Article from

Product Matters

July 2016
Issue 104

An Actuarial Analysis of the Oregon Death with Dignity Act

By Jay M. Jaffe

The Oregon Death with Dignity Act[1] (DWDA) was enacted in 1997. The purpose of the act is to allow terminally ill Oregon citizens "to obtain and use prescriptions from their physicians for self-administered, lethal doses of medications."[2] There are now three other states (California, Vermont, and Washington) with similar acts and a fourth state, Montana, where the state Supreme Court has ruled that "nothing in the state law prohibited a physician from honoring a terminally ill, mentally competent patient's request by prescribing medication to hasten the patient's death."[3]

This article, however, mainly reviews the Oregon act because it has been operative for the longest time. Each year Oregon's Public Health Division publishes a report of the experience under the DWDA that provides insight into the actual operation of the law.

DWDA HIGHLIGHTS[4]

The Oregon DWDA is available only to individuals 18 or older.

The DWDA requires a patient to make an "informed decision . . . that is based on an appreciation of the relevant facts." The decision occurs only after a patient is "fully informed by the attending physician of" the following:

a) The patient's medical diagnosis;
b) The patient's prognosis;
c) The potential risks of the prescribed medication;
d) The probable results of the prescribed medication; and
e) The feasible alternatives (e.g., palliative care, hospice, etc.)

Only patients who have a "terminal disease" are eligible to request to receive the medication. The DWDA defines a terminal illness as "an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months."[5]

GENERAL PROGRAM EXPERIENCE

During the period from 1998 to 2014 there were 869 deaths under this program in Oregon. The median age of patients who have availed themselves of the program is 71.[6]

Almost 80 percent of the patients have suffered from some form of a malignant neoplasm. The next largest underlying illness category (8 percent) has been amyotrophic lateral sclerosis (ALS). Thus, over 85 percent of all patients can be classified into these two general illness groups.[7]

The three major end of life concerns[8] given by the patients prompting them to utilize the DWDA are:

- Loss of autonomy (92 percent)
- Less ability to engage in activities making life enjoyable (89 percent)
- Loss of dignity (79 percent).

These reasons are very understandable given the types of illnesses from which the patients had been suffering and the terminal nature of these conditions.

Patient usage of the DWDA definitely varies by age. At least until now patients in the 45 to 74 year old category have been proportionately the largest users of the DWDA. As a percentage of total deaths in Oregon, the 45 to 74 year old age group has utilized the DWDA 50 percent and 400 percent more often than those in the age groups 75 to 84 and 85+, respectively. There seems to be logic to greater usage by age given the underlying concerns the patients described as prompting them to utilize the DWDA. Namely, younger patients are more concerned about quality of life rather than longevity.

RELATIONSHIP TO INSURANCE AND ANNUITY POLICIES

The DWDA recognizes the interrelationship between its provisions and life, health, accident insurance or annuity policies. It specifies that "the sale, procurement, or issuance" of any of the enumerated policies "shall not be conditioned upon or affected by the making or rescinding of a request by a person for medication to end his or her life in a humane and dignified manner." It then continues to state that "a qualified patient's act of ingesting medication to end his or her life in a humane and dignified manner" shall NOT have an effect upon any of the aforementioned insurance policies.[9]

A brief discussion of the issues associated with the DWDA in relation to several types of insurance follows.

1. **Underwritten Life Insurance**
   Life insurance policies almost always exclude suicide during

the first two years of coverage. However, Section 880 of the DWDA states that "actions taken in accordance with [the DWDA] shall not for any purpose, constitute suicide . . . "[10]

It follows that the DWDA might override the policy terms in at least one situation. For example, in the event an insured were to apply and be approved for a life insurance policy while in good health but shortly after the policy effective date be diagnosed with a terminal illness and elect to terminate his or her life under the DWDA, under these tragic circumstances it is likely that the full death benefit would have to be paid.

2. **Accidental Death Insurance**
   Accidental Death (ADB) insurance is issued both as a rider to a life insurance policy and as standalone policy. An accidental death benefit might also be provided during the initial period of coverage for a graded death benefit policy.

   ADB policies and riders almost always exclude suicide. The exclusion would usually read similar to the following: "Any attempt at suicide, or intentionally self-inflicted injury, while sane or insane." For ADB coverage the suicide provision is operative for all years and not just the first two years.

   An accidental death is typically defined as: "An accidental bodily injury sustained by the Insured which is a direct result of an accident, independent of disease, bodily or mental illness, infirmity, or any other cause, which occurs while the Policy is in force." Moreover, the word injury is probably defined using language such as "injury does not include any accidental result from medical, surgical or dental treatment."

   Therefore, it would appear that under accidental death insurance where accidental death is defined such as described in the prior paragraph, while suicide under the DWDA would not be excluded, the insurance company would not be liable for any accidental death benefit because the cause of death did not involve bodily injury.

   The takeaway from the analysis is that when drafting the definition of accidental death used in policies or riders, the DWDA or similar legislation in other states needs to be carefully considered if this cause of death is to be excluded from ADB coverage. Because assisted death acts are not uniform by state, it is advisable to consider the specific language in each state-by-state laws when drafting any future ADB exclusion provisions.

3. **Health Insurance**
   Assuming that the patient is covered by a health insurance policy, the terms of the health insurance policy would determine whether (a) the medications prescribed for the patient and (b) any medical expenses arising from the taking of the medications would be covered. (However, it is highly unlikely that the circumstances described in (b) would occur.)

   A health insurance company would probably not contest any health insurance related claims considering that several months of qualifying expenses would not be incurred.

