factor in providing care to the terminally ill. Cancer-

69. Stacie B. Dusetzina et al., *Cost Sharing and Adherence to Tyrosine Kinase Inhibitors for Patients with Chronic Myeloid Leukemia*, 32 J. CLINICAL ONCOLOGY 306, 309 (2014).

70. *Id.* at 310.

71. *Id.* at 309–10.

72. See Tammy K. Stump et al., *Cost Concerns of Patients with Cancer*, 9 J. ONCOLOGY PRAC. 251, 253 (2013) (stating that cost concerns exist outside the traditionally “vulnerable” patient group).

73. See *id.* at 254 (stating that a low SES was not a reliable measure to determine a patient's concern over cost of care).

74. See Pisu et al., *supra* note 58, at 1263.

75. Squires & Anderson, *supra* note 54, at 5 (citing a study that found a 50% lower price for pharmaceuticals in Canada, Australia, and the United Kingdom compared to the United States).

76. Schickedanz, *supra* note 37, at 74.

77. *Id.*

78. Kantarjian & Rajkumar, *supra* note 3.

specific spending has doubled in the past twenty years, a larger increase than general medical spending as a whole.⁷⁹ For instance, in 1987 the total medical cost of cancer was \$24.7 billion, adjusted for inflation as of 2007.⁸⁰ From 1987 to 2001 through 2005, the medical cost of cancer increased 98% to \$48.1 billion.⁸¹ Although there is a downward trend in cancer occurrence, cancer spending has increased due to an aging population that is living longer due to medical advancements that prolong life.⁸² Simple changes have helped push against the rise in the cost of cancer care such as providing chemotherapy and radiation treatment in an outpatient setting; however, these changes are unable to combat the rising cost associated with a larger population of those ailing from cancer.⁸³ So who is footing the bill for this care?

As already the biggest bearer of costs, private insurers' burden has swelled to over half of all cancer-caused medical expenditures.⁸⁴ One study found that of the recently diagnosed cancer survivors aged 18 to 64, private insurers pay for nearly 70% of medical expenditures.⁸⁵ One aspect that contributes to the increase in size of private insurers' burden is the implementation of early screening efforts in younger generations.⁸⁶ While the population served by Medicaid is small, its share of the cost experienced the largest relative increase, likely attributable to paying for care associated with cancers that were detected at a late stage.⁸⁷

In order to combat the rising costs of cancer, many medical costs and expenses are being shifted from insurers to patients through higher premiums and higher deductibles.⁸⁸ The cost shift to higher premiums and deductibles puts cancer survivors who are of working age at a serious threat of financial hardship, with one study reporting one in four having experienced financial hardship due to the cost of medical expenditure.⁸⁹ The exposure to higher financial insecurity will only increase with the higher cost of care—seemingly forcing patients to continue to elect for higher deductible plans in order to manage some costs.⁹⁰

79. Tangka et al., *supra* note 53, at 3482.

80. *Id.* at 3479.

81. *Id.* at 3479–80.

82. *Id.* at 3482.

83. *Id.*

84. *Id.*

85. Guy et al., *supra* note 51, at 3754.

86. Tangka et al., *supra* note 53, at 3483.

87. *Id.*

88. K. Robin Yabroff et al., *Financial Hardship Associated with Cancer in the United States: Findings from a Population-Based Sample of Adult Cancer Survivors*, 34 J. CLINICAL ONCOLOGY 259, 265 (2016).

89. *Id.*

90. *Id.*

What is the real-world response to the higher costs? “[E]vidence suggests that cancer survivors with financial hardship or higher out-of-pocket costs are more likely to delay or forgo general medical care and cancer care and have poorer adherence to cancer treatment, compared with those without financial hardship or lower out-of-pocket costs.”⁹¹ One national study estimated two million cancer survivors did not seek required medical services because of cost.⁹² Furthermore, cancer survivors who experience financial hardship are also more likely to report poor quality of life.⁹³

