Aid-in-dying laws and the Implications for Self-Funded Plans

By Maribel E. McLaughlin, Esq.

Two years ago, a woman close to my mother was diagnosed with an aggressive form of brain cancer. Along with her two daughters, she went through the various treatment options presented to her and determined that she was going to try all of them. She wanted to put her best foot forward for her daughters and her granddaughter, and she found the strength to fight the cancer with every cell in her body.

After sixteen months of treatment, losing her hair, the inability to eat properly, and her body being riddled with the toxins that were used to fight the cancer, she decided that she wanted to end her life; her way, on her own terms. She had a lengthy discussion with her daughters about her choice, and as sad as they were that they would soon be losing their mother, they understood that their mother wanted to live every moment to its fullest, but, when she was ready, she would make the decision to die on her own terms.

One particularly difficult night, she pushed herself to take one last walk through the Newport Cliff Walk with her daughters and granddaughter, enjoyed her last Del's lemonade, savored the final clam chowder she was going to have, and decided that this was her chance to end her life on a high note. That night, she took a higher dose of the medicine that she had been taking for the last sixteen months, and never woke up. She purposely overdosed; or, as many would call it, she committed suicide.

D.C.'s New Death with Dignity Act

The Death with Dignity Act went into effect on February 18, 2017 in Washington D.C., and last month, doctors were able to begin the process of prescribing life-ending drugs to terminally ill patients; adding the District to six states that currently authorize that practice.

The D.C. Health Department launched a website where physicians can register to participate in the "Death with Dignity" program, where doctors, pharmacists, and patients can learn about the law's requirements and patients and doctors can download required forms. Patients must be older than eighteen with a prognosis of less than six months to live in order to be eligible.

In addition, they must have made two requests at least fifteen days apart for life-ending medications. They must ingest the drugs themselves, and two witnesses must attest that the patient is making the decision voluntarily.[1]

Affordable Care Act & Physician-Assisted Suicide

According to Section 1553 of the Affordable Care Act ("ACA")[2], a health plan may not discriminate against an individual or institutional healthcare entity because the entity does not provide any healthcare item or service that causes, or assists in causing, the death of any individual, such as by assisted suicide, euthanasia, or mercy killing. Put another way, if terminally ill patient requests that his doctor help him end his life, and the doctor refuses for moral or other reasons, that doctor is protected against discrimination by federal law. This protects the doctor that may be targeted by insurance companies because of their refusal to help patients end their lives.

California's Election of Death of Dignity Law

In California, one of the six states, the law does not make it easy for a patient to elect death with dignity; the patient must be terminally ill to request a doctor's prescription for medications intended to end their lives peacefully.[3]

The End of Life Option Act creates a long list of administrative obstacles that both patients and doctors must overcome. At the time of the law's enactment, it became the fifth state to implement an aid-in-dying law, and it is currently also the most stringent. Patients must get a prescription from a participating physician.

This is not as easy as it may seem. A coordinator may connect the patient with a physician that participates; but, if the patient is a U.S. military veteran that receives healthcare from the U.S. Department of Veterans Affairs, that patient will not be able to utilize this state law since federal law prohibits the use of federal funds for this purpose. Additionally, the forty-eight Catholic and Catholic-affiliated hospitals located in California will not provide patients with the option to end their lives.[4]

Cost of Death vs. Cost of Healthcare

Another obstacle that patients may come across is the cost of the drugs involved with the assisted suicide practice. The patient's health plan may not cover them - and the states that have allowed the practice of assisted suicide do not require health insurers to cover the medications.[5]

Under The Employee Retirement Income Security Act of 1974 (ERISA), there are minimum standards for voluntarily established health plans in private industry to provide protection for individuals in these plans; plans must provide participants with information about plan features and funding, and furnish information regularly and free of charge.[6]

Nothing about the Acts requires that a self-funded plan under ERISA, cover the cost of the death-with-dignity practice. Luckily under ERISA, a Plan still has the liberty to create their own health benefits. A health plan, when drafting their Plan Document, can choose to either allow this practice, or not. The ACA prohibits the discrimination of a provider that does not provide assisted suicide services. The Act does not require health plans to allow the practice. The option is left to the Plan.

