HB 643

Department of Legislative Services

Maryland General Assembly
2020 Session

FISCAL AND POLICY NOTE
First Reader

House Bill 643 (Delegate Pendergrass, *et al.*)
Health and Government Operations and Judiciary

End-of-Life Option Act (Richard E. Israel and Roger "Pip" Moyer Act)

This bill creates a process by which an individual may request and receive aid in dying from the individual's attending physician. The bill exempts, from civil or criminal liability, State-licensed physicians who, in compliance with specified safeguards, dispense or prescribe a lethal dose of medication following a request made by a qualified individual. Criminal penalties are established for violating specified provisions of the bill.

Fiscal Summary

State Effect: General fund expenditures increase by $144,100 in FY 2021 to hire a part-time epidemiologist and establish an electronic data collection system; future year expenditures reflect elimination of one-time-only costs, ongoing contractual services, and annualization. The Medicaid program may realize savings to the extent a qualified individual dies sooner than would otherwise occur; any such impact cannot be reliably estimated, is likely minimal, and is not reflected below. The bill's penalty provisions are not expected to materially affect State finances or operations.

(in dollars)	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Revenues	$0	$0	$0	$0	$0
GF Expenditure	144,100	39,200	39,600	40,600	41,700
Net Effect	($144,100)	($39,200)	($39,600)	($40,600)	($41,700)

Note:() = decrease; GF = general funds; FF = federal funds; SF = special funds; - = indeterminate increase; (-) = indeterminate decrease

Local Effect: The bill's penalty provisions are not expected to materially affect local government operations or finances.

Small Business Effect: None.

Analysis

Bill Summary:

Request for Aid in Dying

The bill allows an attending physician licensed to practice medicine in the State who follows specified procedural safeguards to prescribe self-administered medication to a qualified individual to bring about the individual's death. The bill defines the medical practice of prescribing such medication as "aid in dying." A "qualified individual" is defined by the bill as an adult who (1) has the capacity to make medical decisions; (2) is a resident of the State; (3) has a terminal illness with a prognosis of death within six months; and (4) has the ability to self-administer medications.

An individual may request aid in dying by making an initial oral request for such aid to the individual's attending physician. After the initial oral request, the individual is required to make a written request on a form substantially similar to the one specified in the bill. The request must be signed and dated by the individual and two witnesses. The bill includes restrictions on who may be a witness. The attending physician may not be a witness, and only one witness may be a relative or a person entitled to any benefit on the individual's death. The individual must wait at least 15 days after the initial oral request and at least 48 hours after the written request before making a second oral request to the attending physician for aid in dying. At least one of the oral requests must be made while the individual is alone with the attending physician.

The physician's participation in the process is voluntary. If the physician cannot or does not want to participate, the physician must, on request, transfer the individual's care and a copy of the individual's records to another attending physician.

Determination of Qualifications, Including Required Consultation/Assessment

Upon receiving an individual's written request for aid in dying, the attending physician must determine whether the individual (1) is a qualified individual; (2) has made an informed decision; and (3) has voluntarily requested aid in dying. For the purpose of establishing residency in the State, a physician must accept as proof (1) a valid Maryland driver's license or identification card; (2) registration to vote in the State; (3) evidence of owning or leasing property in the State; (4) a copy of a Maryland resident tax return for the most recent tax year; or (5) based on the individual's treatment history and medical records, the attending physician's personal knowledge of the individual's residency in the State. An attending physician must ensure that an individual makes an informed decision by informing the individual of the individual's medical diagnosis, the individual's prognosis, the potential risks associated with self-administering the medication to be prescribed for

aid in dying, the probable result of self-administering the medication, and any feasible alternatives and health care treatment options, including palliative care and hospice.

