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## FISCAL IMPACT REPORT

SPONSOR SPAC ORIGINAL DATE 1/26/19  
 LAST UPDATED 3/05/19 HB \_\_\_\_\_

SHORT TITLE Elizabeth Whitefield End of Life Options Act SB 153/SPACS

ANALYST Chilton

### ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY19	FY20	FY21	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
<b>Total</b>		\$80.0- \$120.0	\$30.0	\$110.0- \$150.0	Recurring	General Fund

(Parenthesis ( ) Indicate Expenditure Decreases)

Duplicates House Bill 90.  
 Similar to 2017 House Bill 171.

### SOURCES OF INFORMATION

LFC Files

#### Responses Received From

Public School Insurance Authority (PSIA)  
 New Mexico Attorney General (NMAG)  
 Department of Health (DOH)  
 Office of the Superintendent of Insurance (OSI)

### SUMMARY

#### Synopsis of Bill

The Senate Public Affairs Committee Substitute for Senate Bill 153 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, along with other alternatives

related to the patient's care (this if the patient desired to hear of these options) 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, a consultation with a mental health practitioner is mandated, who must render a consultation in person.

Prescriptions written 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. A form that can be used to inform the patient, form a basis for discussion between the patient and the medical care provider, and then possibly signed by the patient, is a resource that is made part of the bill. 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 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 there were a referral to another provider for that purpose, records are to be provided to the new health care provider.

There is a severability clause.

Section 30-2-4 NMSA 1978 is amended to exempt persons aiding patients dying in this way from those who would be considered to have committed suicide and 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."

## **FISCAL IMPLICATIONS**

It appears as if the only appreciable fiscal impact of Senate Bill 153 would fall upon the Department of Health, which indicates its needs as follows:

The Department of Health (NMDOH) 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.

There will be a cost to NMDOH to either develop a new database or to upgrade or modify an existing database. While NMDOH does not have an exact cost at this point in time, the cost to undertake this activity could be significant as a one-time expense. NMDOH could also potentially require a portion of an FTE to maintain and administer the program.

Neither PSIA nor RHCA find any financial impact of this legislation. RHCA states it “would work with all health plan providers on adherence to the Elizabeth Whitefield End of Life Options Act and does not assume a financial impact as a result of the proposed legislation.”

### **SIGNIFICANT ISSUES**

This committee-substituted bill differs from the committee substitute for House Bill 90 in that options for alternatives other than an end of life prescription are in the Senate version, to be discussed when the patient asks; whereas in the HB 90 version, they are to be discussed with each patient.

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 people 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 attachment.

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.

Several other states – California, Washington, Hawaii, and Vermont as well as the District of Columbia – 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. Many other states 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: advance directives, declining life prolonging care, 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.

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).

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."

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 NMAG recounts 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. SB 153 attempts to bring the issue to the proper forum and carves out those exceptions.

DOH notes that "SB 153 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 and accompanying data necessary under the bill."

**TECHNICAL ISSUES**

DOH states that “SB 153 creates a definition of “telemedicine” that differs from the already existing definitions of “telemedicine” at Section 61-6-6(L) NMSA, “Medicine and Surgery” and from Section 13-7-14 (H) NMSA, “Health Purchasing Act”. The SB 153 definition of “telemedicine” does not provide that inscription shall be used and must conform to state and federal privacy laws.”

**WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL**

Terminally ill patients could continue to choose death through removal of life-prolonging treatment but would not be able to avail themselves of prescribed medications for the purpose of causing their death.

LAC/sb