Healthcare costs in the United States have risen astronomically over the past decade and many people fear that insurance companies may look to assisted suicide as a way for a health plan to save money on expensive medical care.[7]

One report concluded that it would save approximately $627 million dollars in 1995.[8] Some, who oppose assisted suicide, argue that insurance companies may begin to limit expensive procedures for patients who are suffering from terminal illnesses such as cancer, AIDS, and multiple sclerosis.

Others argue that even though the aggregate savings is small, the impact on an individual company or an individual family would be a powerful enough financial incentive to encourage the practice even where it was not intended.[9]

Many fear that patients would be more likely to consider physician-assisted suicide as a better alternative with the added bonus of saving their family money and the burden of prolonged, expensive care. Insurance companies may try to exclude life-saving or life-extending drugs and pressure people into thinking about the practice of physician assisted suicide.

Collins and the Suicide Exclusion

Health plans are permitted to include a suicide exclusion that would enable the plan administrator to deny claims associated with the suicide. In Collins v. Unum Life Insurance Co., 185 F. Supp.3d 860 (2016),[10] the Supreme Court held that "Unum reasonably interpreted the suicide exclusion to encompass insane suicide, [and that] Mr. Collins' sanity at death has no bearing on the outcome."[11]

The issue in this case involved a state law which stated that a suicide exclusion would be only be valid if liability was limited to an insured "who, whether sane or insane, dies by his own act."[12] Former Navy SEAL David M. Collins served this country for seventeen years, during which he was deployed to Iraq, Afghanistan, and Kuwait. He served in dangerous and stressful situations, many of which exposed him to enemy gunfire and blasts from mortar fire.[13]

Despite seeking treatment, Mr. Collins was found dead in the driver's seat of his car with a gunshot wound to his head on March 12, 2014. The death was ruled a suicide.[14] Prior to his death, Mr. Collins had been working for Blackbird Technologies, where he participated in an employee benefit plan that provided basic and supplemental life insurance through group policies funded and administered by Unum Life Insurance Company of America.[15]

When Mr. Collins died, his widow, Jennifer Mullen Collins, applied for benefits under both policies. Unum granted benefits under the basic policy, but denied benefits under the supplemental policy's suicide exclusion.[16] In addition, the Court held that it found "substantial evidence in the administrative record to support Unum's conclusion that the suicide exclusion applied."[17] As such, a health plan may be able to exclude the practice and not be held accountable for claims under the physician assisted suicide.

Option to Elect or Exclude Suicide

Plan administrators can take the position of either excluding assisted-suicide claims or paying them. They can allow the practice, and give the power to the patient to make the decision for themselves, and ultimately save the Plan money for care that the patient would have ultimately not wanted; or, they can exclude the practice and have the peace of mind that everything that should have been covered was covered.

Whether you're a broker, a health plan sponsor, third-party administrator, or reinsurer, this is something that should not only spike an interest, but also should make you uneasy if you have health plans in the six states that currently allow physician assisted suicide practices. Specialists in plan document drafting can provide assistance in reviewing your plan document and ensuring that the plan document addresses this issue directly to meet the needs of the group. ■

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2 42 U.S. Code § 18113 (2010)

3 AB-15 End of life.(2015-2016), Bill Text - ABX2-15 End of life. (2015), https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520162AB15 (last visited Aug 9, 2017).

4 Id.

5 Emily Bazar, Aid-In-Dying: Not So Easy Kaiser Health News (2017), http://khn.org/news/aid-in-dying-not-so-easy/ (last visited Aug 9, 2017).

6 29 U.S.C. 18 § 1001

7 Physician Assisted Suicide and Health Care Costs, Low Fat Diet Plan, http://lowfatdietplan.com/weight-loss-routine/end-of-life-care/physician-assisted-suicide-and-health-care-costs (last visited Aug 9, 2017).

8 Id.

9 Id.

10 Collins v. Unum Life Insurance Co., 185 F. Supp.3d 860 (2016)

11 Id. at 882

12 Id. at 871

13 Id. at 863

14 Id. at 864

15 Id. at 863

16 Id. at 865

17 Id. at 880