The cost of cancer is often studied in terms of medical costs; however, “the true burden of cancer includes nonmedical costs for travel and child care, costs incurred by caretakers, and nontangible costs associated with psychological pain and stress, as well as loss of productivity.”⁹⁴ One study reported one in four cancer survivors have experienced psychological hardship in response to the financial difficulty in paying for care.⁹⁵ A cancer diagnosis can interrupt employment and “have negative consequences on earnings, career development, retirement decisions, and a personal sense of self-efficacy.”⁹⁶ This is of concern because employer-provided health insurance is the main source of insurance among working-age individuals and “employment disruption or limitations in the ability to work may reduce access to insurance, and when combined with reduced earnings, may increase the risk of material and psychological financial hardship.”⁹⁷

D. Changes to Health Care

The high cost of cancer care is receiving increasing attention.⁹⁸ For instance, one study suggests that future efforts to change health care could include consumer-driven health care options, such as Health Savings Accounts and High-Deductible Health Plans that would increase a patient’s options while also increasing the burden of care the patient would have to pay in the form of out-of-pocket expenses.⁹⁹ The inevitable rise of the cost of cancer care and the shifting burdens for the associated

91. *Id.*

92. Yabroff, *supra* note 48, at 2012.

93. *Id.*

94. Tangka et al., *supra* note 53, at 3483.

95. Yabroff et al., *supra* note 88, at 263–64.

96. *Id.* at 266.

97. *Id.*

98. *Id.*

99. Tangka et al., *supra* note 53, at 3483.

costs¹⁰⁰ present a bleak, yet crucial question that must be confronted by every person diagnosed with cancer: At what cost?

One cannot accurately respond to that question without understanding the inefficiencies present in the health care market. In an efficient market, consumers' willingness to pay conveys the value consumers place on a given product and signals the proper supply levels to producers.¹⁰¹ However, the U.S. health care system is far from a picture of efficiency. As a general concept, utilization of health insurance skews the incentive-based structure of an efficiently operating market to favor overconsumption as patients are no longer bearing the full cost of the product.¹⁰² One suggested change to the insurance structure is to create a more accurate cost-sharing scheme that is based not on cost but value.¹⁰³ A value-based scheme could lower the copay for high-value products and services to encourage use while simultaneously increasing the amount patients would have to pay to utilize low-value services.¹⁰⁴ A shift towards a value-based approach is likely to help stem the rising cost of care while simultaneously providing patients with care options that best reflect their desires and provide outcomes that are accurately reflected in their pretreatment decision-making analysis.

The Patient Protection and Affordable Care Act¹⁰⁵ (ACA) has been the most expansive and wide-reaching overhaul of the health care industry in the United States since the passage of Medicare and Medicaid.¹⁰⁶ However, despite its passage, health care costs have continued to rise, albeit it at a slower rate due to the ACA implementation.¹⁰⁷ Pursuant to the passage of the ACA, many sectors of the health care industry have been affected by new regulation, including health insurance providers. However, while the ACA is a solid point from which discussion regarding improving the current state of the market can begin, it is by no means a final solution to the inefficiencies of the U.S. health care system.¹⁰⁸

100. *See id.*

101. Schickedanz, *supra* note 37, at 74.

102. *Id.*

103. *Id.*

104. *See id.*

105. Pub. L. No. 111-148, 124 Stat. 119 (codified as amended in scattered sections of 42 U.S.C.).

106. Frederic E. Shaw et al., *The Patient Protection and Affordable Care Act: Opportunities for Prevention and Public Health*, 384 LANCET 75, 75 (2014).

107. *See* PRICEWATERHOUSECOOPERS, MEDICAL COST TREND: BEHIND THE NUMBERS 2017, at 2 (2016) (predicting a 6.5% increase in health care in 2017).

108. *See* Heidi W. Albright et al., *The Implications of the 2010 Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act on Cancer Care Delivery*, 117 CANCER 1564, 1564 (2011).

Society is experiencing an awakening. The creation of the internet helped usher in a new perspective on life across the globe. Alternative medicine is gaining recognition, new lifestyles are being adopted, and many individuals in western culture are turning to what was once written off as “eastern medicine.” The public’s perception of “health” is undergoing rapid and radical change.

