WHO SHOULD PAY FOR US TO DIE? A LOOK THROUGH THE EQUITY LENS OF THE UNITED STATES' LAWS SURROUNDING MEDICAL AID IN DYING AND "DEATH WITH DIGNITY" LEGISLATION

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Introduction: What is the Right to Die?

The United States Constitution and its 27 Amendments enumerate the rights, protections, and freedoms this nation affords its citizens. According to the Supreme Court in *Union Pac. Ry. Co. v. Botsford*, "[n]o right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law."[1] This right to said control over his or her person should include the right to die. Most importantly, medical-aid-in-dying should be covered by health insurance.

The right to die is known by many names, which differ between the legal and medical communities, and the ordinary layperson.[2] According to Merriam-Webster's Medical Dictionary, the right to die is defined as "a law legalizing the self-administration by a terminally ill person of life-ending medication prescribed by a physician."[3] Similarly, physician-assisted suicide ("PAS") is defined as "suicide by a patient facilitated by means (such as a drug prescription) or by information (such as an indication of a lethal dosage) provided by a physician aware of the patient's intent."[4] These definitions are vital to lawmakers, medical professionals, and insurance providers.

Another common term is "death with dignity," originating from Oregon's "Death with Dignity Act," which took effect in 1997.[5] Other acceptable medical terminology include physician-assisted death, physician-assisted dying, aid-in-dying, physician-aid-in-dying, and medical-aid-in-dying ("MAID").[6] Because of its universal

[1] 141 U.S. 250, 251 (1891).

[2] *Frequently Asked Questions*, DEATH WITH DIGNITY, https://deathwithdignity.org/resources/faqs/ (last modified Dec. 12, 2021); Lydia S. Dugdale et al., *Pros and Cons of Physician Aid in Dying*, 92 YALE J. BIOLOGY & MED. 747, 747 (2019).

[3] *Right-to-Die Law*, MERRIAM-WEBSTER, https://www.merriam-webster.com/legal/right-to-die%20law (last visited Nov. 20, 2022).

[4] *Physician-Assisted Suicide*, MERRIAM-WEBSTER, https://www.merriam-webster.com/dictionary/physician-assisted%20suicide (last visited Nov. 20, 2022).

[5] *Our History*, DEATH WITH DIGNITY, https://deathwithdignity.org/history/ (last visited Mar. 25, 2023); OR. REV. STAT. ANN. §§ 127.800-.897 (West 2020).

[6] *Frequently Asked Questions*, *supra* note 2. *See generally Glossary of Terms*, DEATH WITH DIGNITY, https://deathwithdignity.org/resources/assisted-dying-glossary/ (last visited Mar. 25, 2023) (providing the definition of assisted death and other terms it is referred to as).

acceptance in medical and legal communities—and to distinguish it from suicide—MAID will be the term of art most often used in this note. Contrarily, there are four "incorrect and inaccurate terms" that those who oppose the right to die have in their lexicon: assisted suicide, doctor-assisted suicide, physician-assisted suicide, and euthanasia.[7] Unfortunately, these misleading terms are frequently used in everyday jargon to describe the right to die.[8]

In the United States, MAID is an end-of-life option legally allowed in 11 jurisdictions for competent adults who can self-administer medication and who have terminal illnesses that will lead to death within six months.[9] MAID is governed by state legislation,[10] and not all 50 states are on board; only ten states, plus Washington, D.C., have enacted a statute that recognizes "death with dignity."[11] Currently, there are 37 states without active legislation, three of which are considering legislation.[12] Clearly, this polarizing topic is still up for discussion, debate, and even litigation, as our nation is not unified on a resolution.

To pursue MAID services, there are specific steps a person must follow. First, a person must acquire a legal prescription to receive life-ending medications.[13] This prescription is only available in a state

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[7] *Frequently Asked Questions*, *supra* note 2; Dugdale, *supra* note 2, at 747.

[8] *Frequently Asked Questions*, *supra* note 2.

[9] *Frequently Asked Questions*, *supra* note 2; *In Your State,* DEATH WITH DIGNITY, https://deathwithdignity.org/states/ (last visited Mar. 26, 2023).

[10] *Frequently Asked Questions*, *supra* note 2.

[11] *In Your State*, *supra* note 9. *See* OR. REV. STAT. ANN. §§ 127.800-.897 (West 2020); Washington Death with Dignity Act, WASH. REV. CODE §§ 70.245.010-.220-.904 (2020); Montana Rights of the Terminally Ill Act, MONT. CODE ANN. §§ 50-9-101-505 (2019); VT. STAT. ANN. tit. 18, §§ 5281-93 (West 2020); End of Life Option Act, CAL. HEALTH & SAFETY CODE §§ 443.1-.22 (West 2020); End-of-Life Options Act, COLO. REV. STAT. §§ 25-48-101 TO -123 (2020); Death with Dignity Act of 2016, D.C. CODE ANN. §§ 7-661.01-.16 (West 2020); Our Care, Our Choice Act, HAW. REV. STAT. ANN. §§ 327L-1-25 (West 2019); Medical Aid in Dying for the Terminally Ill Act, N.J. STAT. ANN. §§ 26:16-1 TO -20 (West 2020); Maine Death with Dignity Act, ME. STAT. ANN. tit. 22, § 2140 (West 2020); End-of-Life Options Act, N.M. STAT. ANN. § 24-7C-1-8 (West 2021).

[12] *In Your State*, *supra* note 9.

[13] *Frequently Asked Questions*, *supra* note 2. Unfortunately, it is possible to fatally overdose on an over-the-counter medication, such as Acetaminophen, that does not require a prescription. The number of fatalities is low, but not zero. Parivash Nourjah et al., *Estimates of Acetaminophen (Paracetamol)-Associated Overdoses in the United States*, 15 PHARMACOEPIDEMIOLOGY & DRUG SAFETY 398, 403-4 (2006). Further, this country has not yet formulated a "standard" prescription for life-ending medications, blurring the lines as to the typical procedure. Jennie Dear, *The Doctors Who Invented a New Way to Help People Die*, THE

that has passed a "death with dignity" law.[14] Pharmacists can refuse to fill a prescription to ensure the dispensed medication is medically appropriate and fulfills their patients' best interests.[15] There are four factors that an individual must meet to qualify for right-to-die treatment under a "death with dignity" statute.[16] First, the person must be "an adult resident of a state where such a law is in effect."[17] Second, the person must be "capable of making and communicating [their] own healthcare decisions."[18] Third, the person must be "diagnosed with a terminal illness that will lead to death within six months, as confirmed by qualified healthcare providers."[19] Finally, the person must be "capable of self-administering and ingesting medications without assistance."[20]

MAID has been, and continues to be, a common medical practice. In 1996, a study was conducted on 3,102 practicing physicians in fields where patients were most likely to seek assistance with suicide or euthanasia.[21] The physicians in the study filled out questionnaires; of the 1,951 eligible respondents, 18.3 percent "reported having received a request from a patient for medication to use with the primary intention of ending the patient's life."[22] Slightly more than three percent of the sample reported having "written a prescription for a lethal dose of medication" for those looking to end their lives legally.[23] The

ATLANTIC (Jan. 22, 2019), https://www.theatlantic.com/health/archive/2019/01/medical-aid-in-dying-medications/580591/.