The attending physician must refer an individual who has requested aid in dying to a consulting physician who is qualified by specialty or experience to confirm a diagnosis and prognosis regarding an individual's terminal illness. The consulting physician must then (1) examine the individual and relevant medical records; (2) confirm the diagnosis that the individual has a terminal illness; (3) refer the individual for a mental health professional assessment, if required; (4) verify that the individual is a qualified individual, has made an informed decision, and has voluntarily requested aid in dying; and (5) document in writing that the consulting physician's duties have been fulfilled.

If the attending or consulting physician's medical opinion is that the individual may be suffering from a condition causing impaired judgment or that the individual otherwise does not have the capacity to make medical decisions, the physician must refer the individual to a licensed mental health professional for a mental health professional assessment. The mental health professional must perform a mental health professional assessment, and the individual may not receive aid in dying until the mental health professional determines and reports, in writing, that the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder.

Required Notifications/Dispensing Medication

Following the second oral request for aid in dying, the attending physician must inform the individual regarding specified matters relating to the individual's decision, including the individual's ability to rescind the decision at any time. The physician must counsel the individual regarding the self-administration of medication prescribed for aid in dying and must confirm that the individual's request is not based on the coercion or undue influence of another person. The physician must also discuss, alone with the individual (except for an interpreter as necessary), whether the individual is feeling coerced or unduly influenced.

The physician must fulfill all specified documentation requirements and verify that the individual is making an informed decision before the physician may write the prescription for the medication. The physician may dispense the medication for aid in dying, as well as any ancillary medications needed to minimize the individual's discomfort, to the qualified individual if the physician holds a dispensing permit. If the physician does not hold a dispensing permit or does not wish to dispense the medication, the qualified individual may request and provide written consent for the prescription to be dispensed by a pharmacist. The physician must then contact a pharmacist who may fill the prescription. The bill specifies that a pharmacist who has been contacted and to whom an attending physician has submitted a prescription for medication for aid in dying may dispense the medication

and any ancillary medication only to the qualified individual, the attending physician, or an expressly identified agent of the qualified individual.

Required Documentation/Prohibition Against Discovery

The attending physician must ensure that the medical record of a qualified individual contains (1) the basis for determining that the qualified individual is an adult and a resident of the State; (2) all oral and written requests by the qualified individual for medication for aid in dying; (3) the attending physician's diagnosis of terminal illness and prognosis as well as a determination that the qualified individual has the capacity to make medical decisions; (4) documentation that the consulting physician has fulfilled the consulting physician's duties; (5) a report of the outcome of and determinations made during the mental health professional assessment, if applicable; (6) documentation of the attending physician's offer to rescind the qualified individual's request for medication at the time the attending physician wrote the prescription; and (7) a statement by the attending physician that all requirements for aid in dying have been met and specifying the steps taken to carry out the qualified individual's request for aid in dying, including the medication prescribed. The attending physician must submit to the Maryland Department of Health (MDH) any information required by regulation.

Upon death, the attending physician may sign the death certificate. A person that, after the qualified individual's death, remains in possession of medication prescribed for aid in dying must dispose of the medication in a lawful manner.

All records or information collected or maintained as part of the aid in dying process are not subject to subpoena or discovery and may not be introduced into evidence in any judicial or administrative proceeding, with limited specified exceptions. Notwithstanding such limitations, MDH must adopt regulations to facilitate the collection of information from physicians regarding a qualified individual's request for aid in dying. MDH must produce an annual statistical report of information collected from physicians and make that report available to the public.

Legal Effect of Aid in Dying

The bill shields persons who act in accordance with the provisions of the bill, and in good faith, from civil and criminal liability and professional disciplinary actions. A professional organization or association, a health care provider, or a health occupations board may not subject a person to discipline, suspension, loss of license, loss of privileges, loss of membership, or any other penalty for participating or refusing to participate in good-faith compliance with the provisions of the bill. The bill does not, however, limit liability for civil damages resulting from any negligent conduct or intentional misconduct by any person.

An individual's request for aid in dying or an attending physician's prescription of medication made in good faith does not constitute neglect or provide the sole basis for the appointment of a guardian or conservator.

