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BIOETHICS—“WHO DO THEY THINK THEY ARE?”¹:
PROTECTING TERMINALLY ILL PATIENTS AGAINST UNDUE
INFLUENCE BY INSURERS IN STATES WHERE MEDICAL AID
IN DYING IS LEGAL

Mary C. Deneen*

Medical aid in dying has been a controversial topic in the United States for decades. Many contentious issues have arisen with the recent enactment of various state medical aid in dying statutes. Are physicians violating their Hippocratic Oath to patients when prescribing lethal medications? Do insurance coverage limitations inappropriately steer patients toward medical aid in dying? Are terminally ill patients unduly influenced into prematurely ending their lives? Whether or not one agrees with these laws, there is an obvious need for certain protections in place to safeguard vulnerable patients from undue influence in states where medical aid in dying is legal.

This Note examines the history of medical aid in dying statutes and identifies the safeguards currently in place to protect patients from undue influence and coercion. While there are specific guidelines as to who may qualify for medical aid in dying, there have been instances of insurance companies denying patients coverage for life-prolonging treatment prescribed by their physicians but covering the costs of a medically assisted death. This Note argues that medical aid in dying statutes must regulate insurance companies in such a way that insurance payments for non-experimental treatments prescribed by one's physician may not be denied to any person who qualifies under an existing medical

1. Tim Christie, *A Gift of Treatment: When the Oregon Health Plan Fails to Cover a Cancer Drug, the Drugmaker Steps In*, THE REGISTER-GUARD (June 3, 2008), <http://projects.registerguard.com/turin/2008/jun/03/gift-treatment/> [https://perma.cc/U742-25ZL].

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aid in dying statute. Terminally ill patients deserve protection from undue influence and coercion, especially by their insurance providers.

INTRODUCTION

In 2008, Barbara Wagner, a sixty-four-year-old, low-income Oregon resident, learned that her lung cancer had returned after a two-year remission.² Wagner's last hope was a four-thousand-dollar per month drug that her doctor had prescribed,³ but the administrators of her health insurance, Lane Individual Practice Associates (LIPA), refused to cover.⁴ Instead, LIPA sent a letter to Wagner, informing her that it would cover only palliative care, including the medications used for medical aid in dying (MAiD),⁵ which cost about fifty dollars per dose.⁶ Wagner was devastated when she found out that LIPA would not cover the medication that might prolong her life: "To say to someone, we'll pay for you to die,

2. Andrew R. Page, Note, *What's the Cost of Living in Oregon These Days?—A Fresh Look at the Need for Judicial Protections in the Death with Dignity Act*, 22 REGENT U. L. REV. 233, 233 (2009).

3. Susan Donaldson James, *Death Drugs Cause Uproar in Oregon*, ABC NEWS (Aug. 6, 2008), <http://www.patientsrightscouncil.org/site/wp-content/uploads/2019/06/Death-Drugs-Cause-Uproar-in-Oregon-2008-08-06ABC.pdf>. Wagner's oncologist had prescribed her Tarceva, a pill taken once a day for the purpose of slowing the cancer growth and extending her life. Kenneth R. Stevens, *Oregon Rationing Cancer Treatment but Offering Assisted Suicide to Cancer Patients Paying to Die but not to Live*, PHYSICIANS FOR COMPASSIONATE CARE EDUC. FOUND. (June 6, 2008), <http://www.pccf.org/articles/art67.htm> [<https://perma.cc/CRN3-HSZH>].

4. See Page, *supra* note 2, at 233. LIPA administers the Oregon Health Plan in Wagner's county. The Oregon Health Plan is available to adults who earn up to 138% of the Federal Poverty Level. Currently, that level is approximately \$16,752 per year for a single person, or \$34,644 per year for a family of four. See *Do I Qualify?*, CAREOREGON, <https://www.careoregon.org/am-i-eligible/do-i-qualify-for-oregon-health-plan> [<https://perma.cc/9QPS-7KVK>].

5. See Christie, *supra* note 1. Opponents of this aid-in-dying process often refer to it as "physician-assisted suicide." See Browne Lewis, *A Deliberate Departure: Making Physician-Assisted Suicide Comfortable for Vulnerable Patients*, 70 ARK. L. REV. 1, 5 (2017). Proponents of the process frequently refer to it as "Death with Dignity." See generally DEATH WITH DIGNITY, <https://www.deathwithdignity.org> [<https://perma.cc/SV5X-L5N5>]. In order to remain neutral, this Note will refer to the process as "medical aid in dying," or "MAiD." MAiD is the medical process by which a terminally ill, mentally competent adult, who has a prognosis of six months or less to live, has the option to request a prescription for medication that he or she can self-administer through ingestion to shorten the dying process. See *Medical Aid in Dying Is Not Assisted Suicide, Suicide or Euthanasia*, COMPASSION AND CHOICES, <https://www.compassionandchoices.org/about-us/medical-aid-dying-not-assisted-suicide/> [<https://perma.cc/R9XR-C4JZ>].

6. James, *supra* note 3.

but not pay for you to live, it's cruel . . . I get angry. Who do they think they are?"⁷

Unfortunately, Barbara Wagner is not the only person to have endured such a denial of coverage.⁸ Randy Stroup, another Oregon resident, learned that LIPA would not cover the chemotherapy prescribed by his physician for his prostate cancer.⁹ Stroup received a letter from LIPA, explaining that it was unable to approve his physician's request, and that it would only cover comfort and palliative care, which included MAiD.¹⁰ Stroup was appalled at the denial of coverage: "No man is getting the right to offer money to have somebody else killed. . . . To think they could even put a price tag on my life or send me a letter saying they'll pay to kill me, but they won't pay to help me."¹¹ Fortunately, after Stroup went public with his story, the Oregon Health Plan reversed its initial decision and approved his chemotherapy.¹²

Although many health insurance plans cover palliative care,¹³ the medical profession generally has not handled end-of-life care effectively, including pain management.¹⁴ Medical providers tend to over-utilize hospital-based resources at the end of life, often without any benefit to terminal patients.¹⁵ This over-utilization of care results in dying patients receiving costly life-prolonging treatment, even when it is highly likely that increased survival is "limited or non-existent."¹⁶ The medical profession's lack of appropriate end-of-life care has increased support of

7. Christie, *supra* note 1. Ultimately, the manufacturers of Tarceva offered the medication to Wagner at no cost. However, the drugs were unsuccessful, and Wagner died after a hard-fought battle against her lung cancer. *The Barbara Wagner Story*, MARYLAND AGAINST PHYSICIAN ASSISTED SUICIDE (Nov. 2, 2015), <https://stopassistedsuicidemd.org/the-barbara-wagner-story/> [https://perma.cc/ZGK9-TRBP].

8. See James, *supra* note 3.

9. Stevens, *supra* note 3.

10. HOW TO DIE IN OREGON (Cinedigm 2011). This documentary follows the stories of various individuals diagnosed with terminal illnesses in states where MAiD is legal. The documentary details the individuals' thought processes and reasons behind their decisions to take, or not take, the lethal medications. Randy Stroup is one of the individuals interviewed about his experience with terminal cancer and Oregon's Death with Dignity Act. *Id.*

11. *Id.*

12. *Id.* However, even after receiving chemotherapy treatment, Stroup died from his prostate cancer four weeks later. *Id.*

13. Palliative care refers to medical care intended to alleviate symptoms and stress associated with illness. See Barbara A. Noah & Neal R. Feigenson, *Avoiding Overtreatment at the End of Life: Physician-Patient Communication and Truly Informed Consent*, 36 PACE L. REV. 736, 742-43 n.15 (2016).

14. DEREK HUMPHRY & MARY CLEMENT, FREEDOM TO DIE: PEOPLE, POLITICS, AND THE RIGHT-TO-DIE MOVEMENT 48 (1998).

15. Noah & Feigenson, *supra* note 13, at 740.

16. *Id.* at 741.

the right to die movement.¹⁷ Both hospice care and MAiD give patients options for maintaining control and dignity at the end of their lives.¹⁸

Maintaining control and dignity at the end of life is central to the MAiD movement.¹⁹ The main motivating factor surrounding a patient's decision to participate in MAiD tends to be the individual's desire to take back control and to die on his or her own terms.²⁰ MAiD laws "stem from the basic idea that it is the terminally ill people, not government and its interference, politicians and their ideology, or religious leaders and their dogma, who should make their end-of-life decisions and determine how much pain and suffering they should endure."²¹ However, whether or not terminally ill patients truly have full control over these end-of-life decisions is up for debate.²²

Although the United States Supreme Court has ruled that "physician-assisted suicide" is not a liberty interest protected under the Constitution,²³ the states are free to decide whether or not to legalize this process.²⁴ There

17. HUMPHRY & CLEMENT, *supra* note 14, at 49.

18. *Id.* at 51–52.

19. See CENTER FOR HEALTH STATISTICS, OREGON HEALTH AUTHORITY, OREGON DEATH WITH DIGNITY ACT: 2018 DATA SUMMARY 1, 6 (2019) [hereinafter 2018 DATA SUMMARY], <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year21.pdf> [https://perma.cc/W6XX-URSP]; see also Liz Szabo, "Death with Dignity" Laws and the Desire to Control How One's Life Ends, WASH. POST (Oct. 24, 2016), https://www.washingtonpost.com/national/health-science/death-with-dignity-laws-and-the-desire-to-control-how-ones-life-ends/2016/10/24/6882d1e6-9629-11e6-bc79-af1cd3d2984b_story.html?utm_term=.beccbf9a4782 [https://perma.cc/6V3J-96K4]. "Those who have actually used these [MAiD] laws have been far more concerned about controlling the way they exit the world than about controlling pain." *Id.*

20. 2018 DATA SUMMARY, *supra* note 19, at 6.

21. *Death with Dignity Acts*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/learn/death-with-dignity-acts/> [https://perma.cc/599G-HGA3].