II. CASH ME OUTSIDE

A need for a change to health care delivery is evident. Too often the choice of whether to receive additional medical treatment is inherently biased in that additional medical intervention is the default—the vantage point from which patients determine treatment plans—rather than viewing additional medical intervention merely as an option among several alternatives. While open communication within a physician–patient relationship is crucial to a patient’s ultimate decision, a doctor’s own discomfort over a patient’s decision to “do nothing” undoubtedly influences the decision-making process. Emerging medical technology unquestionably allows humans to live longer and certainly in most cases, much better; however, although technology allows patients to reap a longer lifespan, living longer is not necessarily the best plan for every patient suffering from a terminal cancer. Giving patients a right to choose what seems like a radical, fringe possibility is a tenet in patient autonomy that balances the costs and benefits of end-of-life care.

At first glance, the cash-back incentive provision would certainly offend society’s conscience by seeming to put a price on a patient’s life, similar to the death panel discussion that has followed for years after the passage of the ACA.¹⁰⁹ Further, a contractual provision like this would surely come under fire for being offensive to public policy and would be challenged as unenforceable in the courts.¹¹⁰ However, as this Note explains, unsavory contractual terms that are entered into freely by two independent agents should not be stricken as unenforceable merely over the public’s shock of such blunt provisions.¹¹¹ This Part explores the possible hang-ups the cash-rebate provision would likely confront and distinguishes similar, yet different analogies that would likely be made in

109. See, e.g., Sarah Kliff, *Why Talk of Non-Existent Obamacare Death Panels Won’t Die*, WASH. POST (Jan. 9, 2013), https://www.washingtonpost.com/news/wonk/wp/2013/01/09/why-talk-of-non-existent-obamacare-death-panels-wont-die/?utm_term=.a78adafe6b5f (documenting the public outrage that followed Sarah Palin’s Facebook post that criticized the Affordable Care Act’s “death panels” that turned out to be nonexistent).

110. See RESTATEMENT (SECOND) OF CONTRACTS § 178 (AM. LAW INST. 1981).

111. See *id.* ch. 8, intro. note (stating that the principle of freedom to contract is in the public’s best interest to have broad powers in determining terms of an agreement that are reached as a result of a bargain).

comparison to the provision. This Part concludes with legislative suggestions that would take the provision from mere proposition to viable alternative option for patients.

A. *Unenforceability on Grounds of Public Policy*

The predominant hurdle this idea would likely confront is the contention that the agreement between the insurer and patient would be unenforceable as it seemingly violates public policy. Fundamental to all contract law is the principal of an individual's freedom to contract.¹¹² However, while an individual is free to contract, a validly formed contract may nevertheless be held unenforceable for public policy concerns.¹¹³ Contract law holds that an agreement is unenforceable on grounds of public policy if either legislation provides for such unenforceability or "the interest in its enforcement is clearly outweighed in the circumstances by a public policy against the enforcement of such terms."¹¹⁴ Essentially, "the need to protect public policy must outweigh the enforcement of the contract."¹¹⁵

The Restatement of Contracts (Second) provides for a cost-benefit approach to determine whether an agreement is offensive to the public.¹¹⁶ The modern view put forth by the Restatement utilizes a fact-specific analysis to determine whether an agreement is offensive to public policy.¹¹⁷ Courts have acknowledged this approach in striking down consensual agreements on grounds of public policy concerns.¹¹⁸ Accordingly, this fact-specific analysis has produced a wide range of agreements that, while not illegal to perform per se, have been held unenforceable.¹¹⁹ Accordingly, the characterization of these agreements bears little significance and one cannot rely solely upon these distinctions.¹²⁰

When undergoing the cost-benefit analysis proposed by the Restatement, the "court may consider the strength of the policy through legislation or case law, the likelihood that rendering the term or contract

112. Andrea E. White, *The Nature of Taboo Contracts: A Legal Analysis of BDSM Contracts and Specific Performance*, 84 UMKC L. REV. 1163, 1173 (2016).

113. *Id.*

114. RESTATEMENT (SECOND) OF CONTRACTS § 178 (AM. LAW INST. 1981).

115. White, *supra* note 112, at 1173.

116. *See* RESTATEMENT (SECOND) OF CONTRACTS § 178 (AM. LAW INST. 1981).

117. *See* 5 SAMUEL WILLISTON & RICHARD A. LORD, A TREATISE ON THE LAW OF CONTRACTS § 12:1 (4th ed.).

118. *See, e.g., Sw. Sugar & Molasses Co. v. River Terminals Corp.*, 360 U.S. 411, 421 (1959) (acknowledging the importance of insight into the factual circumstances when striking contracts as void for public policy).

