F I S C A L I M P A C T R E P O R T

SPONSOR Armstrong D/ Stefanics/ O'Neill/ Hochman-Vigil **ORIGINAL DATE** 01/28/21 **LAST UPDATED** 03/16/21 **HB** 47/aHHHC/aHJC/aSFl #1/aSFl#2

SHORT TITLE Elizabeth Whitefield End-Of-Life Options Act **SB**

ANALYST Chilton

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY21	FY22	FY23	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total		$80.0-$120.0	$30.0	$80.0 - $150.0	Recurring (at $30.0 per year)	General fund

(Parenthesis ( ) Indicate Expenditure Decreases)

Identical to Senate Bill 308 (excepting the amendments)

SOURCES OF INFORMATION
LFC Files

Responses Received From
Administrative Office of the Courts (AOC; declines)
Office of the Attorney General (NMAG)
Aging and Long-Term Services Department (ALTSD)
Department of Health (DOH)
Human Services Department (HSD)
Medical Board (MB)
Board of Nursing (BN)

SUMMARY

Synopsis of SFl#2

Senate floor #2 amendment to House Bill 47 as amended, removes the name of Elizabeth Whitefield, the New Mexico judge and advocate for end-of-life care and died of cancer in 2018, from both the title of the bill and from each of other eighteen occasions where her name is mentioned within the bill.

Synopsis of SFl#1

Senate floor #1 amendment to House Bill 47 as amended, removes the provisions in now-deleted sections 7 and 8 that would have

1) provided that death certificates for those availing themselves of end-of-life medications

prescribed according to the act would list the underlying disease rather than the medication, as the cause of death, and

2) provided that wills, contracts, and insurance policies could not be changed by use of a medication prescribed in end-of-life care, nor could such provisions be used to affect a patient's to use or not use such a medication.

The amendment in addition strikes civil immunity for those providing or declining to provide end-of-life care, while leaving immunity from criminal immunity in place. Also in section 9 (now renumbered 7) of the bill, the amendment strikes subsection C, which provided that patients' requests for end-of-life prescriptions or provision of such medications not be considered evidence of neglect or abuse and not be basis for appointment of a guardian or conservator.

The amendment also strikes subsection 9 (I) (now 7 (I), which protected health care providers from sanctions to be imposed on them for quality of care related to actions in end-of-life care,

Synopsis of HJC Amendment

The House Judiciary Committee amendment to House Bill 47 as amended, adds several words to require that a physician (allopathic or osteopathic) certifying a dying person as having capacity to decide to request an escape from a terminal illness and to take the necessary prescribed medication has performed "an appropriate examination." It is not specified what constitutes an appropriate examination or whether it must be performed in person.

Synopsis of HHHC Amendment

The House Health and Human Services Committee amendment to House Bill 47 changes one word in the language determining capacity for an end-of-life decision. The person being evaluated for capacity to make an end-of-life decision as defined in the act with a "recent" history of mental health disorder would be required to be further evaluated to determine if that person had capacity to make such a decision.

Synopsis of Original Bill

Senate Bill 308 would provide terminally ill but still mentally competent adults the option of having medical assistance in bringing about their own death. Currently it is illegal for a medical practitioner to provide a prescription that a patient might take to end his/her life; this bill would sanction that practice, with multiple safeguards.

At least one health care provider knowledgeable about the condition causing the patient's terminal situation would have to determine and make a note in the patient's medical record stating that the patient had the mental capacity to make the ultimate decision, had a terminal illness predicted to lead to death within six months, has made the request for aid without coercion from medical care personnel or from family members, can take the prescribed medication on his/her own (which is required), and has been fully informed about other options, including hospice care and palliative care. Risks and probable results of taking the medication prescribed would have to have been discussed with the patient, and the patient would have to take the medication on his/her own. If there is a question about the patient's competency to make an informed decision or if the patient is not enrolled in a hospice program, a consultation with another practitioner is mandated, who must render a consultation in person. The patient

must sign a form, spelled out in the legislation, requesting the service, witnessed by two persons, only one of whom may be a relative.