22. See *infra* Part II.

23. See *Washington v. Glucksberg*, 521 U.S. 702, 703 (1997).

24. See Steven B. Datlof, *Beyond Washington v. Glucksberg: Oregon's Death with Dignity Act Analyzed from Medical and Constitutional Perspectives*, 14 J.L. & HEALTH 23, 25 (1999–2000). In 2001, U.S. Attorney General John Ashcroft attempted to block Oregon's Death with Dignity Act by issuing his "Ashcroft Directive," which authorized "DEA agents to investigate and prosecute doctors who prescribe[d] federally controlled drugs to help terminally ill patients die." *Oregon Death with Dignity Act: A History*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/oregon-death-with-dignity-act-history/> [https://perma.cc/QWM4-EF3F]. However, in 2004, the Ninth Circuit Court of Appeals ruled in favor of Oregon's MAiD statute, holding that the Ashcroft Directive was unlawful and unenforceable because "it violate[d] the plain language of the CSA, contravene[d] Congress' express legislative intent, and overstep[ped] the bounds of the [A.G.'s] statutory authority." *Id.* (quoting *Oregon v. Ashcroft*, 368 F.3d 1118, 1120 (9th Cir. 2004)).

are currently nine jurisdictions²⁵ in the United States that have legalized MAiD through legislation.²⁶ Of these nine jurisdictions, only one has included any provision that attempts to protect individuals against undue influence specifically by insurers.²⁷ California's End of Life Option Act prevents insurance carriers from informing patients about the availability of MAiD medications unless specifically requested by the patients or their physicians.²⁸

While this is an important and necessary provision, states with MAiD statutes need to go even further in protecting vulnerable, terminally ill patients from undue influence and coercion by insurance providers.²⁹ The terminally ill may be unduly influenced by insurers based on their desires to avoid high treatment costs at the end of their lives;³⁰ any undiagnosed depression that is impairing their judgment;³¹ or their wishes to avoid being a burden on their families and caretakers.³² Due to these vulnerabilities, states need to include specific provisions within their MAiD statutes to protect against potential coercion by insurers.³³

Such a provision should require that no publicly funded health insurer issuing a policy that covers MAiD medications shall exclude coverage of

25. CAL. HEALTH & SAFETY CODE § 443 (West 2019); COLO. REV. STAT. § 25-48-101 (West 2019); D.C. CODE § 7-661 (West 2019); HAW. REV. STAT. ANN. § 19-327L (West 2019); ME. REV. STAT. ANN. tit. 22, § 2140 (2019); N.J. STAT. ANN. § 26:16-1 (West 2019); OR. REV. STAT. § 127.800 (West 2018); VT. STAT. ANN. tit. 18, § 5281 (West 2019); WASH. REV. CODE § 11.125.420 (West 2019).

26. MAiD was legalized in Montana by a Montana Supreme Court ruling. *See Baxter v. State*, 224 P.3d 1211, 1239 (Mont. 2009) (holding that physician aid in dying provided to terminally ill, mentally competent adult patients is not against public policy).

27. CAL. HEALTH & SAFETY CODE § 443 (West 2019).

28. *Id.* at § 443.13(c).

29. *See, e.g., Fred R. Garzino, Undue Economic Influence on Physician-Assisted Suicide*, 1 DEPAUL J. HEALTH CARE L. 537, 561 (1997) ("If sufficiently large numbers of these patients can be persuaded by managed-care physicians to pursue or choose [MAiD] and die earlier than they might otherwise, managed-care organizations will undoubtedly enhance their profits.").

30. *See Kathy L. Cerminara & Barbara A. Noah, Removing Obstacles to a Peaceful Death*, 25 ELDER L.J. 197, 200 (2018) ("Medicare data clearly demonstrates that the United States spends substantial health care dollars in the last year and, especially, in the last weeks of life. Approximately one-third of medical expenses for the last year of life are spent in the final month . . .").

31. Datlof, *supra* note 24, at 28.

32. *See Terukazu Akazawa et al., Self-Perceived Burden in Terminally Ill Cancer Patients: A Categorization of Care Strategies Based on Bereaved Family Members' Perspectives*, 40 J. PAIN & SYMPTOM MGMT. 224, 225 (2010), [https://www.jpmsjournal.com/article/S0885-3924\(10\)00311-8/pdf](https://www.jpmsjournal.com/article/S0885-3924(10)00311-8/pdf) (last visited Jan. 3, 2020).

33. *See generally* Ryan Anderson, *Purported Safeguards in Physician-Assisted Suicide are Ripe for Abuse*, THE HERITAGE FOUNDATION (Apr. 7, 2015), <https://www.heritage.org/health-care-reform/report/purported-safeguards-physician-assisted-suicide-are-ripe-for-abuse> [<https://perma.cc/7RV4-XXBZ>].

non-experimental, effective treatment that has been prescribed by a patient's physician.³⁴ Providing this specific language within states' MAiD statutes will prevent insurers from denying prescribed, life-prolonging treatment but offering to pay to end one's life, as was seen in the unfortunate cases of Barbara Wagner and Randy Stroup.³⁵

Part I of this Note reviews the history and background of states' enactment of MAiD statutes, and Part II outlines the ways in which terminally ill patients are vulnerable and lack complete control over their end-of-life decisions. Part III explains why insurance providers often deny terminally ill patients certain treatment coverage and proposes the necessary provisions that states' MAiD statutes should include in order to protect terminally ill patients against undue influence and coercion by health insurance providers.

I. THE HISTORY OF MEDICAL AID IN DYING STATUTES IN THE UNITED STATES

The advent of medical aid in dying and the "right to die" movement has had a long and contentious history in the United States.³⁶ Whether through legislation, federal and state constitutional litigation, statutory litigation, or other means, proponents of MAiD have been fighting for ways to legalize the process for decades.³⁷ The MAiD battle continues to be fought in the courts and amongst the public at large.³⁸ The following section briefly outlines the history of MAiD and where the United States currently stands in this fight for "death with dignity."

A. *Is the "Right to Die with Dignity" a Fundamental Right Protected by the Constitution?*

The first major case to consider the right to withdraw treatment concerned Karen Ann Quinlan, a young woman who was left in a persistent vegetative state in 1975.³⁹ Quinlan's father sought the New

34. "Non-experimental" and "effective" treatment are defined in the text of the full proposed provision. See *infra* notes 221–23.

35. See *supra* notes 1–11 and accompanying text.

36. See generally NEIL M. GORSUCH, *THE FUTURE OF ASSISTED SUICIDE AND EUTHANASIA 1* (Robert P. George ed., 2006). "Whether to permit assistance in suicide and euthanasia is among the most contentious legal and public policy questions in America today." *Id.*

37. See generally Thaddeus Mason Pope, *Legal History of Medical Aid in Dying: Physician Assisted Death in U.S. Courts and Legislatures*, 48 N.M. L. REV. 267 (2018).

38. Lewis, *supra* note 5, at 5.

39. See generally *In re Quinlan*, 355 A.2d 647 (N.J. 1976), *receded from by In re Conroy*, 486 A.2d 1209, 1230 (N.J. 1985) (finding that the court erred in disregarding evidence of

Jersey Superior Court's appointment as her guardian so that he could make the decision to remove her respirator.⁴⁰ After being denied this request by the Superior Court, Quinlan's father appealed to the Supreme Court of New Jersey.⁴¹ The Supreme Court of New Jersey's decision centered on Quinlan's "independent right of choice" and held that her right to privacy could be asserted by her guardian under the "peculiar circumstances" of the case.⁴² The court ruled that, if competent, Quinlan would have the right to refuse treatment under her fundamental right to privacy.⁴³

The first "right to die" case considered by the Supreme Court of the United States concerned Nancy Cruzan, a young woman who was severely injured in an automobile accident that left her in a permanently vegetative state.⁴⁴ After Cruzan was determined to have "virtually no chance of regaining her mental faculties," her parents asked the hospital to terminate her life support, which would cause her death.⁴⁵ The hospital refused to do so without court approval.⁴⁶ While the Supreme Court affirmed the Missouri ruling requiring clear and convincing evidence that the patient would have refused precisely the life-prolonging intervention that she was receiving, under precisely the medical condition that she found herself in,⁴⁷ the Court also established a right to die for mentally competent individuals under certain circumstances.⁴⁸

Supporters of MAiD have argued that *Cruzan's* recognition of a patient's right to refuse life-sustaining treatment effectively established the "right to die with dignity."⁴⁹ However, on June 26, 1997, the Supreme

statements that Quinlan made to friends "concerning artificial prolongation of the lives of others who were terminally ill").

40. *Id.* at 651.

41. *Id.* at 647.

42. *Id.* at 664.

43. *Id.* at 663.

44. *See generally* *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990).

45. *Id.* at 267–68.

46. *Id.* at 268.

47. *See* *Cruzan by Cruzan v. Harmon*, 760 S.W.2d 408, 426–27 (Mo. 1988), *aff'd sub nom.* *Cruzan v. Dir., Missouri Dep't of Health*, 497 U.S. 261 (1990). Missouri's highest court had ultimately held that Cruzan's statements to her roommates while she was alive did not meet the clear and convincing evidence requirement that she preferred death to existence in a vegetative state. *Id.*

48. *See* *Cruzan*, 497 U.S. at 279 ("[W]e assume that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition."). *See also* Datlof, *supra* note 24, at 35.

49. *See* *Cruzan*, 497 U.S. at 309 (Brennan, J., dissenting) ("The right to be free from unwanted medical attention is a right to evaluate the potential benefit of treatment and its possible consequences according to one's own values and to make a personal decision whether

Court decided two cases: *Washington v. Glucksberg*⁵⁰ and *Vacco v. Quill*,⁵¹ both of which addressed the right to assistance in committing suicide.⁵² In each case, the Court found that the state's prohibitions on assisted suicide did not violate the Fourteenth Amendment.⁵³ The Court distinguished the constitutionally protected right to refuse life-sustaining treatment from the right to assisted suicide.⁵⁴ However, "while the Court upheld [each] law prohibiting assisted suicide, this [did] not [necessarily] mean that the Court would strike down a state law permitting assisted suicide."⁵⁵

In *Glucksberg*, Chief Justice Rehnquist "emphasized the need to carefully formulate the liberty interest at issue."⁵⁶ He noted that "extending constitutional protection to an asserted right or liberty interest . . . place[s] the matter outside the arena of public debate and legislative action."⁵⁷ The Court therefore must "'exercise the utmost care whenever [it] [is] asked to break new ground in [a particular] field,' lest the liberty protected by the Due Process Clause be subtly transformed into the policy preferences of the Members of [the] Court."⁵⁸ Justice O'Connor, in her concurring opinion, agreed:

There is no reason to think the democratic process will not strike the proper balance between the interests of terminally ill, mentally competent individuals who would seek to end their suffering and the State's interests in protecting those who might seek to end life mistakenly or under pressure. As the Court recognizes, States are presently undertaking extensive and serious evaluation of physician-assisted suicide and other related issues. In such circumstances, "the . . . challenging task of crafting appropriate procedures for

to subject oneself to the intrusion."). Justice Stevens noted that, "Choices about death touch the core of liberty." *Id.* at 343 (Stevens, J., dissenting). See also Datlof, *supra* note 24, at 34.