119. *See* 5 WILLISTON & LORD, *supra* note 117, § 12:1.

120. *See id.*

unenforceable will advance the policy, the amount of misconduct, and the relationship between any misconduct and the contract terms.”¹²¹ While determining public policy usually boils down to a benefit analysis, courts have also used long-standing precedent to determine what is offensive to the general public.¹²² “Our society prohibits, and all human societies have prohibited, certain activities not because they harm others but because they are considered, in the traditional phrase, ‘contra bonos mores,’ i.e., immoral. In American society, such prohibitions have included, for example, sadomasochism, cockfighting, bestiality, suicide, drug use, prostitution, and sodomy.”¹²³

However, what is important to note in considering sound public policy is the fluctuating and variable nature amid fluctuating circumstances and changing public opinion. For instance, pursuant to a shift in public opinion, sodomy is no longer against public policy due to the Court’s ruling in *Lawrence v. Texas*.¹²⁴ It is difficult to draw clear distinctions to determine what provisions offend public policy, outside of a statutory-driven background.¹²⁵

Enforcement of binding contract provisions maximizes social welfare because it allows for cooperation between parties in otherwise impossible circumstances.¹²⁶ A fundamental understanding in contract theory is that all effects and costs associated with the contract are borne by the contracting parties; however, if the contract produces negative externalities, the contract is unlikely to maximize social welfare.¹²⁷ To deter contracts that produce harmful effects on third parties, society could subject the contracting parties to criminal or civil liability¹²⁸ or the court could refuse enforcement of contracts as offensive to society, thereby setting a precedent in the market.¹²⁹ Thus, from an economic perspective, determining whether a contract offends public policy focuses on “determinations of negative externalities and, after such determinations,

121. White, *supra* note 112, at 1173.

122. See *Roe v. Butterworth*, 958 F. Supp. 1569, 1583 (S.D. Fla. 1997) (quoting *Barnes v. Glen Theatre, Inc.*, 501 U.S. 560, 574–75, (1991)).

123. *Id.*

124. 539 U.S. 558, 578–79 (2003).

125. David Adam Friedman, *Bringing Order to Contracts Against Public Policy*, 39 FLA. ST. U. L. REV. 563, 612 (2012) (showing a higher success rate with an unenforceable defense with matters that have roots in statutory prohibition rather than a broad public policy-based approach).

126. See Note, *A Law and Economics Look at Contracts Against Public Policy*, 119 HARV. L. REV. 1445, 1446 (2006) (highlighting possible examples of outcomes in a system that lacks an enforcement mechanism, namely misappropriation of prepaid funds and incentive to renegotiate terms upon reliance by the other contracting party).

127. See *id.* at 1446–47.

128. See *id.* at 1447. While holding the parties liable could be possible, it is not a feasible solution as the cost of monitoring, litigating, and enforcement would deter such action. *Id.*

129. See *id.*

on whether enforcement would lead to an increase in net social welfare.”¹³⁰ Thus, when considering the proposition, courts should take into account the entire effect of the agreement between the insurer and insured and the role this relationship has on the general public and the health care market as a whole.

B. *Lack of Legislative Prohibition*

Unlike many other agreements that have been held unenforceable, a cash-rebate incentive to forgo end-of-life care has not been addressed by any legislative body nor has any court confronted the idea. Various unsavory contractual agreements, however, have been addressed and prohibited by legislation. For instance, a similar, yet distinguishable analogy to the cash-rebate proposal is the concept of a free market to procure human organs, a proposal that has long been explicitly prohibited by federal law.¹³¹ Contrary to the current proposition, the prohibition of organ sales, while similarly distasteful, was passed not merely because it is a distasteful term but rather for sound policy considerations. Generally, “the public policy defense is more often successfully invoked and resolved in the most ‘ruly’ manner when it is closely linked to a statute or promulgated regulation than when it is not.”¹³²

C. *The Sale of Human Organs*

Similar to the cash-rebate incentive, the sale of human organs raises a similar public unrest due to an “objectification of the human body.”¹³³ While many people elect to become organ donors via state driver’s licenses, the sale of such organs is prohibited.¹³⁴ The National Organ Transplant Act of 1984 (NOTA) was passed by lawmakers to specifically prohibit the sale of organs for “valuable consideration.”¹³⁵ Subsequent to NOTA’s passage and numerous court rulings, society has remained in a constant battle in attempting to balance the dignity of the human body with saving lives.¹³⁶ A cash rebate for forgoing end-of-life care would seemingly fall into similar public distaste due to a feeling of objectifying the human body and stripping away the sanctity of human life to merely dollars and cents in order to maximize corporate profit. Despite a

130. *See id.* at 1448.