4. **Annuities**
   Annuity benefits cease at the death of an annuitant (although there could be joint annuitant, certain period, etc. that would require additional annuity benefits.) Conceivably, someone could contend that any annuity benefits should be continued until the end of the patient's expected lifetime but this would seem to be a very tenuous request given the extremely short life expectancy of the annuitant at the time of death. Practically, there would probably not be enough money at stake to even raise this contention.

IMPACT ON LIFE INSURANCE PREMIUMS FROM DWDA

During the period 2012 to 2014 there were 263[11] deaths from DWDA patients and 99,586[12] total deaths in Oregon for residents over age 15. There is a slight mismatch between these two statistics because no one under 18 is eligible to utilize the DWDA but any distortion is di minimus. DWDA deaths are 0.26 percent (263/99,586) of Oregon's total deaths for the DWDA eligible ages during the recent three year period.

Based on statistics just cited, the early payment of life insurance claims, assuming that deaths occur on average three months prior to natural death, can be calculated according to the following simple model.

1. Assumed annual lost investment income rate: 3 percent
2. Impact of three months' lost investment income (very simplistically) = 3 percent x 0.25 = 0.75 percent
3. Percentage of deaths using DWDA = 0.26 percent
4. Extra death cost from DWDA usage = 0.75 percent x 0.26 percent = 0.2 percent

As the above analysis shows, other than a few DWDA deaths that might would otherwise be denied under the suicide provision during the first year or two of a life insurance policy, the Oregon DWDA should not have any material impact on life insurance claim costs.

ACTUARIAL OPPORTUNITIES

According to one survey, there are 24 other states that have recently considered the death with dignity matter.[13] End-of-life issues are a growing concern. But even without further death

with dignity legislation, both the life insurance industry and the actuarial profession have many opportunities to ease end-of-life problems relating to financial and non-financial matters.

For example, in the past several decades long term care products have been introduced by insurance companies. Another example of a relatively new end-of-life benefit is the option for insureds to accelerate death proceeds from life insurance policies at the option of the policy owner in order to provide for end-of-life needs. A secondary market for life insurance policies now exists (including viatical settlements) that offers another way to liquidate life insurance policies during the life of the insured.

Nothing can prepare any of us for the inevitable, but actuaries can and should take a leadership role to make more options available to ease how we deal with the final stage of life. Here are a few additional opportunities.

1. **Promote living benefits in life insurance policies:** Living benefits that are triggered by end-of-life events (e.g., terminal illness) are now being attached to life insurance policies. These benefits can be added at little or no cost. Actuaries can advise and advocate to their employers and clients that living benefits should be an integral part of each life insurance policy. It should even be possible to add living benefits to existing policies.

2. **Include an end-of-life counseling benefit within health insurance plans:** Discussing end-of-life issues should occur long before each of us is in confronted with the issue. It is often too late to have a rational conversation of end-of-life matters (such as between physician and patient or among family members) when death is eminent.

3. **Offer a package of end-of-life forms to new life insureds:** Many, if not most, people reach end-of-life without having a plan. For example, medical powers of attorney enable a family member or friend to act on our behalf in the event we are incapacitated and help carry out our treatment wishes. Each life insurance policy would be that much more valuable if a new insured could go to a vetted website and find forms to address the most common end-of-life matters in addition to the financial peace of mind they have just acquired through their new life insurance policy.

4. **Make the secondary market for life insurance more accessible:** Presently, the secondary market for life insurance is practically restricted to larger sized life insurance policies. Life insurance carriers should expand the availability of options to policyholders who need to terminate policies prior to the time an accelerated death benefit is available.

CONCLUSION

Medical advances are keeping us alive longer. As professionals and individuals, we face an entirely new set of end-of-life issues. In recent years some governments have made additional end-of-life choices available to us. How we deal with such matters and which options we elect is strictly a personal decision.

But as described earlier in this article, there are several relatively easy and low cost ways that the insurance industry can help to relieve some of the anxieties associated with end-of-life events and provide additional value to our products and services. Actuaries are in position to help implement these and other possible programs to our existing products. ■

ENDNOTES

1 Oregon Death with Dignity Act, Oregon Revised Statute Chapter 127.

2 Oregon Public Health Division (2014) Death with Dignity Act Annual Report, pg. 1. https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year16.pdf

3 Death with Dignity National Center and Death with Dignity Political Fund. https://www.deathwithdignity.org/

4 Oregon Death with Dignity Act, Section 127.800 §1.01

5 Oregon Death with Dignity Act, Section 127.815 §301(L) provides that it is an attending physician's responsibility to prescribe the appropriate medications to be used by the patient.

6 Oregon Public Health Division (2014) Death with Dignity Act Annual Report, pg. 4. https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year16.pdf

7 Oregon Public Health Division (2014) Death with Dignity Act Annual Report, pg. 5. https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year16.pdf

8 Oregon Public Health Division (2014) Death with Dignity Act Annual Report, pg. 6. https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year16.pdf

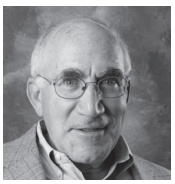
9 Oregon Death with Dignity Act, Section 127.875 §3.13

10 Oregon Death with Dignity Act, Section 127.880 §3.14

11 Oregon Public Health Division (2014) Death with Dignity Act Annual Report, pg. 1. https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year16.pdf

12 Oregon Deaths by Age and Country of Residence, 2012-2014, http://public.health.oregon.gov/BirthDeathCertificates/VitalStatistics/death/Pages/index.aspx

13 Death with National Center survey



Jay M. Jaffe, FSA, MAAA, is president, Actuarial Enterprises Ltd in Chicago. He can be reached at *jay@actentltd.com.*