14 *Frequently Asked Questions*, *supra* note 2.

15 Stephanie Sun et al., *Pharmacist and Prescriber Responsibilities for Avoiding Prescription Drug Misuse*, 23 AMA J. ETHICS 471, 473 (2021). Pharmacists are highly regulated as any misstep could cost a life. Pharmacists study the law and must ask themselves, "What is legal?" and "What is best for the patient?" RICHARD R. ABOOD & KIMBERLY A. BURNS, PHARMACY PRACTICE AND THE LAW 1 (9th ed. 2019).

16 *Frequently Asked Questions*, *supra* note 2.

17 *Id.*

18 *Id.*

19 *Id.*

20 *Id.*

21 While "suicide" and "euthanasia" are not the preferred terms to use, they are the terms the study used. Diane E. Meier et al., *A National Survey of Physician-Assisted Suicide and Euthanasia in the United States*, 338 NEW ENGLAND J. MED. 1193, 1193 (1998).

22 *Id.* at 1194-1195. The physicians' specialties include family or general practice, cardiology, geriatrics, infectious disease, nephrology, neurology, hematology-oncology, pulmonary disease, internal medicine, and other (critical care medicine, critical care surgery, gynecology, pain medicine, and those who did not report a specialty).

23 *Id.* at 1195.

study concluded that a "substantial portion of physicians in the United States in the specialties surveyed report that they receive requests for physician-assisted suicide and euthanasia."[24] More than 25 years later, it is essential to conceptualize with facts and figures how often requests of this nature were made and continue to be made.

More recently, a 2018 study surveyed 1,000 physicians nationwide on their beliefs about PAS national legislation.[25] 500 physicians were randomly selected from all medical specialties, and the other half were chosen from specialties more likely to participate in end-of-life care.[26] Of the 188 responses received, 60 percent believed PAS should be legalized in their state of practice, and nearly 70 percent believed it should be decriminalized.[27] Of the respondents, nine percent indicated that they would "unequivocally perform PAS if it were legal." In comparison, 15 and 13 percent indicated they would "unequivocally be willing to perform [PAS] if it were legal or decriminalized, respectively."[28] Alternatively, 12 percent and 15 percent of those who thought PAS should be legalized or decriminalized would "'never' perform PAS, respectively."[29] There is a discrepancy between belief and willingness in the practice of PAS.[30] It is possible that more physician support of PAS could lead to universal federal legislation or begin a more extensive conversation outside of the 11 jurisdictions permitting it currently.

The American Medical Association ("AMA") created the Council on Ethical and Judicial Affairs ("CEJA") to "promote adherence to high standards of ethical professionalism."[31] In 2019, the AMA House of Delegates, the principal policy-making forum made up of physicians, asked the CEJA "to study the issue of [MAID] with consideration of data collected from the states that currently authorize

24 *Id.* at 1193.

25 While "physician-assisted suicide" is not the preferred term to use, it is the term the survey used. Peter T. Hetzler, III et al., *A Report of Physicians' Beliefs about Physician-Assisted Suicide: A National Study*, 92 YALE J. BIOLOGY & MED. 575, 576 (2019).

26 *Id.* at 576-77.

27 *Id.* at 580.

28 *Id.* at 579.

29 *Id.* at 579-80.

30 *Id.* at 584.

31 *Judicial Function of the Council on Ethical & Judicial Affairs (CEJA)*, AM. MED. ASS'N, https://www.ama-assn.org/councils/council-ethical-judicial-affairs/judicial-function-council-ethical-judicial-affairs-ceja (last visited Oct. 31, 2023).

[MAID], and input from some of the physicians who have provided [MAID] to qualified patients."[32] For the very first time, the AMA affirmed that physicians "may be able to [provide MAID] in accordance with the [principles] of their conscience without violating their professional obligations."[33]

Autonomy is vital; patients have identified it as a reason to seek out MAID, alongside physical discomfort, severe pain, dependence on others, restriction to bed or wheelchair, and loss of control.[34] Synonymous with independence, the patient's autonomy must be protected throughout the process. Respect for autonomy is the foundation for informed consent in healthcare but does not necessarily give patients the authority to compel a healthcare professional to provide care. The AMA understands that physicians must "act on the goals of relieving suffering, respecting autonomy, and maintaining dignity at the end of [a patient's] life."[35] Proponents and opponents alike "agree that patient autonomy is critical and must be respected."[36] Only a few states have given legal permission for the clinical pathway of MAID,[37] though some clinicians find it to be a practice of compassionate care.[38] If MAID is legal in a state, its cost should be covered by some form of insurance. While we cannot choose the method by which we enter the world, expense should not limit access to how we wish to exit the world.

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32 COUNCIL ON ETHICAL & JUD. AFFS., REP NO. 2-A-19, PHYSICIAN-ASSISTED SUICIDE (2019), https://www.ama-assn.org/system/files/2019-05/a19-ceja2.pdf.

33 *Id.* at 10.

34 Patricia Illingworth & Harold Bursztajn*, Death with Dignity or Life with Health Care Rationing,* 6 PSYCH., PUB. POL'Y, & L. 314, 315 (2000).

35 COUNCIL ON ETHICAL & JUD. AFFS., *supra* note 32, at 3. However, the AMA represents less than a quarter of all physicians. Kevin Campbell, *Don't Believe AMA's Hype, Membership Still Declining* (June 19, 2019), https://www.medpagetoday.com/opinion/campbells-scoop/80583.

36 Lois Snyder Sulmasy & Paul S. Mueller, *Ethics and the Legalization of Physician-Assisted Suicide: An American College of Physicians Position Paper*, 167 ANNALS INTERNAL MED. 576, 577 (2017).

37 *In Your State*, *supra* note 9.

38 *Medical Aid in Dying is Not Assisted Suicide, Suicide or Euthanasia*, COMPASSION & CHOICES, https://compassionandchoices.org/about-us/medical-aid-dying-not-assisted-suicide (last visited Mar. 26, 2023).

I. History of the Right to Die

a. Common Law England and the Early American Colonies

The decision to medically end one's life has been controversial for centuries. Without the impactful debate of MAID's inception, there would be no need to contemplate whether insurance coverage is viable.

For over 700 years, "the Anglo-American common-law tradition has punished or otherwise disapproved of both suicide and assisting suicide."[39] The Common Law of England defined suicide, then described as "self-murder,"[40] as when a felonious person "deliberately put[s] an end to his own existence, or commit[s] any unlawful malicious act, the consequence of which is his own death."[41] Further, suicide was not excused when committed "to avoid those ills which [people] had not the fortitude to endure."[42] Should these ideals be followed today, the MAID legislature would be of naught.