131. 42 U.S.C. § 274e(a) (2012) (“It shall be unlawful for any person to knowingly acquire, receive, or otherwise transfer any human organ for valuable consideration for use in human transplantation if the transfer affects interstate commerce.”).

132. Friedman, *supra* note 125, at 601.

133. White, *supra* note 112, at 1179.

134. *Id.*

135. *Id.*

136. *Id.*

prohibition against organ sales, many people feel that if the donor consents to a transplant after being fully informed, then the donor should be able to go through with the transaction, thereby promoting an individual's freedom to contract.¹³⁷ The same can be said for a cash-rebate proposal. While a contract dealing with altering the end of life may be disliked by the public, there will undoubtedly be a segment of society that rejects the paternalistic ideology over end-of-life care in favor of a patient's right to self-determination, albeit tainted with a cash incentive.

1. Unduly Coercive

However, a portion of society also feels that a market to sell organs would be unduly coercive to low-income individuals and would lead to exploitation, undoubtedly another possible hurdle that a cash-rebate incentive program would face.¹³⁸ This is an extreme view that implies that the poor will act as martyrs to a system that monetarily rewards self-sacrifice in an effort to minimize health care expenditure.¹³⁹ However, it ignores the reality that the exchange is not coercive, but rather a voluntary exchange—freely trading an organ for a financial gain.¹⁴⁰ “Offering an individual compensation to donate an organ is ‘no more coercive than paying a coal miner to work in [a] mine, a professor to teach, or a surgeon to provide medical services.’”¹⁴¹ Prices are not a form of undue coercion, but rather a “reward for our efforts” for making an informed decision to abstain from care that provides minimal benefit for a great cost—a sound, rational economic judgment.¹⁴² The inducement to forgo care would only be the price, a present cash value of the cost of what heroic measures would cost.

Additionally, an ironic and counterproductive outcome would result from a prohibition of these agreements on a policy basis to protect the poor.¹⁴³ Prohibiting a cash payment for abstaining from wasteful health care spending would only exacerbate the individual's poverty and

137. Michelle Castillo, *Ethical Dilemmas Surround Those Willing to Sell, Buy Kidneys on Black Market*, CBS NEWS (Jan. 7, 2013, 2:18 PM), <http://www.cbsnews.com/news/ethical-dilemmas-surround-those-willing-to-sell-buy-kidneys-on-black-market/>.

138. *See id.*; *see also* Lars Noah, *Too High a Price for Some Drugs?: The FDA Burdens Reproductive Choice*, 44 SAN DIEGO L. REV. 231, 242 (2007) (citing a cash-based incentive program to reduce unwanted pregnancies that did not face any legal challenges).

139. *See* Cody Corey, *Money as a Motivator: The Cure to Our Nation's Organ Shortage*, 11 HOUS. J. HEALTH L. & POL'Y 93, 106 (2011).

140. *See* T. Randolph Beard & David L. Kaserman, *On the Ethics of Paying Organ Donors: An Economics Perspective*, 55 DEPAUL L. REV. 827, 832 (2006).

141. Corey, *supra* note 139, at 106–07.

142. *See* Beard & Kaserman, *supra* note 140, at 832, 836.

143. *See id.*

perpetuate an inefficient market that rewards health care providers at the expense of individuals' right to freedom to contract.¹⁴⁴

2. The Objectification of the Body

Another similar argument that is often brought up to support the prohibition of organ sales is the idea that the body is being stripped down to merely a commodity and reduces the sanctity of life. It has been warned that a purely economic approach to organ sales would possibly lead to an “ultimate slide down the slippery slope.”¹⁴⁵ Here, however, a cash incentive is markedly different from a sale of an organ. In the sale, one must actively be a participant in a transaction. Such action requires a higher level of thought and participation. Compare that to a cash incentive program that merely offers patients the opportunity to be rewarded for their decision to “do nothing” in the market, the more efficient decision. It is the difference between actively seeking out an unsavory transaction and merely making a responsible decision that would empower autonomy and a patient's right to health care determination—action that should be prohibited as a violation of public policy. It is not an objectification of the human body, but rather an acknowledgment and promotion of the right to determine one's future.