50. 521 U.S. 702 (1997).

51. 521 U.S. 793 (1997).

52. James E. Dallner & D. Scott Manning, *Death with Dignity in Montana*, 65 MONT. L. REV. 309, 317 (2004).

53. See *Vacco*, 521 U.S. at 797 (holding that New York's prohibition on assisting suicide did not violate the Equal Protection Clause of the Fourteenth Amendment); see also *Glucksberg*, 521 U.S. at 728 (holding that "the asserted 'right' to assistance in committing suicide is not a fundamental liberty interest protected by the Due Process Clause").

54. Datlof, *supra* note 24, at 34.

55. *Id.* at 37.

56. *Id.*

57. *Glucksberg*, 521 U.S. at 720.

58. *Id.* (quoting *Moore v. City of East Cleveland*, 431 U.S. 494, 502 (1977)) (internal citation omitted).

safeguarding . . . liberty interests is entrusted to the ‘laboratory’ of the States . . . in the first instance.”⁵⁹

Thus, the decision of whether to enact MAiD statutes has been left to the states.⁶⁰ The Supreme Court has shown “great willingness to allow the states to determine their own policies regarding end-of-life decision making through debate and legislation.”⁶¹ Nine jurisdictions have opted to enact such medical aid in dying statutes.⁶²

B. *Oregon’s Death with Dignity Act*

Oregon’s Death with Dignity Act (DWDA),⁶³ the oldest MAiD statute in the United States, has been in effect for over twenty years.⁶⁴ Oregon enacted its statute in 1997, “allowing terminally ill Oregonians to end their lives through the voluntary self-administration of a lethal dose of medication, expressly prescribed by a physician for that purpose.”⁶⁵ Oregon’s DWDA was a citizens’ initiative passed twice by Oregon voters, once in 1994 and again in 1997.⁶⁶ The Act went into effect shortly after its affirmation in 1997, and implementation began in 1998.⁶⁷ In 2006, the Supreme Court confirmed that Oregon physicians can prescribe life-ending medication under the DWDA without penalty from the Attorney General.⁶⁸ As of 2018, a total of 2,217 people received written

59. *Id.* at 737 (quoting *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261 (1990)) (alteration in original) (internal citations omitted).

60. *Id.*

61. Datlof, *supra* note 24, at 44.

62. *See supra* note 25 (detailing the jurisdictions with MAiD statutes).

63. OR. REV. STAT. § 127.800 (West 2018).

64. *Oregon*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/states/oregon/> [<https://perma.cc/7KSE-G2XX>].

65. *Frequently Asked Questions about the Death with Dignity Act*, OREGON HEALTH AUTHORITY 1 (revised Feb. 27, 2019), <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/faqs.pdf> [<https://perma.cc/265X-L6HH>] [hereinafter *Frequently Asked Questions*].

66. *Id.*

The first time was in a general election in November 1994 when it passed by a margin of 51% to 49%. An injunction delayed implementation of the DWDA until it was lifted on October 27, 1997. In November 1997, a measure was placed on the general election ballot to repeal the DWDA. Voters chose to retain the DWDA by a margin of 60% to 40%.

Id.

67. *Oregon*, *supra* note 64.

68. *See Gonzales v. Oregon*, 546 U.S. 243, 249 (2006) (holding that the Controlled Substances Act does not “prohibit doctors from prescribing regulated drugs for use in physician-assisted suicide, notwithstanding a state law permitting the procedure”).

prescriptions under the DWDA and 1,459 have died from ingesting the lethal medications since the law was passed in 1997.⁶⁹

In order to qualify for MAiD in Oregon, a patient must be at least eighteen years old, a resident of Oregon, mentally capable, and diagnosed with a terminal illness with a prognosis of six months or less to live.⁷⁰ After meeting this criteria, a patient must then take several steps to actually obtain the prescription, including: “making multiple requests for the prescription (separated by at least fifteen days); consulting with multiple physicians; consulting with a psychologist to screen for mental health issues; and attending an informational session about alternatives to end-of-life care, including hospice and palliative care.”⁷¹ However, studies indicate that “[f]ew patients have been referred for psychiatric assessment.”⁷² Between 1998 and 2016, only fifty-seven out of 1,127 patients (5.1%) who requested MAiD medications under the Oregon DWDA were referred to a psychiatrist for mental health evaluation.⁷³ “[Psychiatrist Linda] Ganzini and [her] colleagues have published the only articles looking at the impact of depression in Oregon [patients’] requests for [MAiD medications] and the attitudes of Oregon psychiatrists.”⁷⁴ Dr. Ganzini found that almost all (ninety-five percent) of the psychiatrists “were ‘confident’ that they could determine whether a mental disorder was impacting the decision for [MAiD] in the context of a long term treatment relationship, but only [six] percent were ‘very confident’ that they could make this assessment in a single evaluation.”⁷⁵

Dr. Ganzini’s 2008 study of fifty-eight Oregonians who requested MAiD found that three of the patients who received (and died from) a prescription for the lethal drug under the DWDA met the criteria for depression.⁷⁶ The study concluded that, although the majority of patients

69. 2018 DATA SUMMARY, *supra* note 19, at 5.

70. *Frequently Asked Questions*, *supra* note 65, at 1.

71. Cody Bauer, Note, *Dignity in Choice: A Terminally Ill Patient’s Right to Choose*, 44 MITCHELL HAMLINE L. REV. 1024, 1030 (2018).

72. COUNCIL ON PSYCHIATRY & LAW, AM. PSYCHIATRIC ASS’N, APA RESOURCE DOCUMENT ON PHYSICIAN ASSISTED DEATH, 10 (2017) [hereinafter APA RESOURCE DOCUMENT], https://www.psychiatry.org/File%20Library/Psychiatrists/Directories/Library-and-Archive/resource_documents/2017-Resource-Document-on-Physician-Assisted-Death.pdf (last visited Jan. 3, 2020).

73. *Id.*

74. *Id.* at 10–11.

75. *Id.* at 11 (citing Linda Ganzini et al., *Attitudes of Oregon Psychiatrists Toward Physician-Assisted Suicide*, 153 AM. J. PSYCHIATRY 1469, 1469–75 (1996)).

76. See Linda Ganzini, Elizabeth R. Goy, & Steven K. Dobscha, *Prevalence of Depression and Anxiety in Patients Requesting Physicians’ Aid in Dying: Cross Sectional Survey*, 337 BMJ 1682 (2008), <https://www.bmj.com/content/337/bmj.a1682> [<https://perma.cc/39YQ-TTVW>];

who request MAiD do not have a depressive disorder, “the current practice of legalised aid in dying may allow some potentially ineligible patients to receive a prescription for a lethal drug.”⁷⁷ This conclusion supports the push towards “more active and systematic screening” to determine the need for additional professional assessment.⁷⁸

During 2018, 249 people received prescriptions for lethal medications in Oregon, and 168 people died from ingesting these drugs.⁷⁹ There is a discrepancy between these numbers because the patients ultimately hold the decision as to whether they wish to ingest the medication;⁸⁰ some patients change their minds, some die naturally, and some are unable to physically swallow the drugs.⁸¹ “Of the 168 DWDA deaths during 2018, most patients (79.2%) were aged [sixty-five] years or older. The median age at death was [seventy-four] years. As in previous years, decedents were commonly white (97.0%) and many patients were well educated (47.3% had at least a baccalaureate degree).”⁸² Virtually all decedents (99.3%) had some form of health insurance.⁸³ According to the Oregon Health Authority report, the most frequently reported end-of-life concerns for terminally ill patients were: their decreasing ability to participate in activities that made life enjoyable, their loss of autonomy, and their loss of dignity.⁸⁴

Oregon’s DWDA is considered a huge success by proponents of the MAiD movement.⁸⁵ Statistical reporting has allowed an unbiased assessment of Oregon’s experience with MAiD, and data has shown that the statute’s requirements have largely been followed.⁸⁶ Fears that underprivileged groups would be unduly coerced into MAiD have been

see also AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 156 (5th ed. 2013) (outlining the criteria for depression).

77. Ganzini et al., *supra* note 76, at 3.

78. APA RESOURCE DOCUMENT, *supra* note 72, at 11.

79. 2018 DATA SUMMARY, *supra* note 19, at 5.

80. *Frequently Asked Questions*, *supra* note 65, at 1–2 (emphasizing the “voluntary self-administration” of the lethal medication).

81. See Lynn Terry, *20 Years of Oregon’s Death with Dignity Act*, THE OREGONIAN (Oct. 27, 2017), https://www.oregonlive.com/health/2017/10/20_years_of_oregons_death_with.html [<https://perma.cc/8HMF-YZP9>].

82. 2018 DATA SUMMARY, *supra* note 19, at 6.

83. *Id.* Most patients had Medicare or Medicaid insurance (66.9%), while some had private insurance (32.4%). *Id.*

84. *Id.*

85. See *Oregon*, *supra* note 64 (asserting that the law “has worked as intended and without flaws or any evidence of abuse or coercion”).

86. However, during 2018, “two physicians were referred to the Oregon Medical Board for failure to comply with DWDA requirements.” See 2018 DATA SUMMARY, *supra* note 19, at 3.

unfounded,⁸⁷ and worries that Oregon would become a “suicide center” for the terminally ill have not been substantiated.⁸⁸ However, these statistics do not account for subtle acts of undue influence and coercion, such as when insurance providers deny coverage for life-prolonging treatment but cover the cost of MAiD medications.⁸⁹ Such coverage practices do not send encouraging messages to terminally ill patients looking for ways to prolong their lives.

C. *Medical Aid in Dying Across the United States*

Of the nine jurisdictions that have enacted MAiD statutes,⁹⁰ most have modeled their laws after Oregon’s DWDA.⁹¹ Washington was the first state to follow Oregon’s lead, enacting its DWDA by ballot initiative in 2009.⁹² Like in Oregon, statistics have shown that most DWDA decedents in Washington have been white, educated, and insured.⁹³ In 2017, the Washington legislature proposed a bill to add “the treatment for the purpose of cure and the treatment for the purpose of extending the patient’s life” to the possible alternatives the attending physician would have to inform a requesting patient about under the Washington DWDA.⁹⁴ The bill passed in the Senate on March 7, 2017, and it was reintroduced on January 8, 2018.⁹⁵

87. *Id.* at 6 (where most DWDA patients have been white, educated, and insured).