If there is a history of a mental health disorder or cognitive problem, consultation must be referred to a mental health practitioner, who must determine that the patient has the capacity to make the decision to use end-of-life options.

Prescriptions written cannot be filled until 48 hours after their prescription, and do not create the presumption that they will be taken – the patient will be able to choose whether to take the medication or not [in the Oregon experience, such medications have been used by about two thirds of the patients to whom they have been prescribed.

The legislation specifies that the death certificate would indicate the cause of death to be the underlying illness, not the medication the patient has taken. Insurers would not be permitted to deny coverage or alter health care benefits based on a patient's decision to use or not to use medical aid in dying.

Provisions in the bill expressly prohibit physicians from giving lethal injections or practicing "mercy killing" or "euthanasia." The bill also states that the action of writing a prescription pursuant to this act does not constitute suicide, assisted suicide, euthanasia, mercy killing, homicide or adult abuse under the law.

Provisions in contracts, wills or agreements would have no effect on the options available to terminally ill people under the bill; likewise, obligations made by the patient under a contract would not be affected by provisions of the bill.

Legal immunity and immunity from license actions and from sanctions from health care entities (unless the entity had provided written notice of its unwillingness to provide this service and has acted "reasonably" and not capriciously) are given to health care providers, the patient's caregivers and any other person that "acts to assist the attending health care provider or patient" who acts in good faith to comply with the provisions of the bill; applying neglect or adult abuse sanctions is expressly prohibited. On the other hand, medical care providers would incur no liability for being unwilling to participate in prescribing lethal medication, if a referral was made to another provider for that purpose. The patient's records must then be provided to the new health care provider.
The Department of Health would be charged with providing a framework for reporting actions taken responding to this act, and with providing statistics based on aggregated reports.

Section 30-2-4 NMSA 1978 is amended to exempt persons aiding patients dying in this way from those who might be considered to have assisting in suicide and who might be subject to felony prosecution. For purposes of this amendment, "adult," "attending health care provider," "capacity," "medical aid in dying," "self-administer," and "terminal illness" are defined in the same way as in Section 3 of the bill, including the definition of "terminal illness" as "in accordance with reasonable medical judgment, will result in death within a reasonably foreseeable period of time."

There is a severability clause.

There is no effective date of this bill. It is assumed that the effective date is 90 days following adjournment of the Legislature.

FISCAL IMPLICATIONS

There is no appropriation included in this bill. Some agencies, such as DOH, the Board of Pharmacy and the Office of the Superintendent of Insurance might incur small costs related to changing written policies. DOH states that there would be initial costs to set up the program and continuing costs to administer it:

> An extra 1.5 – 2.5 FTE's in the first year (FY20) at an estimated $80 - $120thousand, to set up administration and for the NMDOH, Office of the General Counsel (OGC) to promulgate rules. Included in this FY20 estimate is estimated costs for NMDOH Information Technology Services Division to develop or identify a program to enable an all HCP provider-submitted information system and reporting, and to support the program. Thereafter, in FY21 and onwards, it is estimated 0.5 of an FTE ($30 thousand) will be required to maintain and administer the program.

While acknowledging that HB47 does not address insurance coverage of aid in dying, HSD nevertheless calculates possible costs to the state of enacting the legislation, since federal law appears to prohibit using Medicaid matching funds to pay for the procedure. Using published data from Oregon and Washington, HSD calculates that as many as 163 and as few as 10 joint Medicaid-Medicare patients would seek coverage for end-of-life medications during any year. It states that end-of-life medications cost between $500 and $15 thousand per person/dose. That cost would be balanced against the cost of care during a dying person's last days, weeks or months. HSD concludes that the net cost to provide such services to Medicaid-Medicare patients is "indeterminate."