For all legal, recordkeeping, and other purposes, a qualified individual's cause of death under the bill is natural and specifically as a result of the underlying terminal illness. For contractual purposes, any provision that deems the cause of death as anything other than the terminal illness is void. A provision in an insurance policy, annuity, contract, or any other agreement issued or made on or after October 1, 2020, is not valid to the extent that it would attach consequences to or otherwise restrict an individual's decision regarding aid in dying. Likewise, an obligation under an *existing* contract (including an insurance policy, contract, or annuity contract) may not be conditioned on or affected by the making or rescinding of a request for aid in dying. A qualified individual's act of self-administering medication for aid in dying may not have an effect under a life insurance policy, a health insurance policy, or an annuity contract that differs from the effect under the policy or contract of the qualified individual's death from natural causes.

Policies Regarding Aid in Dying

A health care provider (including a health care facility) may adopt written policies prohibiting participation in aid in dying. If the provider distributes the policy and finds that a physician participates in violation of the policy, the provider may take specified employment actions. Even so, any written prohibition does not prohibit a health care provider from participating in aid in dying while acting outside the course and scope of employment, or prohibit an individual from privately contracting with the individual's attending physician or consulting physician for aid in dying purposes.

Conversely, a health care facility may not require a physician on staff to participate in aid in dying.

Penalty Provisions

Actions in accordance with the bill do not constitute suicide, assisted suicide, mercy killing, or homicide, and the bill specifically does not authorize a licensed physician or other person to end an individual's life by lethal injection, mercy killing, or active euthanasia.

An individual who willfully alters or forges a request for aid in dying, conceals or destroys another's rescission of a request without authorization, or coerces or exerts undue influence on an individual to make a written request for the purpose of ending the individual's life can be charged with a felony and is subject to a maximum penalty of 10 years in prison, a $10,000 fine, or both. A sentence imposed may be done so separate from and consecutive to or concurrent with a sentence for any crime based on the act establishing the violation.

Current Law/Background: In 1999, Maryland became the 38th state to outlaw physician-assisted suicide with the signing of Chapter 700. The law establishes that any individual who knowingly assists another person's suicide or suicide attempt is guilty of a felony and subject to a fine of up to $10,000, imprisonment for up to one year, or both. The law was passed as part of a national response to Dr. Jack Kevorkian, who assisted in the suicide of a Michigan man suffering from amyotrophic lateral sclerosis.

Refusal of Medical Treatment

A competent adult's right to legally refuse medical treatment stems from the common law principle of bodily integrity. In *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990), the U.S. Supreme Court outlined the corollary notion that an individual generally possesses the right not to consent to and to refuse medical treatment. For purposes of the court's analysis, it assumed that a competent individual's right to refuse treatment also stemmed from the Fourteenth Amendment's Due Process Clause, and the court held it constitutional for a state to require a standard to determine competence. State standards vary, based in the common law, the Fourteenth Amendment right to privacy, or both.

Maryland courts have approached the issue through the common law. In *Stouffer v. Reid*, 413 Md. 491 (2010), the Court of Appeals acknowledged the common law right of a competent adult to refuse medical care under the doctrine of informed consent. The court noted, however, that the right is not absolute and must be balanced against four countervailing State interests: (1) the preservation of life; (2) the protection of interests of innocent third parties; (3) the prevention of suicide; and (4) the maintenance of the ethical integrity of the medical profession.

While the right of a competent adult to refuse medical treatment is well established, issues regarding medical care arise when an individual is deemed incompetent. Maryland codified procedures for medical decision making for an incompetent individual in the Health Care Decision Act passed in 1993 (Health-General Article, Title 5, Subtitle 6). The Act allows an adult who has decision-making capacity to deal with future health care issues through written instructions, a written appointment of an agent, or an oral statement to a physician or nurse practitioner. The advance directive outlines the individual's instructions regarding the provision of health care or withholding or withdrawing health care. The individual may name an agent to make health care decisions under circumstances stated in the directive, and the Act outlines the authority of surrogate decision makers based on their relationships with the individual. The directive becomes effective when two physicians have certified in writing that the patient is incapable of making an informed decision.