88. *Id.* at 5. In the twenty-plus years that Oregon’s DWDA has been in effect, only 2,217 MAiD prescriptions have been written. *Id.* See also Courtney S. Campbell, *Ten Years of “Death with Dignity”*, THE NEW ATLANTIS 33, 36 (2008), https://www.thenewatlantis.com/docLib/20081016_TNA22Campbell.pdf [<https://perma.cc/N6SL-Z69U>].

89. See *supra* notes 2–11 and accompanying text; see also *infra* Part II.

90. See *supra* note 25 (detailing the jurisdictions with MAiD statutes).

91. See Pope, *supra* note 37, at 280; see also Anne Marie Su, Note, *Physician Assisted Suicide: Debunking the Myths Surrounding the Elderly, Poor, and Disabled*, 10 HASTINGS RACE AND POVERTY L.J. 145, 163–65 (2013) (comparing specific provisions from Oregon’s DWDA to Washington’s DWDA).

92. See WASH. REV. CODE § 11.125.420 (West 2019); see also Pope, *supra* note 37, at 280.

93. See *Washington State 2016 Death with Dignity Act Report*, WASH. STATE DEP’T OF HEALTH 1, 6 tbl. 1 (Sept. 2017), <https://www.doh.wa.gov/Portals/1/Documents/Pubs/422-109-DeathWithDignityAct2016.PDF> [<https://perma.cc/RR65-7ESZ>] [hereinafter *Washington State Report*] (finding that of the 239 participants who died in 2016, ninety-seven percent were white, sixty-seven percent had some form of higher education, and ninety-two percent had some type of health insurance).

94. See S.B. 5433, 65th Cong. (Wash. 2017); see also *Washington*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/states/washington/> [<https://perma.cc/PZP9-3DUY>].

95. See *Washington*, *supra* note 94.

In 2013, Vermont became the third state to legalize MAiD, this time through legislation.⁹⁶ Vermont's Patient Choice and Control at the End of Life Act includes many of the same provisions as Oregon's: requiring consultations with more than one physician, separate written requests, and physician protection from prescribing these lethal medications.⁹⁷ In 2016, the Vermont Alliance for Ethical Healthcare initiated a lawsuit challenging the Act, claiming that physicians morally opposed to MAiD were being forced "to counsel their patients for physician-assisted suicide."⁹⁸ However, the district court found for the defendant, holding that the Act clearly stated that physicians are under no obligation to participate in MAiD.⁹⁹

In October 2015, California became the fourth state to legalize MAiD after passing its End of Life Option Act.¹⁰⁰ The California Act is virtually identical to MAiD statutes in Oregon, Washington, and Vermont.¹⁰¹ In 2018, the California Department of Health released its 2017 report on the use of the End of Life Option Act.¹⁰² This report yielded results similar to those in Oregon and Washington.¹⁰³ The Colorado legislature passed its End of Life Options Act in 2016,¹⁰⁴ and Washington, D.C.'s DWDA became effective in February 2017.¹⁰⁵ Hawaii's Our Care, Our Choice Act went into effect on January 1, 2019,¹⁰⁶ and New Jersey passed the Aid

96. See VT. STAT. ANN. tit. 18, § 5281 (West 2019); see also Pope, *supra* note 37, at 280–81.

97. Bauer, *supra* note 71, at 1034.

98. Complaint at 2, *Vt. All. for Ethical Healthcare, Inc. v. Hoser*, 274 F. Supp. 3d 227 (D. Vt. 2017) (No. 5:16-cv-205), 2016 WL 3971010.

99. *Vt. All. for Ethical Healthcare, Inc. v. Hoser*, 274 F. Supp. 3d 227, 234 (D. Vt. 2017) ("Section 5286 permits a health care facility to prohibit its physicians from writing prescriptions for lethal medication intended for terminally-ill patients in residence. This provision authorizes an entire hospital, such as a religiously-based institution, to opt out of participating in assisted suicide." (internal citations omitted)).

100. See CAL. HEALTH & SAFETY CODE § 443 (West 2019).

101. See Pope, *supra* note 37, at 281; see generally CAL. HEALTH & SAFETY CODE § 443 (West 2019).

102. See generally CAL. DEP'T OF PUB. HEALTH, CALIFORNIA END OF LIFE OPTION ACT 2017 DATA REPORT 1 (June 2018), <https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/2017EOLADataReport.pdf> [<https://perma.cc/JU96-K439>].

103. *Id.* at 6. Most MAiD participants were white (88.9%), educated (54.8% had some form of higher-education degree), and had some known form of health insurance (84.3%). *Id.*

104. COLO. REV. STAT. § 25-48-101 (West 2019).

105. D.C. CODE § 7-661 (West 2019).

106. HAW. REV. STAT. ANN. § 19-327L (West 2019).

in Dying for the Terminally Ill Act on April 12, 2019.¹⁰⁷ Most recently, Maine passed its Death with Dignity Act on June 12, 2019.¹⁰⁸

All nine jurisdictions with MAiD statutes provide similar provisions and outline detailed requirements for individuals who may obtain the lethal medication.¹⁰⁹ Under each law, a patient must be at least eighteen years of age, be mentally competent to make the decision, have a terminal disease, and be free from undue influence or coercion.¹¹⁰ Each MAiD statute requires that physicians refer patients who may be suffering from a mental disorder or depression to a licensed psychiatrist or psychologist.¹¹¹ However, as discussed previously, California's MAiD statute is the only MAiD statute to include a specific provision against undue influence by insurers.¹¹² Although there are many safeguards already in place to protect terminally ill patients, more needs to be done to protect against undue influence by patients' insurers.¹¹³

II. TERMINALLY ILL PATIENTS ARE EXPOSED TO UNDUE INFLUENCE AND COERCION

Before any jurisdictions in the United States permitted MAiD, the Supreme Court worried that its legalization would lead to involuntary euthanasia or abuses by physicians of vulnerable patients.¹¹⁴ However, these concerns have generally been unfounded.¹¹⁵ The Oregon statute requires seven different steps in order to obtain a MAiD prescription from a physician, and more than one physician is involved in the process.¹¹⁶ Yet, although there is little evidence of any obvious coercion, there are subtle ways terminally ill patients are exposed to pressure to prematurely

107. N.J. STAT. ANN. § 26:16-1 (West 2019).

108. ME. REV. STAT. ANN. tit. 22, § 2140 (2019).

109. See *supra* note 25 (detailing the jurisdictions with MAiD statutes).

110. See, e.g., OR. REV. STAT. § 127.800 (West 2018).

111. See, e.g., D.C. CODE § 7-661.04(a)–(b) (West 2019).

If, in the opinion of the attending physician or the consulting physician, a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment, either physician shall refer the patient to counseling. No covered medication shall be prescribed until the patient receives counseling and the psychiatrist or psychologist performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.

Id.

112. See CAL. HEALTH & SAFETY CODE § 443.13(c) (West 2019).

113. See, e.g., *supra* notes 2–11 and accompanying text.

114. See Su, *supra* note 91, at 146.

115. *Id.* at 175. Data from Oregon and Washington show that careful monitoring and safeguards are in place to protect patients from involuntarily ending their lives. *Id.*

116. Bauer, *supra* note 71, at 1030.

end their lives.¹¹⁷ Take Barbara Wagner and Randy Stroup, for example.¹¹⁸ LIPA's letters could have influenced them to qualify for MAiD, had they felt out of options after their insurance company's denial of coverage.¹¹⁹ Part II outlines the ways in which vulnerable patients may be unduly influenced into obtaining a MAiD prescription, including the costs of end-of-life care, the denial of certain life-prolonging treatments by health insurance providers, and the prevalence of depression in terminally ill patients.

A. *The Substantial Costs of End-of-Life Care*

Expenses for end-of-life care are extremely high.¹²⁰ Medicare data shows that substantial health care expenditures are made in the last year of life, and especially in the last weeks of life.¹²¹ Approximately one-third of medical expenses for the last year of life are spent in the final month, with high-intensity therapies and other interventions accounting for nearly eighty percent of these costs.¹²² In 2009, Medicare paid fifty-five *billion* dollars for doctor and hospital bills alone during the last two months of patients' lives.¹²³ "[I]t has been estimated that [twenty] to [thirty] percent of these medical expenditures may have had no meaningful impact."¹²⁴ "[O]pponents of the legalization of [MAiD] argue that, in order to reduce health care costs, physicians and insurance companies may aggressively encourage elderly and disabled patients to request prescriptions for the lethal dose of medication."¹²⁵

In 2015, the Centers for Medicare and Medicaid Services (CMMS) released a potential plan to "reimburse physicians and other qualified health professionals . . . for having one or more discussions with Medicare patients and families about advance care planning."¹²⁶ Opponents of this counseling option argued that these payments would create "a bias against life-prolonging treatment and could exert pressure on some people to

117. See *supra* notes 2–11 and accompanying text.

118. See *supra* notes 2–11 and accompanying text.

119. See *supra* notes 2–11 and accompanying text.

120. See Lewis, *supra* note 5, at 39.

121. See Baohui Zhang et al., *Health Care Costs in the Last Week of Life: Associations with End-of-Life Conversations*, 169 ARCHIVES INTERNAL MED. 480, 482–84 (2009).

122. *Id.*

123. See Kerry Shannon, *The Long (and Expensive) Good-Bye*, FTI J. (Mar. 2014), <http://www.ftijournal.com/article/the-long-and-expensive-good-bye> [<https://perma.cc/F85K-C99A>]; see also *The Cost of Dying*, CBS NEWS (Nov. 19, 2009), <https://www.cbsnews.com/news/the-cost-of-dying/> [<https://perma.cc/SA7B-B8GC>].