The early American colonies adopted this perspective. Circa thirteenth century, legal treatise writer Henry de Bracton observed that "[j]ust as a man may commit felony by slaying another so may he do so by slaying himself."[43] Suicide was originally an ecclesiastical crime,[44] ranked "among the highest crimes."[45] The colonies established severe penalties, which were abolished over time.[46]

American perspectives of this right have evolved since its inception, including the distinctions between suicide and MAID. States recognized that it was "impractical" to punish someone who had committed suicide since they were already deceased.[47] In the United

39 Washington v. Glucksberg, 521 U.S. 702, 711 (1997).

40 *Id.* at 712 (quoting 4 W. Blackstone, Commentaries 189) [internal quotation marks omitted].

41 Shelly A. Cassity, *To Die or Not to Die: The History and Future of Assisted Suicide Laws in the U.S.,* 2009 UTAH L. REV. 515, 517 (2009).

42 *Glucksberg,* 521 U.S. at 712.

43 *Id.* at 711 (quoting 2 Bracton on Laws and Customs of England 423, note 150) [internal quotation marks omitted].

44 Cassity, *supra* note 41.

45 *Glucksberg*, 521 U.S. at 774 (quoting 4 W. Blackstone Commentaries 188-189) [internal quotation marks omitted].

46 *Id.* at 713.

47 Cassity, *supra* note 41, at 518.

States, the earliest statute to outlaw assisted suicide was enacted in New York in 1828, with many states subsequently following its lead.[48]

b. Twentieth and Twenty-First Century United States of America

Novel court cases like *People v. Kevorkian*[49] and *Washington v. Glucksberg,*[50] decided in 1994 and 1997, respectively, have paved the way for the nation's current MAID legislation. Oregon's trailblazing MAID legislation "has become the blueprint for other states seeking to enact" similar laws.[51] As previously mentioned, there are only 11 jurisdictions where MAID is permitted.[52] Death with Dignity, the "national leader in end-of-life advocacy and policy reform," is on a mission to spread awareness on how the legal and healthcare systems can unite to improve how those with terminal illnesses die.[53]

II. The Constitutional Issue: Equal Protection and Due Process

One of the earliest cases addressing the issue of whether PAS is constitutional was *Kevorkian*[54] in 1994. In this landmark decision, the Michigan Supreme Court held that the Constitution "does not prohibit states from imposing criminal penalties on one who assists another in committing suicide."[55] Jack Kevorkian, nicknamed "Dr. Death,"[56] was an active proponent of assisted suicide. He became the "central figure in a national drama surrounding assisted suicide" when he "challenged social taboos about disease and dying" by "arguing for

48 *Glucksberg,* 521 U.S. at 715.

49 447 Mich. 436 (1994).

50 *Glucksberg,* 521 U.S. at 702.

51 Stephanie M. Richards, *Death with Dignity: The Right, Choice, and Power of Death by Physician-Assisted Suicide,* 11 CHARLESTON L. REV. 471, 483 (2017).

52 *In Your State, supra* note 9.

53 *About Death with Dignity*, DEATH WITH DIGNITY, https://deathwithdignity.org/about/ (last visited Nov. 23, 2022).

54 447 Mich. 436 (1994).

55 *Id.* at 444.

56 Keith Schneider*, Dr. Jack Kevorkian Dies at 83; A Doctor Who Helped End Lives*, N.Y. TIMES (June 3, 2011) https://www.nytimes.com/2011/06/04/us/04kevorkianotehtml.

the right of the terminally ill to choose how they die."[57] In Justice Mallett's opinion, he believed that "[a] terminally ill individual who is suffering from great pain and who has made a competent decision should have a constitutional due process right to hasten his death."[58] Ultimately, the majority of the justices opined that the Constitution allows the state to impose criminal penalties upon a person "who assists another in committing suicide."[59]

Three years later, the Supreme Court in *Glucksberg* was tasked to answer whether Washington's "prohibition against 'caus[ing]' or 'aid[ing]' a suicide" violated the Due Process Clause of the Fourteenth Amendment."[60] The Court unanimously held that it did not.[61] At the time of this ruling, Washington law provided that "[a] person is guilty of [the felony of] promoting a suicide attempt when he knowingly causes or aids another person to attempt suicide."[62] However, this ruling was made over ten years before Washington passed its "death with dignity" legislation, which changed the landscape of criminal punishments.

In the same year *Glucksberg* was decided, the Supreme Court was faced with determining whether a state-specific ban on assisted suicide was unconstitutional.[63] The Court in *Vacco v. Quill* held that New York's ban on physician-assisted suicide did not violate the Fourteenth Amendment's Equal Protection Clause.[64] Similarly, in 2006, the Supreme Court in *Gonzales v. Oregon* answered the question of whether the Controlled Substances Act ("CSA") allows the United States Attorney General "to prohibit doctors from prescribing regulated drugs for use in physician-assisted suicide, notwithstanding a state law permitting the procedure."[65] The Court ultimately held that the CSA's prescription requirement "does not authorize the Attorney

[57] *Id.*
[58] *Kevorkian,* 447 Mich. at 524-525.
[59] *Id.* at 714.
[60] *Glucksberg*, 521 U.S. at 705-6.
[61] *Id.* at 706.
[62] *Id.* at 707.
[63] Vacco v. Quill*,* 521 U.S. 793, 797 (1997).
[64] *Id.*
[65] 546 U.S. 243, 248-9 (2006).

General to bar dispensing controlled substances for assisted suicide in the face of a state medical regime permitting such conduct."[66]

Physician-assisted death continues to be litigated today. A 2016 lawsuit arose from a doctor's fear of being prosecuted for manslaughter.[67] A retired physician suffering from incurable prostate cancer sought end-of-life treatment from a doctor willing to prescribe the lethal dose necessary.[68] A patient and his doctor, the Plaintiffs in this matter, argued that applying manslaughter laws to MAID was against the Equal Protection and Substantive Due Process right under the Massachusetts Constitution.[69] According to the Massachusetts Supreme Judicial Court, in a 2022 ruling, it is against the state constitution to allow doctors to contribute in PAS.[70] Until states that have not implemented Death with Dignity legislation do so, litigation will be the best course of action to fight the injustice of impeding someone from ending their own suffering through safe, medical means.

a. Exisiting Law Governing the Right to Die

The only way to receive a legal prescription for life-ending medication is to be in a state with a "death with dignity" law.[71] As previously mentioned, there are currently only 11 jurisdictions that have a death with dignity statute.[72] The majority of the states do not have active legislation.[73] These laws are implemented as safeguards to protect individuals from coercion, abuse, or inappropriate misuse.[74]

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66 *Id.* at 274-275.

67 Kligler v. Attorney General, 198 N.E.3d 1229, 1238 (Mass. 2002).

68 *Id.* at 1238.

69 *Id.* at 1238-9.

70 *Id.* at 1237.