The Act specifically establishes that withdrawing or withholding health care that results in the individual's death is not assisted suicide and that there is no criminal or civil liability for those who act in good faith under the Act. However, if a party destroys or falsifies

another's advance directive revocation or falsifies an advance directive or affidavit with the intent to cause actions contrary to the patient's wishes, that party is guilty of a misdemeanor and faces a maximum penalty of one year in jail and/or a $10,000 fine. The party is also susceptible to other criminal charges.

Assisted Suicide

The U.S. Supreme Court has drawn a legal distinction between withdrawing life support and assisted suicide based on causation and intent. In *Gonzales v. Oregon,* 546 U.S. 243 (2006), the court found that a state law prohibiting assisted suicide did not violate the Due Process Clause or the Equal Protection Clause of the U.S. Constitution, emphasizing the court's deference to the states in formulating policy regarding assisted suicide.

A majority of states have specific laws prohibiting assisted suicide. Most laws are codified, but some are based in the common law. Other states have no specific law, or their law is otherwise unclear. In Maryland, as outlined above, assisted suicide is a felony and carries a maximum penalty of one year incarceration and/or a $10,000 fine. As of 2019, California, Colorado, the District of Columbia, Hawaii, Maine, New Jersey, Oregon, Vermont, and Washington have physician-assisted dying statutes. Physician-assisted dying is also legal in Montana by way of a 2009 state Supreme Court ruling. To qualify under death with dignity statutes, one must meet specified requirements, including that the individual is mentally competent.

Aid in Dying in Other States

As noted above, currently, eight states (California, Colorado, Hawaii, Maine, New Jersey, Oregon, Vermont, and Washington) and the District of Columbia have laws that allow a doctor to write lethal prescriptions for dying patients to self-administer. Such laws are generally referred to as "end-of-life option" laws, "death with dignity" laws, "aid in dying" laws, and "patient choice and control at end-of-life" laws.

Oregon was the first state to legalize physician aid in dying when its Death with Dignity Act was adopted through ballot measure in 1994. The Act exempts from civil or criminal liability state-licensed physicians who, in compliance with specific safeguards, dispense or prescribe a lethal dose of drugs upon a terminally ill patient's request. In response to the Oregon action, in 2001, the U.S. Attorney General issued an interpretive rule addressing the implementation and enforcement of the Controlled Substances Act with respect to Oregon's Death with Dignity Act. The rule determined that using controlled substances to assist suicide is not a legitimate medical practice and, as a result, dispensing or prescribing them for that purpose was illegal under federal law. The U.S. Supreme Court rejected the Attorney General's rule, again showing deference to the states.

The Oregon Health Authority tracks that state's Death with Dignity Act and publishes an annual report. In its April 2019 report, the most recent report available, the Oregon Health Authority advises that, since the law's passage, 2,217 prescriptions have been written and 1,459 patients have died from ingesting the prescribed medications. In 2018, 249 prescriptions were written and 168 people died from ingesting the medications. The median age at death was 74, and 79.2% of those who died were age 65 or older.

In 2008, Washington voters adopted an initiative mirroring the Oregon Death with Dignity Act. The standards and procedures are very similar to those in Oregon. The state also tracks statistics in an annual report. In 2018, medication was dispensed to 267 individuals; 251 are known to have died. Of those individuals who died, 203 died after ingestion of medication, and 29 died without the medicine. Whether the remaining 19 individuals ingested the medication is unknown.