124. See *The Cost of Dying*, *supra* note 123.

125. Lewis, *supra* note 5, at 41.

126. Noah & Feigenson, *supra* note 13, at 752–53.

forego medical treatment in order to reduce costs.”¹²⁷ CMMS approved payment for voluntary end-of-life counseling in 2016.¹²⁸ Medicare reimburses providers about eighty-six dollars per initial half-hour office visit, and about seventy-five dollars for each additional end-of-life counseling session.¹²⁹

Many low-income individuals rely on state Medicaid programs for health insurance, and, as a result of the Affordable Care Act, the number of economically disadvantaged people relying on Medicaid has increased. This increase will require states to look for ways to reduce costs, and opponents of MAiD fear that “Medicaid programs and private insurance companies may see the [MAiD] practice as a cost-saving measure. . . . [T]erminally-ill patients with limited financial resources may be steered towards [MAiD].”¹³⁰

In 2014, the Institute of Medicine released a report, calling the United States’ system of caring for the terminally ill “largely broken” and “poorly designed to meet the needs of patients,” and pointing out the “need of major reorientation and restructuring” of Medicare and Medicaid.¹³¹ Opponents of MAiD argue that mixing cost-cutting “treatment” such as MAiD with a “broken, cost-conscious health care system” is dangerous to those whose health care costs are the highest—namely, the disabled, the elderly, and the terminally ill.¹³²

The terminally ill face extraordinarily high treatment costs.¹³³ “Even with insurance, cancer patients often face unpredictable or unmanageable costs including high co-insurance, high deductibles, having to seek out-of-network care, and needing a treatment that is not covered by their

127. *Id.* at 753.

128. See 575K Medicare Beneficiaries Participated in End-of-Life Counseling Last Year, *Federal Data Show*, ADVISORY BOARD (Aug. 16, 2017, 8:00 AM), <https://www.advisory.com/daily-briefing/2017/08/16/medicare-eol> [https://perma.cc/9P82-XTLC].

129. *Id.*

130. *Id.*

131. See INSTITUTE OF MEDICINE, DYING IN AMERICA: IMPROVING QUALITY AND HONORING INDIVIDUAL PREFERENCES NEAR THE END OF LIFE (2014); see also Diane Coleman, *Who’s Really Hurt by Assisted Suicide*, CNN (Nov. 4, 2014), http://www.cnn.com/2014/11/03/opinion/coleman-assisted-suicide/index.html?hpt=hp_t4 [https://perma.cc/Q9RS-G54V].

132. Coleman, *supra* note 131.

133. See Elaine K. Howley, *Why Is Cancer Treatment So Expensive?*, U.S. NEWS (June 20, 2018, 10:14 AM), <https://health.usnews.com/health-care/patient-advice/articles/2018-06-20/why-is-cancer-treatment-so-expensive> [https://perma.cc/EN6B-LX43].

plan.”¹³⁴ A report from the Cancer Action Network found that “in 2014[,] cancer patients paid nearly [four] billion [dollars] out-of-pocket for cancer treatments.”¹³⁵ Compare that with the low cost of MAiD medications.¹³⁶

Cancer treatment represents a significant portion of total U.S. health care spending, with roughly \$87.8 billion spent on cancer-related care in 2014.¹³⁷ Globally, spending on anticancer drugs is about one hundred billion dollars per year, which is predicted to rise to \$150 billion by 2020.¹³⁸ Anticancer drugs are expensive for a number of reasons: the high cost of drug development; the “monopoly” of cancer drugs; and patients’ willingness to pay the high price of treatment.¹³⁹ However, many cancer patients cannot afford to pay these exorbitant costs.¹⁴⁰ In the U.S., one-third of cancer survivors between the ages of eighteen and sixty-four have incurred debt as a result of their treatment, with fifty-five percent owing more than \$10,000 and three percent having declared bankruptcy.¹⁴¹

The Cancer Action Network has proposed ways in which state and federal policymakers can address cancer patients’ costs:

Ensuring cancer patients, survivors[,] and those at risk for cancer have access to health insurance that is adequate, available, affordable[,] and easy to understand[.] . . . Providing all Americans access to no cost prevention and early detection services—preventing cancer and diagnosing it earlier can reduce patient costs[.] . . . Passing public policies that prevent cancer and its costs to patients and society by reducing tobacco use and exposure to secondhand smoke, promoting healthy eating and active living, and protecting Americans from increased skin cancer risk associated with exposure to UV radiation emitted by indoor tanning devices[.]¹⁴²

134. Jennifer Singleterry, *The Costs of Cancer: Addressing Patient Costs*, CANCER ACTION NETWORK 1, 3 (Apr. 11, 2017), <https://www.fightcancer.org/policy-resources/costs-cancer> (last visited Jan. 3, 2020).

135. *Id.* at 2.

136. MAiD medications typically cost less than three hundred dollars per patient. Coleman, *supra* note 131.

137. Singleterry, *supra* note 134, at 2.

138. Vinay Prasad et al., *The High Price of Anticancer Drugs: Origins, Implications, Barriers, Solutions*, 14 NATURE REV. CLINICAL ONCOLOGY 1, 1 (2017).

139. Mustaqeem Siddiqui & S. Vincent Rajkumar, *The High Cost of Cancer Drugs and What We Can Do About It*, 87 MAYO CLINIC PROC. 935, 935–38 (Oct. 2012), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3538397/> [<https://perma.cc/Z9DA-XZB6>].

140. *See generally* Singleterry, *supra* note 134.

141. *The State of Cancer Care in America, 2017: A Report by the American Society of Clinical Oncology*, 13 J. ONCOLOGY PRAC. e353, e360 (Apr. 2017) [hereinafter *The State of Cancer Care*].

142. Singleterry, *supra* note 134, at 3.

By enacting these policies, cancer-related costs would decrease, allowing cancer patients more control over their treatment and more options for their care.¹⁴³ An increase in adequate health insurance would allow patients more freedom in their treatment options, and they would no longer be restricted based on their inability to pay.¹⁴⁴

B. *Denial of Treatment Coverage Unduly Influences the Terminally Ill*

With the substantial medical costs and the insurance denials of certain physician-prescribed medications, terminally ill patients are often left without any options.¹⁴⁵ They will either have to pay the expenses out of pocket, or else go without that physician-recommended treatment.¹⁴⁶ Health insurance plans do not always cover every treatment as a way to control their costs.¹⁴⁷ As a result, “patient out-of-pocket costs increase considerably if the patient decides to proceed with the recommended course of treatment. Costs for non-covered services do not count towards a patient’s out-of-pocket maximum (where applicable), so patient costs for non-covered treatments are unlimited and can add up quickly.”¹⁴⁸ Denial of treatment coverage requires that terminally ill patients consider alternative options, like MAiD or palliative care, when they otherwise would not have had their original treatment been covered.¹⁴⁹

Although data has shown that virtually all MAiD participants have insurance, the statistics fail to disclose whether any insured participants have been denied coverage for more expensive treatments, such as chemotherapy, that were specifically prescribed by their physicians.¹⁵⁰ For example, Stephanie Packer, a terminally ill California resident, alleged that her insurance company refused to cover more chemotherapy treatments after the state passed its End of Life Option Act.¹⁵¹

Packer said that her insurance company initially indicated that it would cover a new chemotherapy drug at the recommendation of her doctors, but had “a change of heart” after California’s MAiD law was

143. *Id.*

144. *Id.*

145. *See supra* notes 2–11 and accompanying text.

146. *See* Singletery, *supra* note 134, at 4–5.

147. *Id.* at 18.

148. *Id.*

149. *See generally id.*

150. 2018 DATA SUMMARY, *supra* note 19, at 6.

151. Bradford Richardson, *Assisted-Suicide Law Prompts Insurance Company to Deny Coverage to Terminally Ill California Woman*, WASH. TIMES (Oct. 20, 2016), <https://www.washingtontimes.com/news/2016/oct/20/assisted-suicide-law-prompts-insurance-company-den> [https://perma.cc/CER4-KNRT].

passed.¹⁵² Packer's physicians appealed the insurance company's decision twice, without any success.¹⁵³ Packer argued that the MAiD statute creates an incentive for insurance companies to deny terminally ill patients healthcare coverage.¹⁵⁴ Speaking to *The Washington Times*, she said, "[P]atients fighting for a longer life end up getting denied treatment, because this will always be the cheapest option."¹⁵⁵

Even for insured Americans, health care "coverage often falls short."¹⁵⁶ In 2007, medical debt accounted for sixty-two percent of personal bankruptcy filings, and the majority of these filers had some health insurance coverage.¹⁵⁷ Health insurance denials often occur to the insurers' "costliest customers—the seriously ill."¹⁵⁸ The reasons for insurance denials can range from a simple bookkeeping error to the more controversial finding that a patient's procedure is not medically necessary.¹⁵⁹ Patient advocates claim that insurance companies have become "increasingly aggressive" in denying claims, especially for costly treatments for diseases like cancer.¹⁶⁰

Denials of insurance coverage leave patients with fewer alternatives and may incite them to consider MAiD.¹⁶¹ As seen with Barbara Wagner and Randy Stroup, their insurance provider specifically offered MAiD as an alternative to their rejected treatment.¹⁶² This denial of treatment coverage may unduly influence vulnerable, terminally ill patients to consider the "cheap" options, rather than pursue expensive treatment.¹⁶³ Thus, insurance companies should not be permitted to push MAiD on terminally ill patients as a way to cut costs.¹⁶⁴

152. *Id.*

153. *Id.*

154. *Id.*

155. *Id.*

156. Caroline E. Mayer, *The Health Claim Game*, AARP (Nov./Dec. 2009), https://www.aarp.org/health/medicare-insurance/info-09-2009/health_claim_game.html [<https://perma.cc/C444-EHBK>].

157. *Id.*

158. *Id.*

159. *Id.*

160. *Id.*

161. See, e.g., Andrea Peyser, *Terminally Ill Mom Denied Treatment Coverage—But Gets Suicide Drug Approved*, NY POST (Oct. 24, 2016, 12:28AM), <https://nypost.com/2016/10/24/terminally-ill-mom-denied-treatment-coverage-but-gets-suicide-drugs-approved/> [<https://perma.cc/Y7KA-A5X6>]. After Stephanie Packer was denied coverage of a chemotherapy drug, "she asked if the company covered the costs of drugs to put her to death. She was told the answer is yes—with a co-payment of \$1.20." *Id.*

162. See *supra* notes 2–11 and accompanying text.

163. See Singletery, *supra* note 134, at 18.

164. See *supra* notes 2–11 and accompanying text.

C. *The Prevalence of Depression in Terminally Ill Patients Exposes Them to Undue Influence and Coercion*

When experiencing a terminal illness and the impending threat of death, individuals naturally may feel symptoms of depression: anxiety, sadness, loneliness, loss of energy, and reduced interest in activities.¹⁶⁵ Terminally ill patients' "existential suffering manifests itself in feelings of meaninglessness, hopelessness, and futility."¹⁶⁶ However, it can be difficult to discern whether these symptoms are caused by the individual's illness or an underlying depressive disorder.¹⁶⁷

People who wish to commit suicide are considered depressed.¹⁶⁸ Yet a patient's request for a physician's help in hastening death may be the patient's attempt to regain control over his or her life, rather than the result of an independent depressive disorder.¹⁶⁹ It falls to the physicians, then, to determine the underlying root of the patient's request. MAiD statutes require that physicians refer patients to mental health professionals for counseling if they suspect that the patients are requesting MAiD because of a mental health condition, such as depression.¹⁷⁰ However, few psychiatrists feel confident enough to diagnose a mental disorder in a single evaluation.¹⁷¹ This lack of confidence suggests that the safeguards currently in place may not be effective in preventing coercion.