71 *Frequently Asked Questions*, *supra* note 2. Currently, Oregon and Vermont passed new laws removing the residency requirement. *Oregon*, DEATH WITH DIGNITY, https://deathwithdignity.org/states/oregon/ (last visited Mar. 26, 2023); *Vermont*, DEATH WITH DIGNITY, https://deathwithdignity.org/states/vermont/ (last visited Mar. 26, 2023).

72 *In Your State , supra* note 9.

73 *Id.*

74 David R. Grube, M.D., *Ten Facts About Medical Aid in* Dying, HCP LIVE (Aug. 28, 2018) https://www.hcplive.com/view/ten-facts-about-medical-aid-in-dying.

b. *Timeline of "Death with Dignity" Legislation*

Mere months after the Supreme Court decided *Glucksberg*, Oregon's "Death with Dignity Act" became law.[75] In 2008, Washington's "Death with Dignity Act" passed with a majority vote and went into effect the following year.[76] Also, in 2009, in *Baxter v. State*, the Montana Supreme Court held that "nothing in Montana Supreme Court precedent or Montana statutes indicat[ed] that physician aid in dying [was] against public policy."[77] Further, the Court also concluded that "the Montana Rights of the Terminally Ill Act indicate[d] legislative respect for a patient's autonomous right to decide if and how he will receive medical treatment at the end of his life."[78] Simply, a terminally ill patient may seek and consent to physician-aid-in-dying.[79] Since this decision, Montana's "death with dignity" legislation has been threatened as lawmakers have attempted to remove physician protections, potentially exposing them to legal action.[80]

Four years later, Vermont's governor signed a bill called the "Patient Choice and Control at End of Life Act," making it the fourth state to enact "death with dignity" legislation.[81] California's governor signed the "End of Life Option Act" into law in 2015.[82] In 2016, Colorado voters approved the "End of Life Options Act,"[83] and

[75] *Physician-Assisted Suicide Fast Facts*, CABLE NEWS NETWORK (CNN), https://www.cnn.com/2014/11/26/us/physician-assisted-suicide-fast-facts (last updated May 26, 2022); *see* OR. REV. STAT. ANN. §§ 127.800-.897 (West 2020).

[76] *CNN*, *supra* note 75*; See* WASH. REV. CODE §§ 70.245.010-.220-.904 (2020).

[77] 224 P.3d 1211, 1222 (Mont. 2009).

[78] 224 P.3d 1211, 1222 (Mont. 2009)*; see* MONT. CODE ANN. §§ 50-9-101-505 (2019).

[79] *Baxter*, 224 P.3d at 1221.

[80] *Montana*, DEATH WITH DIGNITY, https://deathwithdignity.org/states/montana/ (last visited Nov. 20, 2022).

[81] *Chronology of Assisted Dying*, DEATH WITH DIGNITY NAT'L CTR., https://perma.cc/VQE5-GVUE/ (last visited Nov. 20, 2022.); *Vermont*, DEATH WITH DIGNITY, https://deathwithdignity.org/states/vermont/ (last visited Mar. 26, 2023); *see* VT. STAT. ANN. Tit. 18, §§ 5281-93 (West 2020).

[82] *California*, DEATH WITH DIGNITY, https://deathwithdignity.org/states/california (last visited Sept. 24, 2023)*; see* CAL. HEALTH & SAFETY CODE §443.1-.22 (West 2020).

[83] CNN, *supra* note 75; *see* COLO. REV. STAT. §§ 25-48-101 TO -123 (2020).

Washington, D.C. signed the "Death with Dignity" law, which went into effect the following year.[84]

More recently, in 2018, Hawaii's "Our Care, Our Choice Act" was signed into law.[85] Following the Aloha state, New Jersey and Maine governors signed the "Aid in Dying for the Terminally Ill Act" and "Death with Dignity Act" into law in 2019.[86]

New Mexico became the eleventh United States jurisdiction to enact a MAID law when its governor signed the "End of Life Options Act" in 2021,[87] allowing "terminally ill adults with a prognosis of six months or less to live to ask physicians for lethal medication."[88]

Ideally, all 50 states would unite to enact right-to-die legislation universally. More people suffering from debilitating diseases who feel they cannot continue to endure extreme pain or want to protect their families from such pain would have access to MAID as an option. Federal access to MAID services may prevent potential overuse of those services only accessible in a limited number of states.

c. Criteria Necessary to Satisfy the Right to Die Qualification

As previously mentioned, specific clinical criteria are necessary to satisfy the right-to-die requirements. In July 2012, Compassion & Choices, "the nation's oldest and largest nonprofit organization working to improve care and expand choice at the end of life," created the Physician Aid-in-Dying Clinical Criteria Committee to develop clinical criteria physicians willing to provide MAID services must follow.[89] The committee comprised various medical and legal experts who generated these criteria over one year.[90] According to each MAID statute, to begin the process of obtaining MAID treatment, the patient must make two oral requests for treatment, separated by at

84 CNN, *supra* note 75; *see* D.C. CODE ANN. §§ 7-661.01-.16 (West 2020).

85 CNN, *supra* note 75; *see* HAW. REV. STAT. ANN. §§ 327L-1-25 (LexisNexis 2019).

86 CNN, *supra* note 75; *see* N.J. STAT. ANN. §§ 26:16-1 TO -20 (West 2020); ME. STAT. tit. 22, § 2140 (West 2020).

87 *New Mexico*, DEATH WITH DIGNITY, https://deathwithdignity.org/states/new-mexico/ (last visited Nov. 20, 2022); *see* N.M. STAT. ANN. § 24-7C-1-8 (West 2021).

88 CNN, *supra* note 75.

89 David Orentlicher et al., *Clinical Criteria for Physician Aid in Dying*, 19 J. PALLIATIVE MED. 259, 260 (2016).

90 *Id.*

least 15 days,[91] and must also make a written request on a specified form,[92] separated by a waiting period of 48 hours between the request and the writing of the prescription.[93]

First and foremost, MAID services may only be provided to eligible patients.[94] Eligibility is determined by whether the patient has "an incurable condition that will likely result in death within six months,"[95] that is, those who are terminally ill. It is essential to recognize that the people pursuing this treatment are already at the end of their lives. According to a study aggregating 23 years of data on MAID in the United States, those who choose to die under MAID tend to be "older, white, educated, and diagnosed with cancer."[96] Patients and doctors seek alternative treatments, including MAID, when standard cancer treatment, alongside treatment for other terminal illnesses, is unduly burdensome economically and physiologically.[97]

Secondly, the patient must be an adult resident of a state with a MAID statute.[98] A patient must also be evaluated based on the "physical, psychological, spiritual, financial, and social issues" that may influence an end-of-life decision.[99] A mental health evaluation is

[91] CAL. HEALTH & SAFETY CODE § 443.2(a) (West 2020); COLO. REV. STAT. § 25-48-104(1) (2020); D.C. CODE ANN. § 7-661.02(a)(1) (West 2020); ME. REV. STAT. ANN. tit. 22, § 2140(11)–(13) (West 2020); N.J. STAT. ANN. §§ 26:16-10 (West 2020); OR. REV. STAT. ANN. §§ 127.840, .850 (West 2020); VT. STAT. ANN. tit. 18, § 5283(a)(2) (West 2020). Some states have a longer waiting period, such as Hawaii's Act that necessitates 20 days between oral requests. HAW. REV. STAT. ANN. §§327L-2,-9 & -11 (West 2020). Others, however, have a shorter waiting period, such as Washington's Act that necessitates at least 7 days between oral requests. WASH. REV. CODE §§ 70.245.090, .110(1) (2020).