SIGNIFICANT ISSUES

Oregon enacted a Death with Dignity Act in 1997, which was affirmed by a large majority of voters in a subsequent election. In the first 20 years after that, 1,545 Oregonians had prescriptions written to aid in their dying, and 991 actually used those prescriptions. In the most recent year available, 2017, 144 people died having used these medications (66.1 percent of the 218 patients given end of life prescriptions; i.e., one third of patients given the prescriptions chose not to end their lives in that way after all), but the proportion of deaths in this way was less than 0.5 percent of the total deaths in Oregon in 2017. Over 90 percent of patients dying in this way were receiving hospice care; over 90 percent died at home. The majority of patients had cancer, although amyotrophic lateral sclerosis (Lou Gehrig disease) and severe lung and heart disease were responsible for a moderate number of terminal illnesses so treated. Almost all patients died from use of a prescribed barbiturate. The results of the Oregon Health Authority's analysis of the data both from 2017 and for the period from 1998 to 2017 are in the chart below.

The proportion of patients dying with an assist from physician-prescribed medication thus remains low in Oregon. Physicians in Oregon are required to make a report to the Health Authority within 10 days of the death and are asked to specify what factors the physician believes led to the request. The most common reasons specified are loss of autonomy (93 percent), decreasing ability to participate in activities making life enjoyable (88.7 percent), and loss of dignity (50.3 percent). Inadequate pain control (23.7 percent) and financial concerns (2.9 percent) are far less common.

As noted by ALTSD, the District of Columbia and several other states – California, Washington, Colorado, New Jersey, Maine, Hawaii, and Vermont – have adopted variations of the "death with dignity" principle into statute; Montana allows physician aid in dying pursuant to a court order, but New Mexico's Supreme Court declined to affirm a lower court's decision to allow the practice in 2016, stating that the matter should be decided legislatively, not judicially. Arizona, New York and Indiana are considering legislation on the subject, according to the National Conference of State Legislatures.

Both the Oregon statute and the New Mexico proposal specify that medical care providers must discuss options with patients before prescribing life-ending medications. This could be looked upon as a benefit of a death with dignity or End of Life Options Act: that patients would be made aware of other options: requesting all available medical care, adopting advance directives, declining life prolonging care, adding palliative care and hospice care through having that discussion openly with their medical care providers as specified in this bill.

NMAG notes that the 2009 Uniform health-care decisions act specified that physicians were immune from prosecution for withdrawing life support at a patient's request:

> The elements of the right to exercise self-determination over medical decision making are well recognized in both federal and state law. The UHCDA authorizes competent adults to terminate life sustaining treatment even if such termination would result in death. Competent adults can exercise the right to hasten death and can provide advance directives in anticipation of such a circumstance. § 24-7A-2(A). A physician who withdraws life sustaining medical treatment pursuant to the UHCDA is immune from criminal liability for such actions. § 24-7A-9(A) (1). A physician who administers pain medication to a patient, resulting in the natural hastening of death is also immune from liability under the Pain Relief Act, §24-2D-3… Sections 10 and 12 of this Act would nullify *Morris v. Brandenburg*, 2016-NMSC-027, 376 P.3d 836, which held that the activity described in the Act promotes suicide, a fourth-degree felony under Section 30-4-2.

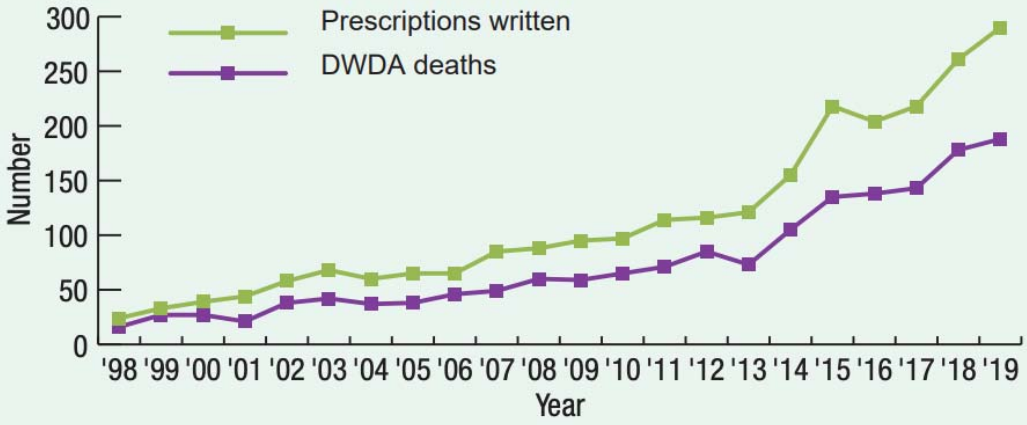
Although there appears to be movement toward greater acceptance among physicians of medical aid in dying, the American Medical Association's Ethical Code states, "Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks." (AMA Principles of Medical Ethics: I, IV, 5.7 Physician-Assisted Suicide). MB makes reference to this clause.