Researchers have found that psychological factors are associated with patients' "considerations and planning" of MAiD.¹⁷² A 2000 study on terminally ill patients' and their caregivers' attitudes towards MAiD suggested a tension between the reasons people find MAiD acceptable (mainly pain management) and the "main factor motivating interest" in MAiD (patient depression).¹⁷³ Ezekiel Emanuel and his colleagues found

165. See HUMPHRY & CLEMENT, *supra* note 14, at 56.

166. *Id.*

167. Erica Cirino, *Depression in the Face of a Terminal Illness and Death*, HEALTHLINE (Mar. 14, 2016), <https://www.healthline.com/health/depression/terminal-illness> [<https://perma.cc/ZC74-VM3B>].

168. *Id.*

169. *Id.*

170. See, e.g., OR. REV. STAT. § 127.825, § 3.03 (West 2018) ("[I]f either [the proscribing or consulting physician] believes the patient has a psychiatric or psychological disorder that might impair judgment, then 'either physician shall refer the patient for counseling'").

171. See Linda Ganzini et al., *Attitudes of Oregon Psychiatrists Toward Physician-Assisted Suicide*, 153 AM. J. PSYCHIATRY 1469, 1469–75 (1996).

172. Ezekiel J. Emanuel et al., *Attitudes and Desires Related to Euthanasia and Physician-Assisted Suicide Among Terminally Ill Patients and Their Caregivers*, JAMA (Nov. 15, 2000), <https://jamanetwork.com/journals/jama/fullarticle/193281#REF-JOC01512-4> [<https://perma.cc/34QD-8VX4>].

173. *Id.*

that about fifty percent of the terminally ill patients interested in MAiD changed their minds over the course of the study, and terminally ill patients who had not previously considered MAiD began to do so.¹⁷⁴ The researchers concluded that physicians who receive requests for MAiD should recognize the patients' "volatility and not take such requests as settled views but should evaluate patients for depression."¹⁷⁵ Patients with depressive symptoms were more likely to change their minds about considering MAiD.¹⁷⁶

Although each MAiD statute requires a physician to refer patients to a licensed psychiatrist or psychologist if the physician fears the patients are suffering from a mental disorder or depression,¹⁷⁷ these referral rates are low.¹⁷⁸ During 2018, Oregon reported that 249 prescriptions were written, but only three patients were referred for psychological or psychiatric evaluation.¹⁷⁹ Likewise, during 2016, Washington reported that only five percent of DWDA participants were referred for psychiatric or psychological evaluation.¹⁸⁰ Given the prevalence of depressive symptoms in dying patients,¹⁸¹ one would expect a higher rate of referrals for mental health evaluations.

However, the low number of referrals is not the only problem: there is a shortage of mental health professionals willing to engage in this type of work.¹⁸² Many therapists object to MAiD on ethical grounds; others have financial reasons for refusing to evaluate.¹⁸³ When these evaluations do occur, there are concerns about quality, as many psychiatrists feel that

174. *Id.*

175. *Id.*

176. *Id.* Fortunately, patients retain autonomy over the physical act of ingesting the lethal medication. Patients frequently go through the process of obtaining MAiD prescriptions just to have the option available to them, should they wish to use it. *See HOW TO DIE IN OREGON* (Cinedigm 2011).

177. *See, e.g.*, D.C. CODE § 7-661.04(a)–(b) (West 2019).

178. *See, e.g.*, 2018 DATA SUMMARY, *supra* note 19, at 7.

179. *Id.*

180. *Washington State Report*, *supra* note 93, at 9.

181. *See* William Breitbart et al., *Depression, Hopelessness, and Desire for Hastened Death in Terminally Ill Patients With Cancer*, 284 JAMA 2907, 2907, 2909 (Dec. 13, 2000), <https://jamanetwork.com/journals/jama/fullarticle/193350> [https://perma.cc/NS7V-SUUP] (“Desire for hastened death among terminally ill cancer patients is not uncommon.”).

182. Susan Gilbert, *Physician-Assisted Death: Trouble with Psychiatric Evaluations*, THE HASTINGS CENTER (Oct. 17, 2008), <https://web.archive.org/web/20170712184238/http://www.thehastingscenter.org/physician-assisted-death-trouble-with-psychiatric-evaluations/>.

183. *Id.* “Surveys show that [forty-four] percent of psychiatrists and [twenty-two] percent of psychologists in Oregon oppose the [DWDA], and most of them would refuse to evaluate a patient who asked for a doctor’s help in committing suicide.” *Id.* Some therapists will not do evaluations if the patient is not covered by Medicare. *Id.*

one evaluation is not enough to determine whether a patient has a mental illness that is impairing his or her judgment in requesting MAiD.¹⁸⁴ Although the majority of terminally ill patients who received MAiD are not depressed, there is still room for improvement.¹⁸⁵

Additionally, a patient's fear of being a burden on family members is often a consideration for patients with chronic illnesses who wish to discontinue treatment.¹⁸⁶ Medical professionals often underestimate this self-perceived burden experienced by patients, which has been associated with "negative psychological outcomes, such as suicidal ideation, loss of dignity, hopelessness, anxiety, and depression."¹⁸⁷ A Japanese study of terminally ill cancer patients concluded that patients' self-perceived burden can cause "profound suffering and acts as a barrier to the achievement of an optimal quality of life."¹⁸⁸

When terminally ill patients suffer from undiagnosed depression, and then are subsequently denied prescribed treatment coverage by their insurance provider, they may be unduly influenced into qualifying for MAiD.¹⁸⁹ Although these instances may be rare, protections are needed to guard against these possibilities.¹⁹⁰ More thorough screening for depression in the terminally ill will safeguard against these opportunities for undue influence and coercion, as well as an overall increase in mental evaluations for those applying for MAiD.¹⁹¹ Additionally, including specific provisions in states' MAiD statutes that prevent insurers from pushing MAiD on patients could further protect depressed, terminally ill patients from undue influence and coercion.¹⁹²

184. *Id.*

185. *Id.*

186. Julia O. Johnson et al., *Patients' Experiences of Being a Burden on Family in Terminal Illness*, 9 J. HOSPICE & PALLIATIVE NURSING 264, 264 (2007), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2632772/> [<https://perma.cc/58UK-F6BZ>].

187. Terukazu Akazawa et al., *Self-Perceived Burden in Terminally Ill Cancer Patients: A Categorization of Care Strategies Based on Bereaved Family Members' Perspectives*, 40 J. PAIN & SYMPTOM MGMT. 224, 225 (2010), [https://www.jpmsjournal.com/article/S0885-3924\(10\)00311-8/pdf](https://www.jpmsjournal.com/article/S0885-3924(10)00311-8/pdf) (last visited Jan. 3, 2020).

188. *Id.*

189. Emanuel et al., *supra* note 172.

190. *See infra* notes 221–23 and accompanying text.

191. *See* Ganzini et al., *supra* note 76.

192. *See infra* note 224 and accompanying text.

III. PROTECTING TERMINALLY ILL PATIENTS FROM UNDUE INFLUENCE AND COERCION BY INSURERS

Of the jurisdictions with MAiD statutes, each one includes provisions requiring that the patient be free from undue influence and coercion.¹⁹³ However, California is the only state to go one step further and specifically prohibit undue influence by a patient's insurance company.¹⁹⁴ The statute prohibits an insurance carrier from providing MAiD information to an individual, unless specifically requested by the patient or the patient's physician.¹⁹⁵

Had a provision like the one found in California's MAiD statute been included in Oregon's statute, the unfortunate incidents of Barbara Wagner and Randy Stroup may have been avoided, where they were told that their insurance company would cover the cost of ending their lives.¹⁹⁶ However, this California provision permits insurance providers to deny life-prolonging treatment yet cover the cost of lethal medications.¹⁹⁷ Thus, there is a need for specific safeguards in each MAiD statute to prevent insurers from covering life-ending treatment, but denying coverage for non-experimental, life-prolonging treatment.¹⁹⁸

A. *Terminally Ill Patients and Futile Medical Treatment*

Over the last few decades, there has been a shift in the relationship between patients and physicians: there is now an increased emphasis on "shared decision-making" as the best way to determine important medical decisions.¹⁹⁹ Today, patients are active participants in their treatment decisions.²⁰⁰ However, insurance companies enter into this relationship by "unilaterally deciding coverage and patient cost-sharing levels. There is no meaningful dialogue among insurance companies, patients, and their physicians."²⁰¹ Health insurance companies can deny coverage of

193. See, e.g., OR. REV. STAT. § 127.890 (West 2018) ("A person who coerces or exerts undue influence on a patient to request medication for the purpose of ending the patient's life, or to destroy a rescission of such a request, shall be guilty of a Class A felony.").

194. CAL. HEALTH & SAFETY CODE § 443.13(c) (West 2019).

195. *Id.*

196. See *supra* notes 2–11 and accompanying text.

197. See generally CAL. HEALTH & SAFETY CODE § 443 (West 2019).

198. See, e.g., *supra* notes 2–11 and accompanying text.

199. Dennis N. Bourdette et al., *Practices of US Health Insurance Companies Concerning MS Therapies Interfere with Shared Decision-Making and Harm Patients*, 6(2) NEUROLOGY CLINICAL PRAC. 177, 179 (2016), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4828681/> [<https://perma.cc/E3P9-PPZ8>].