[92] CAL. HEALTH & SAFETY CODE §§ 443.3(b), .11 (West 2020); COLO. REV. STAT. §§ 25-48-104, -112 (2020); D.C. CODE ANN. §§ 7-661.02, 7-661.02(b)–(c) (West 2020); HAW. REV. STAT. ANN. §§ 327L-2, -9, -23 (West 2020); ME. REV. STAT. ANN. Tit. 22, § 2140(4)–(5), (24) (West 2020); N.J. STAT. ANN. §§ 26:16-4, -5, -20 (West 2020); OR. REV. STAT. ANN. §§ 127.810, .897 (West 2020); VT. STAT. ANN. Tit. 18, § 5283(a)(4) (West 2020); WASH. REV. CODE §§ 70.245.030, .090, .220 (2020).

[93] D.C. CODE ANN. § 7-661.02(a)(2) (2020); HAW. REV. STAT. ANN. § 327L-11(West 2020); ME. REV. STAT. ANN. tit. 22, § 2140(13) (West 2020); N.J. STAT. ANN. § 26:16-10 (West 2020); OR. REV. STAT. ANN. § 127.850(1) (West 2020); WASH. REV. CODE § 70.245.110(2) (2020).

[94] Orentlicher, *supra* note 89.

[95] *Id.*

[96] The data was collected from the nine jurisdictions with MAID laws between 1998 and 2020. Elissa Kozlov et al., *Aggregating 23 Years of Data on Medical Aid in Dying in the United States*, 70 J. AM. GERIATRICS SOC'Y 3040, 3042 (2022).

[97] *Id.* at 3042-43.

[98] Orentlicher, *supra* note 89.

[99] *Id.*

required to pursue MAID treatment, which can be "a mechanism to ensure autonomy."[100] Informed consent must be established for an ethical pursuit of this treatment. This process includes three elements: the decision maker must be (1) competent, (2) informed, and (3) free.[101] These elements existed long before most states adopted their MAID legislation and may not be identical between states. However, every MAID statute requires the patient to have the decision-making capacity to understand the benefits, risks, and alternatives to MAID and make and communicate an informed healthcare decision.[102]

Certain safeguards are put in place to protect those seeking end-of-life care. Once a patient is deemed eligible, a physician willing to provide MAID services must receive informed consent that this is the treatment the patient wishes to pursue.[103] This means that the physician must explore and explain all other end-of-life options to the patient, who is making an informed and voluntary decision when seeking MAID.[104] These alternatives include aggressive management of symptoms, palliative care, and hospice, which should be the doctor's first recommendations.[105] Additionally, the physician should request a second opinion from an expert in palliative care to ensure that MAID is the best decision for the patient.[106] However, should this step be unfeasible, the patient's access to MAID remains the same.[107]

Physicians must thoroughly document the "elements of an informed request" in the patient's medical record, including their diagnosis, prognosis, and above-referenced alternatives to MAID.[108] "[M]AID must reflect a considered and voluntary choice by the

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100 Illingworth, *supra* note 34, at 317. Note, however, that if a mental health evaluation is applied mechanically, or in a perfunctory manner, it can hinder an individual's autonomy.

101 *Id.* at 320.

102 Thaddeus Mason Pope, *Medical Aid in Dying: Key Variations Among U.S. State Laws*, 14 J. HEALTH & LIFE SCI. L. 25, 38; CAL. HEALTH & SAFETY CODE § 443.1(c) (West 2020).

103 Orentlicher, *supra* note 89, at 260.

104 *Id.*

105 *Id. See also Medical Aid in Dying*, COMPASSION & CHOICES, https://compassionandchoices.org/our-issues/medical-aid-in-dying (last visited Feb. 10, 2023).

106 Orentlicher, *supra* note 89, at 260.

107 *Id.* Palliative care is defined as "medical and related care provided to a patient with a serious, life-threatening, or terminal illness that is not intended to provide curative treatment but rather to manage symptoms, relieve pain and discomfort, improve quality of life, and meet the emotional, social, and spiritual needs of the patient." *Palliative Care*, MERIAM-WEBSTER, https://www.merriam-webster.com/medical/palliative%20care (last visited Feb. 10, 2023).

108 Orentlicher, *supra* note 89, at 260.

patient."[109] The physician must also explain, and the patient must understand:

(1) the near certainty that ingesting the prescribed life-ending medication will cause death; (2) the possibility that ingesting the medication could cause nausea or vomiting or, rarely, could fail to cause death; (3) that the patient always retains the right to decide against AID; and (4) that the physician is willing to continue caring for the patient and to address subsequent palliative needs, whether or not the patient chooses to take the medication.[110]

The physician is required to alert the patient to the self-administration requirement.[111] Only the patient has physical control over the treatment.[112]

Various drugs are used in MAID, including barbiturates,[113] which slow down the brain's electrical activity.[114] One of Oregon's most prescribed drugs for end-of-life treatment is secobarbital.[115] The second leading drug in Oregon is pentobarbital.[116] However, cost varies based on medication type and availability. [117] There are also specific drug administration requirements; i.e., they must be self-administered.[118] Participation from physicians and pharmacists is voluntary, and those who become involved in MAID "are granted some immunity from liability."[119]

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109 *Id.*

110 *Id.*

111 *Id.* at 261.

112 *Id.*

113 Ana Worthington et al., *Efficacy and Safety of Drugs Used for 'Assisted Dying,'* 142 BRITISH MED. BULLETIN 15, 17 (2022).

114 Sean Riley, *Navigating the New Era of Assisted Suicide and Execution Drugs*, 4 J. L. & BIOSCIENCES 424, 427 (2017).

115 Jennifer Fass & Andrea Fass, *Physician-Assisted Suicide: Ongoing Challenges for Pharmacists*, 68 AM. J. HEALTH-SYS. PHARM. 846, 847 (2011).

116 *Id.*

117 *Frequently Asked Questions, supra* note 2.

118 Orentlicher, *supra* note 89, at 261.

119 Kevin B. Kroeker & Marisa E. Andelson, *Who Will Pay for Aid-in-Dying Drugs?*, DAILY JOURNAL (Oct. 3, 2016), https://www.crowell.com/a/web/kENUF3BHyRY6L4cYmdb5Qy/4TtkGz/20161003-who-will-pay-for-aid-in-dying-drugs-kroeker-adelson.pdf. Because the patient is choosing this type of treatment, responsibility is not put entirely in the physicians' hands.