In 2017, the American College of Physicians, which represents a majority of the country's practitioners of internal medicine, reaffirmed earlier policy opposing medical aid in dying: "On the basis of substantive ethics, clinical practice, policy, and other concerns . . . the ACP does not support legalization of physician-assisted suicide. It is problematic given the nature of the patient-physician relationship, affects trust in the relationship and in the profession, and fundamentally alters the medical profession's role in society." That stance has not been updated since 2017.

In contrast, the American Academy of Family Physicians in October 2018 reversed its long-standing opposition to end of life options, moving to what it calls "engaged neutrality." The AAFP has also not re-addressed the issue since 2018.

The most recent data from Oregon, the state that has had a death with dignity act for the longest period, now 22 years, suggests a gradual increase in the number of prescriptions written pursuant to the act. The proportion of those prescriptions actually taken by patients has remained at about 66 percent. In 2019, 290 prescriptions, of which 188 were taken and resulted in death (64.8 percent).

Figure 1: DWDA prescription recipients and deaths*, by year, Oregon, 1998-2019



**As of January 17, 2020*
See Table 2 for detailed information

The NMAG recounted recent history of legal action regarding medical aid in dying:

> In 2014, a New Mexico district court held that NMSA 1978, Section 30-2-4 was unconstitutional. The New Mexico Court of Appeals reversed that decision. The New Mexico Supreme Court in *Morris v. Brandenburg*, 2016-NMSC-027 declined to hold that there is a fundamental right to have a physician aid in dying and concluded that Section 30-2-4 was not unconstitutional. The Supreme Court noted that the exceptions to the social deterrence to suicide occur as a result of debate in the legislature. HB47 attempts to bring the issue to the proper forum and carves out those exceptions.

ADMINISTRATIVE IMPLICATIONS

DOH states that it "will be required to adopt rules regarding time frames and forms for health care providers to report their participation in an act of medical aid in dying. NMDOH will also be required to generate annual statistical reports on the information provided by such forms regarding the number, demographics, and underlying conditions of individuals receiving medical aid in dying medication prescriptions written statewide and the number of health care providers issuing such prescriptions."

As also noted by DOH, "HB407 affects the Board of Pharmacy (BOP), as it may need to amend the Drug, Device and Cosmetics Act to create this new category of drug ("medical aid in dying medication") and those authorized to prescribe it. The BOP may also need to amend its regulations to provide pharmacists with specific guidelines of the 48-hour waiting period, the exception available to the 48-hour waiting period and accompanying data necessary under the bill."

IDENTICAL to Senate Bill 308, except for the amendment.

TECHNICAL ISSUES

AOC suggests the following be considered for change:

- "Section 11 amends the Public Health Act but includes no citation. Citing to the Public Health Act, NMSA 1978, Sections 24-1-1 through 24-1-41 could improve the clarity of Section 11.

- "It appears from Section 3(A) that the prescribing physician is explicitly required to make a capacity determination of an individual seeking aid-in-dying medication, so that relying on the certification of another "physician or osteopathic physician" as Section 3(F) provides would be insufficient.

- "Section 3(H) provides a sample form that a physician must give to a patient considering aid-in-dying medication, but the Act contains no requirement for a patient to complete the form, or for the form to be included in a record."

Board of Nursing makes two points:

1) The definition of "advanced practice nurse in the bill differs from that in the Nurse Practice Act, and
2) It is not clear whether mental health professionals with prescriptive authority can prescribe end-of-life medications.

LAC/al/rl