200. *Id.*

201. *Id.* at 180.

treatments that patients and their physicians have decided upon with little or no input from either party.²⁰²

In the case of terminally ill patients, insurance companies' refusal of coverage often comes from their determination that a treatment may be "potentially inappropriate" or "futile."²⁰³ Futility in medical treatment is an ancient concept.²⁰⁴ However, there is no uniform definition of medical futility, and state laws rarely define "medically futile" or "ineffective care."²⁰⁵ The American Medical Association notes that it is not possible to offer a "single, universal definition of futility," and instructs physicians to only recommend and provide interventions that are medically appropriate and that "reflect the physician's considered medical judgment about the risks and likely benefits of available options in light of the patient's goals for care."²⁰⁶ Others argue that physicians must be "certain that an intervention will fail to accomplish its intended goal" before determining that the treatment would be medically futile.²⁰⁷ However, physicians will not always be right in their determination of futility; there are always exceptions.²⁰⁸

Without a clear definition of "medical futility," insurance providers are left to decide for themselves whether a particular treatment will be in vain, and reasonable minds can differ on what treatment is "futile."²⁰⁹ For example, the Oregon Health Plan (Oregon's Medicaid program) prioritizes "prevention services with evidence of effectiveness" and health maintenance.²¹⁰ While ineffective, futile care is not covered, MAiD is, since it is considered a means of providing comfort—no different from

202. *Id.* at 179.

203. See Gabriel T. Bosset et al., *An Official ATS/AACN/ACCP/ESICM/SCCM Policy Statement: Responding to Requests for Potentially Inappropriate Treatments in Intensive Care Units*, 191 AM. J. RESPIRATORY & CRITICAL CARE MED. 1318, 1318 (June 1, 2015).

204. Deborah L. Kasman, MD, *When Is Medical Treatment Futile?*, 19 J. GEN. INTERNAL MED. 1053, 1053 (2004). Hippocrates stated that physicians should "refuse to treat those who are overmastered by their disease, realizing that in such cases medicine is powerless." *Id.*

205. Mary S. McCabe & Courtney Storm, *When Doctors and Patients Disagree About Medical Futility*, 4 J. ONCOLOGY PRAC. 207, 207 (2008), <http://ascopubs.org/doi/full/10.1200/JOP.0848503> [<https://perma.cc/N9GR-8NWH>].

206. AMA, CODE OF MED. ETHICS OPINION 5.5, MEDICALLY INEFFECTIVE INTERVENTIONS, <https://www.ama-assn.org/delivering-care/medically-ineffective-interventions> [<https://perma.cc/54XP-7ARE>].

207. McCabe & Storm, *supra* note 205, at 207.

208. Kasman, *supra* note 204.

209. See generally McCabe & Storm, *supra* note 205.

210. See generally *Prioritized List of Health Services (Annotated)*, OREGON HEALTH AUTHORITY (Oct. 1, 2018), <https://www.oregon.gov/oha/HPA/DSI-HERC/PrioritizedList/10-1-2018%20Prioritized%20List%20of%20Health%20Services.pdf> [<https://perma.cc/4L9E-UD7N>].

hospice care or pain medication.²¹¹ To Randy Stroup, treatment that would not cure, but would ease his pain and potentially extend his life by six months, was certainly not futile treatment.²¹² Yet this treatment was denied by the Oregon Health Plan.²¹³ Stroup asked, “What is six months of life worth? . . . To me it’s worth a lot. This is my life they’re playing with.”²¹⁴

B. *Proposed Provisions that Each MAiD Statute Should Include*

Medicare and Medicaid profoundly influence end-of-life decisions for the elderly, the terminally ill, and disabled individuals because of what they will and will not pay for, along with a “host of incentives and regulatory restrictions.”²¹⁵ Medicare covers approximately seventy-five percent of the people who die each year in the United States; thus, it is a “major force” influencing Americans’ end-of-life care.²¹⁶ “As the single largest . . . health insurer [in the United States], Medicare also influences the policies of other insurance companies and thus indirectly plays a role in the way that *everyone* with health insurance dies in [this country].”²¹⁷

Because Medicaid “is a major source of financing for end-of-life care,”²¹⁸ it is imperative that MAiD statutes include specific provisions that require federally- and state-funded insurers cover non-experimental treatment for terminally ill patients, should they cover MAiD medications.²¹⁹ “Treatment is covered if medically necessary but not if experimental or investigational.”²²⁰ Therefore, patients who are eligible for MAiD should not be denied treatments that their physicians have prescribed.

In every state where MAiD is legal, such statutes should include the following provision:

211. James, *supra* note 3.

212. *Id.*

213. *Id.* Stroup’s physician had requested the drug mitoxantrone, but LIPA refused coverage. *Id.*

214. *Id.*

215. Muriel R. Gillick, *How Medicare Shapes the Way We Die*, 8 J. HEALTH & BIOMEDICAL L. 27, 28–29 (2012).

216. *Id.*

217. *Id.* at 29.

218. See Jane Tilly & Joshua Weiner, *Medicaid and End-of-Life Care*, LAST ACTS 1, 3 (2001), <https://www.urban.org/sites/default/files/publication/61746/410409-Medicaid-and-End-of-Life-Care.PDF> [<https://perma.cc/X79C-5AAH>].

219. See, e.g., *infra* notes 221–23 and accompanying text.

220. Kathy L. Cerminara, *Dealing with Dying: How Insurers Can Help Patients Seeking Last-Chance Therapies (Even When the Answer Is “No”)*, 15 HEALTH MATRIX 285, 294 (2005) (internal quotations omitted).

No publicly funded health insurer issuing a policy which provides coverage for medical aid in dying drugs shall exclude coverage of non-experimental, effective treatment prescribed by a patient's physician.²²¹ A treatment is non-experimental "if it is widespread, safe, and a significant improvement on traditional therapies."²²² A treatment is effective if it will have "the effect it purports or is represented to have under the conditions of use prescribed, recommended, or suggested in the labeling."²²³

Each state should also adopt California's End of Life Option Act provision regarding insurance providers' communications with terminally ill patients:

An insurance carrier shall not provide any information in communications made to an individual about the availability of an aid-in-dying drug absent a request by the individual or his or her attending physician at the behest of the individual. Any communication shall not include both the denial of treatment and information as to the availability of aid-in-dying drug coverage.²²⁴

By not providing any specific information about MAiD to individuals—unless specifically requested—patients will be protected against undue influence and coercion by their insurers.²²⁵ In the cases of Barbara Wagner and Randy Stroup, they were informed about MAiD after their physician-recommended treatments were denied.²²⁶ This caused outrage and anguish,²²⁷ and it could have unduly influenced them into requesting MAiD. Including this provision within each state's MAiD statute will help ensure that vulnerable patients are protected against undue influence by their insurers.²²⁸

Medicare Part A covers, among other things, inpatient hospital stays, including cancer treatments received while in the hospital, blood, and some costs of clinical research studies while in the hospital.²²⁹ Medicare

221. This provision is loosely based on Melody Harness's proposed provision for health insurance coverage of off-label drug use. See Melody L. Harness, Note, *What is Experimental Medical Treatment: A Legislative Definition is Needed*, 44 CLEV. ST. L. REV. 67, 96 (1996).

222. See *Henderson v. Bodine Aluminum, Inc.*, 70 F.3d 958, 960 (8th Cir. 1995).

223. See 21 U.S.C.A. § 355(d). Whether or not a treatment will be effective is often speculative. However, if a treatment is purported to have beneficial results, such as life-prolongation or palliation of symptoms, that treatment should be considered "effective." *Id.*

224. CAL. HEALTH & SAFETY CODE § 443.13(c) (West 2019).

225. See *supra* Section II.B.

226. See *supra* notes 2–11 and accompanying text.

227. See *supra* notes 2–11 and accompanying text.

228. See, e.g., CAL. HEALTH & SAFETY CODE § 443.13(c) (West 2019).

229. See *What Part A Covers*, MEDICARE.GOV, <https://www.medicare.gov/what-medicare-covers/what-part-a-covers> [<https://perma.cc/S47X-E87Y>].

Part B covers doctors' visits, many chemotherapy drugs, some oral chemotherapy treatments, radiation treatments, outpatient surgeries, and more.²³⁰ Medicare Part D covers most prescription medications and some chemotherapy treatments and drugs.²³¹ Based on these covered treatments, it is not unreasonable to ensure, through statute, that publicly funded health insurers cover the costs of effective, non-experimental treatment, particularly for those who qualify for MAiD.²³²

If every state where MAiD is legal were to adopt both of these provisions in their MAiD statutes, vulnerable, terminally ill patients would have increased protection against undue influence and coercion, specifically by their insurance providers.²³³ Insurance companies would not be permitted to favor coverage of MAiD medications and deny coverage of physician-prescribed life-prolonging treatment.²³⁴ Treatment prescribed by one's physician that is deemed non-experimental and effective should never be denied to patients.²³⁵ Insurance companies do not have the right to "play God," determining whether or not a patient deserves the chance to prolong his or her life. That decision should be left to the patient and his or her physician after discussing all the options available and the likelihood of success for each treatment option.²³⁶

C. Addressing Arguments Against Such MAiD Provisions

There are arguments to be made against including such provisions in each MAiD statute, some of which have merit. However, the advantages of including such provisions and preventing undue influence and coercion by insurers far outweigh the drawbacks.²³⁷ One of the arguments against such provisions is that insurance companies cannot afford to pay for everything everyone wants; there simply is not enough money.²³⁸ About forty-eight million Americans sixty-five years and older are covered by

230. See *What Part B Covers*, MEDICARE.GOV, <https://www.medicare.gov/what-medicare-covers/what-part-b-covers> [https://perma.cc/ZM9Y-2NG9].

231. See *Drug Coverage (Part D)*, MEDICARE.GOV, <https://www.medicare.gov/drug-coverage-part-d> [https://perma.cc/65B9-VQTU].

232. See *supra* notes 221–23 and accompanying text.

233. See, e.g., CAL. HEALTH & SAFETY CODE § 443.13(c) (West 2019).

234. See *supra* notes 2–11 and accompanying text.

235. See, e.g., *supra* notes 2–11 and accompanying text.

236. See Ronald M. Epstein et al., *Communicating Evidence for Participatory Decision Making*, 291 JAMA 2359, 2359 (May 19, 2004), <https://jamanetwork.com/journals/jama/fullarticle/198765> [https://perma.cc/3YYS-BT46].

237. See *supra* Section III.B.

238. See Sarah O'Brien, *Medicare Doesn't Cover Everything. Here's How to Avoid Surprises*, CNBC (May 3, 2018, 11:18 AM), <https://www.cnbc.com/2018/05/03/medicare-doesnt-cover-everything-heres-how-to-avoid-surprises.html> [https://perma.cc/J456-PL8G].