Ingesting end-of-life medication is a two-step process.[120] The patient first takes an antiemetic,[121] which is typically used to thwart nausea and vomiting.[122] About an hour later, the patient ingests a barbiturate, which must be consumed within 30 to 120 seconds.[123] As a type of sedative, the barbiturate will relax the patient, slowing down the activity of their brain cells, helping to ease the patient into a deep sleep,[124] ultimately resulting in a coma and then death. Friends, family, and even the physician may surround the patient to show love and support. If the physician is not physically present, someone must notify them, hospice, or even a funeral home of the time of death.[125]

One of the caveats of the right-to-die treatment is that a person is not allowed to travel to a state with a "death with dignity" law solely to obtain the medication to travel back home afterward.[126] The law has established that a person must be a resident of one of the "death with dignity" states to plan to die in that state.[127] However, it is possible to move to a "death with dignity" state to pursue this option.[128]

Following informed consent and thorough documentation, the attending physician must inform the patient that they can change their mind anytime during the process.[129] The patient must be made aware that even if they are prescribed and have obtained the life-ending medication, they are not obligated to ingest it.[130]

Finally, the attending physician must offer the patient "an opportunity to rescind their request."[131] Someone may change their mind at any time throughout this process. Specific legislation requires a waiting period between the first request for MAID treatment and when a

120 Orentlicher, *supra* note 89, at 261.

121 *Id.*

122 Jacquelyn Cafasso, *Antiemetic Drugs*, HEALTHLINE, https://www.healthline.com/health/antiemetic-drugs-list (last updated Sep. 3, 2018).

123 Orentlicher, *supra* note 89, at 261.

124 *Barbiturates*, Cleveland Clinic, https://my.clevelandclinic.org/health/treatments/23271-barbiturates (last visited Feb. 10, 2023).

125 Orentlicher*, supra* note 89, at 261.

126 *Frequently Asked Questions*, *supra* note 2.

127 *Id.*

128 *Id.* Note, however, that the patient must be able to show that they are currently a resident of such state and nevertheless qualify for MAID.

129 COMPASSION & CHOICES, *supra* note 105.

130 *Id.*

131 *Id.*

prescription is written.[132] With something as permanent as death, both the physician and patient must be sure that this is a process they want to follow through with. If the physician is uncertain that the patient is requesting this treatment "voluntary[il]y, [and] rational[ly]," the physician should schedule a follow-up appointment 10 to 15 days later to ensure the treatment is still desired.[133] This time buffer "generally will clear up any residual doubts."[134] However, this waiting period may also hinder someone's ability to receive the treatment should they make a definitive decision during the time they are instructed to wait.

III. Is the Right to Die a Service Covered by Health Insurance?

The statutes that govern the right to die do not specify who or what entity pays for the services.[135] There is a common misconception that pursuing right-to-die treatment will negatively impact insurance coverage.[136] According to Compassion & Choices, "there is NO connection between denial of insurance coverage and [MAID]."[137] Most importantly, there has not been one instance where an insurance company denied treatment due to the MAID option.[138]

However, for those who rely on federally funded health insurance, the right to die is financially inaccessible.[139] According to a 2016 article by the Daily Journal titled "*Who Will Pay for Aid-in-Dying Drugs?*," "[f]ederal funds for Medicare, Medicaid, and other federal health care programs cannot be used to pay…for health benefit coverage that includes any coverage for items or services related to assisted suicide."[140] Most people who request MAID services "must pay for MAID prescriptions out-of-pocket, as Medicare and other federal health insurance programs do not cover aid in dying

132 Orentlicher, *supra* note 89, at 261.

133 *Id.*

134 *Id.*

135 *Frequently Asked Questions*, *supra* note 2.

136 *Insurance Coverage & Medical Aid in Dying*, COMPASSION & CHOICES, https://compassionandchoices.org/resource/insurance-coverage-medical-aid-dying/ (last visited Nov. 23, 2022).

137 *Id.*

138 *Id.*

139 *Frequently Asked Questions*, *supra* note 2.

140 Kroeker, *supra* note 119.

costs."[141] Between 2010 and 2016, of the 35 patients participating in the Death with Dignity program at the Fred Hutchinson Cancer Research Center in Washington State, 66% "either chose to pay cash for the medication or were insured through a federally funded plan (including 7 Medicare beneficiaries, 2 federal employees, 1 Tri-Care enrollee, and 1 Community Health Plan of Washington enrollee) that did not cover any portion of the [drug] cost."[142] Statistically speaking, people who want MAID treatment will either have to pay a significant amount out-of-pocket or opt out of receiving it entirely due to its unaffordability.

Portions of the United States Code regulate this type of funding. The Assisted Suicide Funding Restriction Act of 1997 "prohibits the use of Federal funds to provide or pay for any health care item or service, or health benefit coverage, for the purpose of causing, or assisting to cause, the death of any individual including mercy killing, euthanasia, or assisted suicide."[143] According to former President, William J. Clinton, who signed the bill into law, the Act restricts access to public funds, ensuring that taxpayer dollars will not be used to "subsidize or promote assisted suicide."[144] As of January 2021, the Centers for Medicare & Medicaid Services did not foresee any revisions to this existing policy.[145]

Additionally, the "Restriction on Use of Federal Funds Under Health Care Programs" explains that:

[N]o funds appropriated by Congress for the purpose of paying (directly or indirectly) for the provision of health care services may be used—(1) to provide any health care item or service furnished for the purpose of causing, or for the purpose of assisting in causing, the death of any individual, such as by assisted suicide, euthanasia, or mercy killing; (2) to pay (directly, through payment of Federal financial participation or other matching payment, or otherwise) for such

141 Kozlov, *supra* note 96, at 3042.

142 Veena Shankaran et al., *Insurance Coverage and Aid-in-Dying Medication Costs–Reply*, 3 JAMA ONCOL. 1138, 1138 (Aug. 2017), https://jamanetwork.com/journals/jamaoncology/fullarticle/2628763.

143 42 U.S.C. §14401 (1997).

144 William J. Clinton, *Statement on Signing the Assisted Suicide Funding Restriction Act of 1997*, THE AM. PRESIDENCY PROJECT (Apr. 30, 1997), https://www.presidency.ucsb.edu/node/224220.

145 42 U.S.C. §14401 (1997).

an item or service, including payment of expenses relating to such an item or service; or (3) to pay (in whole or in part) for health benefit coverage that includes any coverage of such an item or service or of any expenses relating to such an item or service.[146]

Subsection (d) clarifies that the restriction on funding applies to Medicare, Medicaid, and any other federal health program.[147] This type of restraint may prohibit a healthcare program that receives federal funding from rendering MAID treatment,[148] thereby limiting resources for those in need.

Adversely, commercial insurance plans are free to choose whether to cover MAID drugs and services.[149] This may favor those passionate enough to fight for insurance coverage for MAID.