D. Surrogacy Contracts

As a result of emerging technologies, couples previously unable to have children outside of adoption can resort to an alternative to satisfy the desire to have closer biological ties with their offspring—surrogacy.¹⁴⁶ “The typical surrogacy arrangement involves an agreement, usually by contract, for the surrogate to be artificially inseminated with the semen of the husband of the infertile couple, to carry the fetus to term, and to relinquish parental rights upon birth.”¹⁴⁷ In the landmark case *In re Baby M.*,¹⁴⁸ the New Jersey Superior Court's Chancery Division recognized the right to enter into surrogacy contracts, but struck down the contract as unenforceable for public policy concerns.¹⁴⁹ Since the inception of this alternative to child rearing, concerns of dehumanization, exploitation, and black-market babies have been raised.¹⁵⁰ The “common

144. *See id.* at 832–33.

145. Corely, *supra* note 139, at 110.

146. Steven M. Recht, Note, ‘M’ is for Money: Baby M and the Surrogate Motherhood Controversy, 37 AM. U. L. REV. 1013, 1017 (1988).

147. *Id.* at 1019.

148. 217 N.J. Super. 313, 525 A.2d 1128 (Ch. Div. 1987).

149. Recht, *supra* note 146, at 1038–39.

150. *Id.* at 1020.

denominator” for these concerns is money.¹⁵¹ Subsequently, despite a freedom to contract,¹⁵² surrogacy contracts are struck down because of legislation that prohibits the exchange of consideration in connection with adoption.¹⁵³ However, with the proposition at hand, there is no prohibition for a cash incentive payment unlike that of surrogacy contracts. Again, courts are unlikely to strike down contracts merely because they seem offensive without any link to statutory precedent.¹⁵⁴

E. Viatical Settlements

The Acquired Immune Deficiency Syndrome (AIDS) epidemic of the 1980s and 1990s was one of the most destructive times in modern health history.¹⁵⁵ Not only was the epidemic tragic from a human health perspective, the outbreak was wrought with legal issues ranging from employment discrimination to the patients’ rights to publicly funded treatments.¹⁵⁶ However, one of the most consequential results from the epidemic was the public’s acknowledgment of the “gravity of the United States health care crisis, as society [witnessed an] . . . increasing population of terminally ill individuals struggling bitterly to secure finances for medical treatment.”¹⁵⁷ As a result of the dire financial straits in which many terminally ill patients found themselves, a new financial tool emerged—the viatical settlement.¹⁵⁸ The market for viatical settlements emerged to allow terminally ill individuals an opportunity to receive an immediate cash payout by selling their insurance policies for a discounted price of the full value.¹⁵⁹ Generally, a viatical settlement is a sale of a life insurance policy to a third party.¹⁶⁰ More specifically, a terminally ill person will sell his or her life insurance policy to a third party for an immediate cash settlement.¹⁶¹ The patient is usually paid anywhere from 50% to 80% of the policy’s full value, depending on the

151. *Id.* at 1026.

152. *Id.* at 1020.

153. *Id.* at 1026.

154. *See* Friedman, *supra* note 125, at 601.

155. Lee Ann Dean, *Acquired Immune Deficiency Syndrome, Viatical Settlement, and the Health Care Crisis: Aids Patients Reach into the Future to Make Ends Meet*, 25 RUTGERS L.J. 117, 117 (1993).

156. *Id.* at 118–19.

157. *Id.* at 120.

158. *Id.* at 121.

159. Jennifer Berner, Note, *Beating the Grim Reaper, or Just Confusing Him? Examining the Harmful Effects of Viatical Settlement Regulation*, 27 J. MARSHALL L. REV. 581, 583–84 (1994).