Vermont became the first state to pass aid in dying legislation, passing a law modeled after the Oregon and Washington laws on May 20, 2013. Certain safeguards, including a waiting period between a patient's requests for medication and requiring physicians to report prescriptions to the state's department of health, were scheduled to terminate July 1, 2016; however, legislation that passed in May 2015 retained these requirements. The 2015 legislation also required the state's department of health to generate a public report about utilization and compliance with the law every two years, starting in 2018. According to the 2018 report, between May 31, 2013, and June 30, 2017, 52 "events" met the legislation's definition and 48 of those events have a death certificate on file with the Vermont Vital Records' Office. The remaining 4 cases are assumed to still be living. Among the 48 confirmed deaths, 29 utilized the prescribed medication; 17 died from underlying disease; 1 died from other causes; and in 1 case the cause of death is unknown.

In 2009, the Montana Supreme Court was asked to determine whether the consent defense to homicide could be applied to a doctor who prescribed medication to a mentally competent, terminally ill patient for the patient to self-administer to end the patient's life. In weighing the factors that would prevent a consent defense, the court determined that there was "no indication in Montana law that physician aid in dying provided to terminally ill, mentally competent adult patients is against public policy." While Montana has not codified an aid in dying exception, based on the court's ruling, a physician has an affirmative defense to a homicide charge.

In 2015, California passed the End of Life Option Act, similar to the Oregon, Vermont, and Washington acts. The bill was first introduced during the regular session, but it failed to gain support and was withdrawn. The bill was reintroduced during a special legislative session on health care later in the summer, and it passed after a sunset provision requiring lawmakers to vote on renewing the bill in 10 years was added. According to the annual report, for 2018, 531 individuals started the end-of-life option process by making

two verbal requests to their physicians at least 15 days, apart and 180 unique physicians prescribed 452 individuals aid in dying drugs. Of the 452 individuals prescribed such drugs, 314 were reported by their physician to have died following ingestion of the drugs, and 59 individuals died without ingestion of the drugs. The ingestion status of the remaining 79 individuals is unknown, but 42 of them have died and the status for, the remaining 37 individuals is unknown altogether. Twenty-three individuals with prescriptions written in 2017 ingested and died from the drugs in 2018. Though the subject of ongoing litigation, the California End of Life Option Act remains in effect.

On November 8, 2016, Colorado voters adopted Proposition 106, the End of Life Options Act, by a vote of 65% to 35%. The standards and procedures are similar to those in other states. The law went into effect on December 16, 2016. According to the Colorado Department of Public Health and Environment (CDPHE), in 2019, 170 patients received prescriptions for aid in dying medications. Among those *prescribed* aid in dying medication, CDPHE received death certificates for 139 patients. CDPHE notes that not all deceased patients were *dispensed* aid in dying medication, and deaths may have been due to ingestion of aid in dying medication, the underlying terminal illness or condition, or other causes.

The District of Columbia Death with Dignity Act of 2016 became effective February 18, 2017, and applicable as of June 6, 2017, following a period of congressional review. In 2018, four prescriptions were written for a covered medication and two qualified patients with dispensed medications died. Two qualified patients died before ingesting prescribed medications.

In 2018, Hawaii passed the Our Care, Our Choice Act. The standards and procedures are similar to those in other states. The law went into effect on January 1, 2019, and requires the Hawaii Department of Health to track specified information about the use of the Act and to issue an annual report by July 1 each year. For the first reporting period there were a total of eight qualified patients who received aid in dying prescriptions. Of those eight, three patients died: two ingested the aid in dying medication and one died from lung cancer without ingesting the medication.

The Maine Death with Dignity Act was signed into law in June 2019. New Jersey's Aid in Dying for the Terminally Ill Act took effect on August 1, 2019, and is in effect pending litigation.

Approximately 16 states are considering aid in dying legislation during their legislative sessions, including New York, Pennsylvania, and Virginia.

Prior Maryland Legislation and Workgroup

In 2015, Maryland considered end-of-life option legislation, largely based on the Oregon statute. Senate Bill 676 and House Bill 1021 of 2015 both received a hearing, but no further action was taken. A legislative workgroup was convened after the legislative session to study issues related to the 2015 legislation. Three meetings were scheduled between September and December to allow senators and delegates to (1) receive additional comments regarding Maryland's legislation from interested parties in the State; (2) learn about the implementation and use of similar end-of-life option laws in other states; and (3) discuss the components of end-of-life option legislation and areas of agreement and disagreement. Senate Bill 418 and House Bill 404 of 2016 included several changes that, in part, sought to address concerns raised during the 2015 legislative session and the subsequent workgroup meetings.