Before 2012, patients paid $500 for a lethal drug prescription.[150] By 2016, that amount rose to upwards of $25,000.[151] The cost of Secobarbital increased by roughly 643 percent over just six years and costs nearly ten times as much as Pentobarbital.[152] Price gouging is a "problem [that] stems from lack of coverage of the practice by most forms of health insurance."[153]

Alternatively, there are ongoing concerns that, for some, dying is less expensive than having the support and services needed to live. There are instances of Canadians who have chosen MAID because their living conditions cannot be improved.[154] For example, an Ontario woman was approved for MAID after her chronic condition became intolerable, and her disability stipend was financially insufficient.[155] Canada's first MAID legislation was passed on June 17,

146 42 U.S.C. § 14402(a) (1997).

147 42 U.S.C. § 14402(d) (1997).

148 Kroeker, *supra* note 119.

149 *Id.*

150 Riley, *supra* note 114, at 429-30.

151 *Id.* at 430.

152 *Id.*

153 *Id.*

154 Leyland Cecco, *Are Canadians Being Driven to Assisted Suicide by Poverty or Healthcare Crisis?*. THE GUARDIAN-CANADA (May 11, 2022), https://www.theguardian.com/world/2022/may/11/canada-cases-right-to-die-laws.

155 *Id.*

2016,[156] with amendments following on March 17, 2021.[157] The amendments repealed the requirement that "permitting access to medical assistance in dying for competent adults" be "reasonably foreseeable," changing the outlook of the law in its entirety.[158] Three United Nations human rights experts warned that this law could devalue the lives of those who are disabled, suggesting that death is the better alternative to living with a disability.[159] MAID should not be a last resort for the disabled or underserved communities.

While federal funds alone may not be used for MAID treatment, state funds can pay for joint state and federal programs.[160] The use of these funds would provide greater access to healthcare to hundreds of people who may be unable to afford it on their own dime. When considering whether it is right to provide government funds for MAID treatment, it is essential to recognize the alternative; if someone cannot afford and, therefore, is not granted access to medically recognized end-of-life treatment, that person may choose a more dangerous way to end their life.

Unfortunately, it is more expensive for insurance companies to offer aid in dying than to provide care while an individual is alive.[161] This means that all expenses will be paid out-of-pocket by the patient requiring or requesting them.[162] Of the family members or friends that step forward to foot the bill, "nearly one-third will end in poverty because they will be forced to spend all of their savings on costly end-of-life treatments."[163] Since mandated payment for life-ending

156 *See* An Act to Amend the Criminal Code and to Make Related Amendments to Other Acts (medical assistance in dying), S.C. 2016, c 3 (Can.), https://www.parl.ca/Content/Bills/421/Government/C-14/C-14_4/C-14_4.PDF.

157 *See* An Act to Amend the Criminal Code (medical assistance in dying) S.C. 2021, c 2 (Can.), https://parl.ca/Content/Bills/432/Government/C-7/C-7_4/C-7_4.PDF.

158 S.C. 2016, c 3 (Can.); S.C. 2021, c 2 (Can.).

159 U.N. Hum. Rts. Off. of the High Comm'r, *Disability is not a Reason to Sanction Medically Assisted Dying – UN Experts* (Jan. 25, 2021), https://www.ohchr.org/en/press-releases/2021/01/disability-not-reason-sanction-medically-assisted-dying-un-experts.

160 Kroeker, *supra* note 119.

161 Helena Berger, *When Insurance Companies Refuse Treatment "Assisted Suicide" Is No Choice at All*, AM. ASS'N OF PEOPLE WITH DISABILITIES (Jan. 24, 2017), https://www.aapd.com/when-insurance-companies-refuse-treatment-assisted-suicide-is-no-choice-at-all/.

162 *Id.*

163 Kelly Lyn Mitchell, *Note: Physician-Assisted Suicide: A Survey of the Issues Surrounding Legalization*, 74 N.D. L. REV. 341, 347 (1998); According to the U.S. Bureau of Labor Statistics, the average annual expenditures of a household in 2021 was $66,928, and of that, $5,452 was

services does not exist, entire families suffer financially and emotionally after losing a loved one. This financial pressure may be debilitating enough to prevent someone from pursuing end-of-life treatment altogether.

There is a strict dichotomy between MAID treatment and other end-of-life treatments, such as hospice or palliative care. The latter may be covered by federal and private health insurance.[164] The difference between palliative care and MAID services is that the former's purpose is to "enhance a person's current care by focusing on quality of life for them and their family."[165] Similarly, hospice care "focuses on the care, comfort, and quality of life of a person with a serious illness who is approaching the end of life."[166] Arguably, that is the same objective as end-of-life treatment; some people choose death as the better alternative so their families no longer have to watch their loved ones suffer. Not all suffering can be satisfactorily assuaged through hospice or palliative care.

Hospice and palliative care organizations are reluctant to support MAID. While the National Hospice and Palliative Care Organization ("NHPCO") supports individuals' right to bodily autonomy, it is opposed to MAID "as a societal option to alleviate suffering" for many reasons.[167] Among these reasons is the lack of research regarding the outcomes of MAID and the disparities in health and medical care.[168] Ultimately, the NHPCO supports medical care for patients so long as sources of suffering are assessed, and other interventions to prevent or reduce suffering are offered.[169]

spent on healthcare. The average number of people in a household was 2.4. BLS Reports, *Consumer Expenditures in 2021*, U.S. BUREAU OF LAB. STATS. (Jan. 2023), https://www.bls.gov/opub/reports/consumer-expenditures/2021/home.htm#:~:text=Average%20annual%20expenditures%20rose%20by,decline%20from%202019%20to%202020.

164 *What are Palliative Care and Hospice Care?*, NAT'L INSTS. OF HEALTH, https://www.nia.nih.gov/health/what-are-palliative-care-and-hospice-care (last visited Mar. 26, 2023).

165 *Id.*

166 *Id.*

167 *Statement on Medical Aid in Dying*, NAT'L HOSPICE & PALLIATIVE CARE ORG. (June 16, 2021), https://www.nhpco.org/wp-content/uploads/Medical_Aid_Dying_Position_Statement_July-2021.pdf.

168 *Id.*

169 *Id.*

Polling outlet, Gallup, has been reporting on MAID for years, recording a steady increase in the approval of MAID each year.[170] In 2015, 68 percent of Americans supported medical aid in dying,[171] and five years later, that number rose to 74 percent.[172] This support has nearly doubled since 1947, when Gallup conducted its first poll.[173]

a. *The Right to Die's Effect on Life Insurance*

According to the National Association of Insurance Commissioners ("NAIC"), life insurance "provides financial protection for loved ones should the policyholder die."[174] An insurer cannot cancel their life insurance policy based on a change in the policyholder's health.[175] However, "choosing death may void [one's] life insurance coverage" in certain circumstances.[176]

Life insurance coverage depends on the type of policy purchased, including exclusions and, in some cases, suicide clauses.[177] This particular contract is "intended to shift to the insurer the risk of loss arising from an occurrence that is beyond the insured's control," a terminal illness in this case.[178] Should an insured hasten their own death, a "suicide clause" will customarily be included in the policy, which is "intended to perpetuate the fortuity of death and square up relative positions of the insurer and the insured in terms of their agreed allocation of risk."[179]

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170 *Polling on Voter & Healthcare Provider Support for Medical Aid in Dying*, COMPASSION & CHOICES, https://compassionandchoices.org/resource/polling-medical-aid-dying (last visited Feb. 10, 2023).