160. Dean, *supra* note 155, at 121 n.17.

161. Berner, *supra* note 159, at 584.

patient's life expectancy.¹⁶² The company is then paid upon the assignor's death.¹⁶³ Specifically, the contract that governs the agreement is a product of negotiation between the patient and the third party that eventually results in a mutually agreeable price and assignment of the policy from the patient to the third party.¹⁶⁴ The central argument in challenging viatical settlements, which is analogous to the argument against a cash rebate to forgo end-of-life care, is "whether an individual's right to use his property to secure life-sustaining treatment outweighs a state's historical and fundamental interest in preserving the 'sanctity of life.'"¹⁶⁵ One argument in support of the viatical-settlement market states that loss of employment and associated financial hardship imposed by the high cost of care for AIDS treatment creates a compelling interest in those who want to sell their life insurance policies, "one that outweighs moral objections to the process."¹⁶⁶ The cost of cancer care has since been on the rise and is predicted to continue,¹⁶⁷ furthering the proposition that the true cost of cancer care should be balanced against the moral objections to the process.¹⁶⁸ Similar to the acquiescence to the advent of a viatical-settlement market, a cash-rebate incentive for the terminally ill should be permitted in order to help those individuals find peace of mind and financial security¹⁶⁹ and even realize lifelong and unaffordable dreams.¹⁷⁰

F. Proposed Legislation

As a practical matter, while there lacks any prohibition against the policy, legislation authorizing such incentive provisions in insurance premiums would be highly preferred. Not only would legislation regulating the market serve to establish an efficient market, legislation could provide transparency to alleviate any public concern and provide for clear and transparent regulation. The public concern over a cash-rebate incentive payment would likely be fueled by the risk of overreaching and undue influence upon vulnerable victims.¹⁷¹ Similar concerns were brought up in opposition to the viatical-settlement market.¹⁷² However, in response to those concerns, legislatures

162. *Id.*

163. Dean, *supra* note 155, at 121.

164. *Id.* at 135–36.

165. *Id.* at 141.

166. *Id.*

167. See Mariotto et al., *supra* note 24, at 124.

168. Dean, *supra* note 155, at 141.

169. Berner, *supra* note 159, at 585–86.

170. Kara Swisher, *Allstate to Offer Discounts to Buy Policies of the Terminally Ill*, WASH. POST, Aug. 1, 1991, at B8.

171. Berner, *supra* note 159, at 586.

172. *Id.*

throughout the United States drafted laws to regulate the industry.¹⁷³ Viatical settlements came under the control of state insurance commissioners or administrators.¹⁷⁴ Similarly, a centralized state overseer would help keep public concern over cash-rebate fraud at bay.

Various requirements contained in legislation regulating viatical settlements could similarly serve to protect patients in a cash-rebate incentive program. For instance, a purchaser entering into a viatical settlement must obtain a written statement from a medical professional affirming the seller is not acting under undue influence.¹⁷⁵ Like the seller in a viatical settlement, a patient who decides to forgo care can be required to get written consent from an independent third-party medical professional to assure the patient is not being subject to any undue influence or coercion. Additionally, like viatical-settlement regulation, regulation with cash incentives could require additional counseling by medical professionals so the patient understands the illness, the benefits of receiving care, and the terms of the settlement.¹⁷⁶

CONCLUSION

In a time of massive political discord in the United States, sweeping change could eventually come in the form of repeal of the status quo and a possible establishment of a new scheme.¹⁷⁷ A cash-rebate incentive provision would be one of many changes to U.S. health care that could provide lower costs to both insurers and patients. A cash-rebate provision should not be prohibited as unenforceable contracts under the guise of protecting the public. A cash-rebate provision serves to reduce the high cost of care and more closely align the true cost of care with the benefits received and a patient's genuine desire. Ultimately, it would help cut the cost of wasteful cancer spending that is unlikely to result in beneficial outcomes.¹⁷⁸

173. *Id.*

174. *Id.*

175. *Id.* at 588.

176. *See id.*

177. *See* Mike DeBonis, *Anxious Lawmakers to GOP Leaders: What's the Plan to Replace Obamacare?*, WASH. POST (Jan. 12, 2017), https://www.washingtonpost.com/powerpost/anxious-lawmakers-to-gop-leaders-whats-the-plan-to-replace-obamacare/2017/01/12/bddea6bc-d8e1-11e6-9a36-1d296534b31e_story.html?utm_term=.5261a9ce8f7d.

178. *See* Earle et al., *supra* note 41, at 3952.