Additional Background

Richard E. ("Dick") Israel, one of the individuals for whom the bill is named, was born and raised in Hutchinson, Kansas, and graduated from the University of the South (BA), Washington and Lee University (LLB), and Oxford University (MA). Mr. Israel came to Annapolis in 1975 and joined the staff of the then Maryland Department of Legislative Reference and later served for 25 years as an assistant Attorney General. A resident of Annapolis for 30 years, Mr. Israel was elected to the Annapolis City Council in 2005 where he sat on the Rules and City Government Committee and the Economic Matters Committee and chaired the Finance Committee. Mr. Israel suffered from Parkinson's disease for which there is no cure. Mr. Israel died in July 2015.

Roger "Pip" Moyer, the second individual for whom the bill is named, was born on August 16, 1934, in Annapolis. He was elected to the Annapolis City Council in 1961 and as mayor in 1965 and 1969. Mr. Moyer was known as a leader in civil rights and historic preservation. He successfully campaigned for the city's historic district, protected the waterfront from high-rise development, and ushered in boat shows. After serving as mayor, Mr. Moyer worked as a leader in the Annapolis Housing Authority. Mr. Moyer died in January 2015, 20 years after being diagnosed with Parkinson's disease.

State Expenditures: MDH indicates that the Vital Statistics Administration (VSA) will be responsible for implementing the bill's requirements. VSA estimates that it needs one part-time (25%) epidemiologist to develop required regulations, oversee the development and implementation of an electronic data collection system, prepare instructional materials, provide training and technical assistance to physicians, review records, analyze data, and prepare the annual report. The MDH Office of Information Technology estimates the initial cost of developing and implementing the data collection system at $117,000, with ongoing annual maintenance costs of $10,000.

As a result, MDH general fund expenditures increase by $144,099 in fiscal 2021, which accounts for the bill's October 1, 2020 effective date. This estimate reflects the cost of contractual services to develop and implement the data collection system and hiring one part time, grade 17 epidemiologist. It includes a salary, fringe benefits, contractual services, one-time start-up costs, and ongoing operating expenses. The estimate assumes that the data required to be collected under regulations will include detailed demographic, personal, and medical information.

Position	0.25
One-time Contractual Services	$117,000
Salary and Fringe Benefits	20,439
One-time Start-up Expenses	4,891
Ongoing Operating Expenses	1,769
Total FY 2020 State Expenditures	**$144,099**

Future year expenditures reflect a part-time salary with annual increases and employee turnover, ongoing operating expenses, and contractual services to maintain the data collection system.

Additional Information

Prior Introductions: SB 311 of 2019, a nearly identical bill, received a favorable with amendments report from the Senate Judicial Proceedings Committee but failed on second reading in the Senate. Its cross file, HB 399, passed the House with amendments and was referred to the Senate Judicial Proceedings Committee, but no further action was taken. HB 370 of 2017, a similar bill, received a hearing in the House Health and Government Operations Committee, but no further action was taken. Its cross file, SB 454, received a hearing in the Senate Judicial Proceedings Committee but was withdrawn. As discussed above, similar legislation was also introduced in the 2016 and 2015 legislative sessions.

Cross File: SB 701 (Senator Waldstreicher, *et al.*) - Judicial Proceedings.

Information Source(s): Judiciary (Administrative Office of the Courts); Maryland Department of Health; Maryland Insurance Administration; California Department of Public Health; Colorado Department of Public Health and Environment; Hawaii Department of Health; Oregon Health Authority; Vermont Department of Health; Washington State Department of Health; DC.gov; www.deathwithdignity.org; Department of Legislative Services

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