Medicare, as well as another nine million or so younger individuals with disabilities.²³⁹ If each person covered by Medicare were to request life-prolonging cancer treatment, it would be impossible to cover everyone.²⁴⁰ However, public policy weighs against covering the costs of physically causing someone to die, while denying the costs of continued treatment.²⁴¹

The cost of treating cancer has skyrocketed over recent years.²⁴² In 2000, the average yearly cost of a cancer treatment drug was less than ten thousand dollars.²⁴³ However, in 2012, twelve out of thirteen newly approved drugs for cancer cost more than one hundred thousand dollars.²⁴⁴ Nevertheless, high treatment costs do not sufficiently justify the denial of coverage to persons in need.²⁴⁵ If the United States was to implement ways to lower cancer drug costs, treatment costs might become more affordable, and insurance companies would be able to provide more coverage.²⁴⁶

There are many reasons why a terminally ill patient may opt for life-prolonging treatment: the patient can manage the possible side effects of treatment; the patient does not think that treatment will interfere with his or her quality of life; or the patient has personal goals that he or she still wishes to pursue and achieve.²⁴⁷ Stephanie Packer, for example, said that her children motivated her to fight her terminal illness.²⁴⁸ Because a patient should have a say in his or her treatment decisions, these decisions should not be made solely because of an inability to pay for treatment.²⁴⁹

239. *Id.*

240. *See id.*

241. *See, e.g., supra* notes 2–11 and accompanying text.

242. Helaine Olen, *Even the Insured Often Can't Afford Their Medical Bills*, THE ATLANTIC (June 18, 2017), <https://www.theatlantic.com/business/archive/2017/06/medical-bills/530679/> [<https://perma.cc/ZZ8A-8GWJ>].

243. Hagop Kantarjian et al., *High Cancer Drug Prices in the United States: Reasons and Proposed Solutions*, 10 J. ONCOLOGY PRAC. e208, e208 (July 2014), <http://ascopubs.org/doi/full/10.1200/JOP.2013.001351>.

244. *Id.*

245. *See supra* Section II.A.

246. *See The State of Cancer Care, supra* note 141 (proposing ways in which the United States can lower cancer drug costs).

247. *See Deciding About Life-Prolonging Treatment*, HEALTHWISE (current as of Apr. 18, 2018), <https://myhealth.alberta.ca/Health/aftercareinformation/pages/conditions.aspx?hwid=av2673> [<https://perma.cc/94Z9-YC3D>].

248. Richardson, *supra* note 151 (“I want to live for my kids. I want them to see that dying is a part of life. Your end of life can be that opportunity to appreciate things that you didn’t appreciate before, to say things that you didn’t say before.”).

249. *See supra* Section II.B.

Another argument against including such MAiD provisions is that statistical data has shown that terminally ill patients are not being unduly influenced into prematurely ending their lives through MAiD.²⁵⁰ While that is true, not all acts of undue influence and coercion are overt.²⁵¹ Insurance companies may be unaware that their actions are subtly influencing terminally ill patients to consider MAiD.²⁵² Patients may have undiagnosed depression; patients may have insurance, but their insurer has denied coverage of their treatment; or patients' experiences as self-perceived financial or emotional burdens may influence their end-of-life decisions.²⁵³ Although unprivileged groups, like minorities, the elderly, and the poor, are statistically not being coerced into MAiD,²⁵⁴ the terminally ill are subtly influenced and coerced by a variety of sources.²⁵⁵ Protection against subtle acts of undue influence and coercion are as necessary as protection against overt acts.²⁵⁶

Finally, opponents of these proposed provisions may argue that insurance companies are only denying futile treatment, and to cover futile treatment does more harm to the patient than good.²⁵⁷ Indeed, treating for the sake of treating, when there are absolutely no benefits, is unnecessary.²⁵⁸ The United States' healthcare system should work to increase the utilization of hospice and palliative care.²⁵⁹ However, individuals like Barbara Wagner and Randy Stroup have shown that physicians may prescribe them effective, non-experimental treatments that their insurance providers nevertheless refuse to cover.²⁶⁰

Barbara Wagner's oncologist prescribed her Tarceva, a treatment approved by the U.S. Food and Drug Administration for certain types of lung cancer.²⁶¹ According to trial results, patients who took Tarceva had a sixty-six percent lower risk of the cancer getting worse or of death than

250. 2018 DATA SUMMARY, *supra* note 19, at 6.

251. *See supra* Sections II.B–C.

252. The letters sent by LIPA to patients previously unaware of MAiD as an option may lead them to consider the lethal medication. *See supra* notes 2–11 and accompanying text.

253. *See supra* Part II.

254. *See, e.g.*, 2018 DATA SUMMARY, *supra* note 19, at 6.

255. *See supra* Part II.

256. *See supra* notes 221–23 and accompanying text.

257. *See* Nancy S. Jecker, *Medical Futility*, ETHICS IN MEDICINE, <https://depts.washington.edu/bhdept/ethics-medicine/bioethics-topics/detail/65> (last visited Oct. 5, 2019).

258. *See* Noah & Feigenson, *supra* note 13, at 740.

259. *Id.* at 741–42.

260. *See supra* notes 2–11 and accompanying text.

261. *See Tarceva (Erlotinib)*, LUNG CANCER NEWS TODAY, <https://lungcancernewstoday.com/tarceva-erlotinib-nscl/> [<https://perma.cc/D9EE-J879>].

those who received chemotherapy.²⁶² “Tumors shrank or disappeared for [sixty-five] percent of patients who received Tarceva and [sixteen] percent of patients who received chemotherapy.”²⁶³ There was no basis for LIPA to deny Wagner coverage of Tarceva as “futile” medical treatment.²⁶⁴ Had the Oregon DWDA included the proposed provisions recommended in this Note, Wagner’s Tarceva medications never would have been denied, and she never would have received the letter from LIPA, telling her that they would cover the cost of ending her life.²⁶⁵

While there is a need to avoid overtreatment at the end of life, these end-of-life decisions should be left to the patient and his or her physician, not the insurance company.²⁶⁶ The issue becomes apparent when patients are being denied coverage for effective, non-experimental treatment, but the cost of ending their lives is covered.²⁶⁷ While these instances may not be common, additional provisions in MAiD statutes would prevent them from ever occurring.²⁶⁸ Patients should have control over their end-of-life decisions, and cost should not be the main motivating factor in this process.²⁶⁹

CONCLUSION

Medical aid in dying has been a highly contested issue in the United States for many years.²⁷⁰ Although the Supreme Court did not identify a fundamental right to determine the time and manner of one’s death,²⁷¹ states have the ability to enact statutes that legalize the medical aid in dying process.²⁷² This Note does not argue against the enactment of MAiD laws; rather, it outlines the importance of including specific provisions designed to protect vulnerable individuals against undue influence and coercion from a variety of sources.²⁷³

262. *Id.*

263. *Id.*

264. See Hoffmann-La Roche, *A Study of Tarceva (Erlotinib) in Patients with Advanced Non-Small Cell Lung Cancer Naïve to Chemotherapy*, U.S. NAT’L LIBR. OF MED. (Dec. 17, 2013), <https://clinicaltrials.gov/ct2/show/NCT02013206> [<https://perma.cc/NGB5-SS9E>].

265. See *supra* notes 2–6 and accompanying text.

266. See Epstein et al., *supra* note 236, at 2359.

267. See *supra* notes 2–11 and accompanying text.

268. See *supra* notes 221–23 and accompanying text.

269. See *supra* Section II.B.

270. See generally GORSUCH, *supra* note 36; see also *supra* Section I.A.

271. See *Washington v. Glucksberg*, 521 U.S. 702, 728 (1997) (holding that “the asserted ‘right’ to assistance in committing suicide is not a fundamental liberty interest.”); see also Lewis, *supra* note 5, at 4.

272. See Datlof, *supra* note 24, at 37.

273. See *supra* Part II.

Specifically, this Note argues that MAiD statutes must protect vulnerable patients against undue influence by insurance providers.²⁷⁴ As seen in the cases of Barbara Wagner, Randy Stroup, and Stephanie Packer, insurance providers have the ability to deny patients physician-prescribed treatments, while offering coverage of MAiD medications.²⁷⁵ The lack of specific regulatory provisions in MAiD statutes regarding insurance companies exposes patients to undue influence and coercion.²⁷⁶ Therefore, insurance companies must be regulated by MAiD statutes such that insurance payments for non-experimental, effective treatments prescribed by one's physician may not be denied to any person who is qualified under an existing MAiD statute.²⁷⁷

Regulating insurance companies in this manner can be achieved by including the specific provisions discussed above in each state's MAiD statute.²⁷⁸ After outlining the vulnerability of terminally ill patients, the current process shows that there are not enough protections in place.²⁷⁹ There are currently eighteen states considering the legalization of MAiD.²⁸⁰ Should any or all of these states decide to legalize MAiD, there will be more opportunities for abuse, undue influence, and coercion of terminally ill patients.²⁸¹

Any state that enacts a MAiD statute should include the proposed provisions outlined above in order to put increased safeguards in place for vulnerable patients.²⁸² Each enacted MAiD statute already includes provisions that aim to protect this vulnerability of terminally ill patients,²⁸³ and the proposed provisions of this Note would simply add to the protections in place to prevent undue influence and coercion.²⁸⁴ These provisions aim to prevent undue influence and coercion by one's

274. *See supra* Section II.A.

275. *See supra* notes 2–11 and accompanying text.

276. *See supra* notes 2–11 and accompanying text.

277. *See supra* Section III.B.

278. *See supra* notes 221–23 and accompanying text.

279. *See supra* Parts I–II.

280. *See Take Action in Your State, DEATH WITH DIGNITY*, <https://www.deathwithdignity.org/take-action/> (current as of Nov. 2, 2019). The following states are currently considering MAiD: Arizona, Arkansas, Connecticut, Delaware, Indiana, Iowa, Kansas, Maryland, Massachusetts, Minnesota, Nevada, New Mexico, New York, North Carolina, Rhode Island, Utah, Virginia, and Wisconsin. *Id.*

281. *See supra* Section II.B (discussing the exposure of terminally ill patients to undue influence and coercion).

282. *See supra* Section III.B.

283. *See, e.g., supra* notes 70–71 and accompanying text (outlining the criteria to qualify for MAiD).

284. *See supra* Section III.B.

insurance provider, hopefully avoiding the unfortunate incidents of Barbara Wagner, Randy Stroup, and Stephanie Packer in the future.