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Who will pay for aid-in-dying drugs?

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On June 9, the California End of Life Option Act took effect. The law allows certain adults with terminal illnesses to request a prescription for a drug that will end their life ("aid-in-dying drug"). The law was inspired by Brittany Maynard, a 29-year-old terminally ill California teacher who, in 2014, under much publicity, moved to Oregon to take advantage of that state's similar law.

Separate from its hot-button nature, the act generates significant questions for health insurers and patients about who is responsible for paying for these drugs and related services. Under current federal law, federal funds for Medicare and other federal health care programs cannot be used for items or services related to assisted suicide or to pay in whole or in part for benefit coverage that includes coverage of these items or services. This means that many federal government health programs, including traditional Medicare, Medicare Advantage, and other programs cannot provide coverage for the aid-in-dying drugs or service in California, but jointly state and federally funded programs may be able to provide these services using state funds. For example, Medi-Cal, the California Medicaid program, covers the drugs and services through its fee-for-service (FFS) program and as a FFS carve-out benefit for managed care plans. The law does not impose an obligation on private health insurers, including commercial plans selling employer group and individuals policies, to cover these services, nor are these plans prohibited from covering them.

End of Life Option Act Requirements

The act allows terminally ill adults to request a prescription for an aid-in-dying drug that will end their life. To be eligible, multiple conditions must be satisfied, including the requirements that the individual be a California resident, have the physical and mental ability to self-administer the drug, and make three (two oral, and one written) requests for the drug. Physicians and pharmacist participation is entirely voluntary and those involved in the process are granted some immunity from liability.

While laying out many details about the overall regulatory scheme, the End of Life Option Act is silent as to responsibility for payment for the aid-in-dying drugs or related services among the patient, the insurer or government program covering the patient, or other entities. This ambiguity generates practical questions and concerns for people enrolled in certain federal health care programs. Commercial plans may choose to cover the aid-in-dying drugs and services or not. The law additionally specifically prohibits insurers and health care service plans from providing any information in communications about the availability of the aid-in-dying drugs without a request by the individual or her physician at the behest of that individual.

Federal Ban on Health Program Funding for Assisted Suicide

Federal funds for Medicare, Medicaid and other federal health care programs cannot be used to pay (in whole or in part) for health benefit coverage that includes any coverage for items or services related to assisted suicide.

It appears that the federal programs listed in the applicable federal law, and health insurers under those programs, cannot cover either the aid-in-dying drugs or the services provided to facilitate the taking of these drugs as set forth under the End of Life Option Act.

In 1997, Congress passed a law that restricts funding for health care programs that include coverage of assisted suicide services. 42 U.S.C. Section 14402(a) explains:

"no 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 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."

Subsection (c) states that the restriction covers Medicare, Medicaid, the Federal Employee Health Benefits Program (FEHBP), Veterans Health Administration, TRICARE/ CHAMPUS, and many other federal health programs.

Thus, the above federal law on its face prohibits many government programs and their payors from covering items and services that assist in causing death, which would include the drugs and services addressed by the End of Life Option Act. The specific limitation in 42 U.S.C Section 14402(a)(3) barring the use of federal funds to pay in whole or in part for "health benefit coverage" including assisted suicide services could possibly prohibit a health program that receives any federal funding, such as a state Medicaid program, from covering any of the End of Life Option Act drugs or services. Alternately, the statute could be interpreted to mean that the federal funds allocated for such a program could not be used for these drugs or services, meaning that a joint state and federally funded program such as Medicaid could still cover these items using state funds. The California Medicaid agency, the Department of Health Care Services (DHCS), appeared to follow the second interpretation when it announced in All Plan Letter 16-006 (June 2016) that the Medi-Cal Feefor- Service (FFS) program would cover the End of Life Act services, and Medi-Cal managed care plan members could receive these services as a FFS carve-out benefit.

Commercial Insurance Coverage

The End of Life Option Act neither specifically requires nor prohibits coverage of these services by commercial insurers and health care service plans in California that provide individual and employer-sponsored coverage. The California Department of Managed Health Care (DMHC), which regulates health care service plans, provided informal comments on the law during a call with health plan representatives on May 31, 2016. DMHC explained that it did not interpret the act to create a benefit mandate that requires coverage of the aid-in-dying drugs, and plans could choose to cover the drugs just as they would any others. DMHC added that it considers other services related to the End of Life Act to be basic health care services that plans must cover. In line with the prohibition from providing information to members about the availability of the aid-in-dying drugs absent a request, DMHC explained that plans cannot refer to these services in evidences of coverage (EOCs) or in materials that show which providers participate in administration of the aid-in-dying drugs.

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