171 Andrew Dugan, *In U.S., Support Up for Doctor-Assisted Suicide*, GALLUP (May 27, 2015), https://news.gallup.com/poll/183425/support-doctor-assisted-suicide.aspx.

172 *The Facts about Medical Aid in Dying*, COMPASSION & CHOICES, https://compassionandchoices.org/resource/the-facts-about-medical-aid-in-dying (last visited Feb. 10, 2023).

173 *Id.*

174 *Life Insurance*, NAT'L ASS'N OF INS. COMM'RS, https://content.naic.org/cipr-topics/life-insurance (last updated June 23, 2022).

175 *Id.*

176 Schimri Yoyo, *How do Life Insurance Companies Handle Death with Dignity Cases?*, QUICKQUOTE, https://www.quickquote.com/life-insurance-and-death-with-dignity/ (last updated July 28, 2023).

177 *Id.*

178 Frederick R. Parker, Jr. et al., *Life Insurance, Living Benefits, and Physician-Assisted Death,* 22 BEHAV. SCI. & L. 615, 618 (2004).

179 *Id.*

It is clearly and understandably riskier for an insurance company to cover someone closer to death. A suicide clause reflects the inconsistency of providing life insurance to those who wish to end their life; the policy's purpose must be weighed against the risk from which the insured seeks protection.[180] However, suicide is distinctive from MAID,[181] and life insurance policies should reflect that difference.

Insurance clauses and payouts differ on whether a state has a "death with dignity" law.[182] Further, there are exclusions that a life insurance company will not cover, such as when an insurer commits suicide during the first two years of a policy.[183] Unfortunately, life insurance providers have not instituted a "death with dignity quote."[184] This excludes terminally ill patients from taking one vital avenue to bestow upon their loved ones an inheritance.

It is essential to recognize that aid-in-dying legislation specifies that "death with dignity is not suicide."[185] This means that the choice to end life under a MAID statute does not affect any type of insurance, including life insurance.[186]

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180 *Id.*

181 The American Association of Suicidology recognizes the difference between suicide and MAID. In 2017, it came out and said that "'[s]uicide' is not the same as 'physician aid in dying.'" In fact, they are more opposite than meets the eye. The first is that in suicide, a life that could have been lived is cut short, while in MAID, the person is terminally ill and does not have much life left to live. Another key difference is that a person choosing suicide is in such despair and cannot enjoy life enough to find it worth living, while in MAID, the person does not necessarily want to die but instead wants to live but cannot do so. The American Association of Suicidology, *"'Suicide' is Not the Same as 'Physician Aid in Dying'"* (Oct. 30, 2017), https://ohiooptions.org/wp-content/uploads/2016/02/AAS-PAD-Statement-Approved-10.30.17-ed-10-30-17.pdf.

182 Yoyo, *supra* note 176.

183 *Id.*

184 *Id.*

185 *Frequently Asked Questions*, *supra* note 2; *See also* OR. REV. STAT. ANN. §§ 127.800-.897 (West 2020); Washington Death with Dignity Act, WASH. REV. CODE §§ 70.245.010-.220-.904 (2020); Montana Rights of the Terminally Ill Act, MONT. CODE ANN. §§ 50-9-101-505 (2019); VT. STAT. ANN. tit. 18, §§ 5281-93 (West 2020); End of Life Option Act, CAL. HEALTH & SAFETY CODE §§ 443.1-.22 (West 2020); Colorado End-of-Life Options Act, COLO. REV. STAT. §§ 25-48-101 TO -123 (2020); Death with Dignity Act of 2016, D.C. CODE ANN. §§ 7-661.01-.16 (West 2020); HAW. REV. STAT. ANN. §§ 327L-1-25 (West 2019); N.J. STAT. ANN. §§ 26:16-1 TO -20 (West 2020); ME. STAT. ANN. tit. 22, § 2140 (West 2020); N.M. STAT. ANN. § 24-7C-1-8 (West 2021).

186 *Id.*

b. Proposed Solution for Who Should Pay for Access to Right to Die Services

Under the Patient Self Determination Act of 1990, certain healthcare providers and health maintenance organizations are required "to assure that individuals receiving services will be given an opportunity to participate in and direct healthcare decisions affecting themselves."[187]

Since neither Medicaid, Medicare, nor private insurance contribute full or partial payment towards MAID, the best solution to allow this treatment to be given to anyone who desires or requires it is for someone to pay for it. Putting the entire financial responsibility on one person, or even one family, is unduly burdensome. This differs from traditional healthcare costs because the person for whom the healthcare would benefit is deceased and can no longer financially contribute. For this to happen, it may require each state and Congress to expand its Medicare, Medicaid, and private insurance coverage. Since MAID is not legal nationwide, handling this type of expansion state-by-state makes the most sense. Further, it may even require these insurance companies to include it in their policy. By including a "death with dignity" clause, private insurance companies may expand their business and make more money.

NAIC defines "medical necessity" when describing coverage offered under a benefit plan.[188] As part of the certification process, an insurer may request a "Letter of Medical Necessity" from the provider regarding the treatment necessitated.[189] It is unfair that insurance companies, not doctors directly, retain the power to determine whether a type of treatment suits a patient. Physicians determine what is clinically appropriate and have the education to do so. In contrast, the insurance companies determine whether and how much they will pay for it consistent with the terms of the relevant contract. While the insurance companies should ensure the underlying patient-specific

187 Patient Self Determination Act of 1990, H.R. 4449, 101st Cong. (1990). 42 U.S. Code § 1395cc(f); 42 U.S. Code § 1396a(w)

188 *Understanding Health Care Bills What is Medical Necessity?* NAT'L ASS'N OF INS. COMM'RS, https://content.naic.org/sites/default/files/consumer-health-insurance-what-is-medical-necessity.pdf (last visited Mar. 26, 2023).

189 *Id.* at 2.

facts satisfy the terms of the contract, insurance companies are not the ones meeting face-to-face with the patient and observing their pain and suffering.

Society must weigh the benefits and detriments of alternative means of payment. The money would come from taxpayers' pockets if federal funds were to cover this form of healthcare. Indisputably, increasing funding sources to include federal funding would meet less resistance in a state with "death-with-dignity" legislation.

Conclusion

Access to MAID services is limited to those who can afford it. Having right-to-die statutes enacted enables patients to control the end of their life story, providing them full autonomy during their darkest hour. We do not choose the way we enter this world, but if suffering from a terminal illness, we should be able to choose the way we leave this world.