Office of Senate Floor Analyses
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THIRD READING

Bill No: SB 380
Author: Eggman (D), et al.
Amended: 4/22/21
Vote: 21

SENATE HEALTH COMMITTEE: 8-1, 3/24/21
AYES: Pan, Eggman, Gonzalez, Hurtado, Leyva, Limón, Roth, Wiener
NOES: Grove
NO VOTE RECORDED: Melendez, Rubio

SENATE APPROPRIATIONS COMMITTEE: 5-2, 5/20/21
AYES: Portantino, Bradford, Kamlager, Laird, Wieckowski
NOES: Bates, Jones

SUBJECT: End of life

SOURCE: Compassion and Choices Action Network

DIGEST: This bill deletes the January 1, 2026 sunset date of the End of Life Option Act (EOLA); permits an individual to make a second oral request a minimum of 48 hours from the first request for medical aid in dying; eliminates the final attestation form required to be filled out by the qualified individual within 48 hours prior to self-administering the aid-in-dying medication; and requires health care providers who elect not to participate in EOLA to inform a patient and transfer records to another health care provider.

ANALYSIS:

Existing law:

1) Establishes EOLA, which authorizes a process for terminally ill adults living in California to obtain and self-administer drugs for medical aid in dying. Sunsets EOLA on January 1, 2026. [HSC §443-443.22]

2) Requires an individual seeking to obtain a prescription for an aid-in-dying drug to submit two oral requests, a minimum of 15 days apart, and a written request to his or her attending physician. Requires the attending physician to directly, and not through a designee, receive all three requests. [HSC §443.3]

3) Requires the written request to be on a prescribed form, signed and dated, by the individual seeking the aid-in-dying drug in the presence of two witnesses who attest that the individual is personally known to them, or has provided proof of identity, voluntarily signed the request in the witnesses presence, is believed to be of sound mind and not under duress, fraud, or undue influence, and not for whom either witness is the attending physician, consulting physician, or mental health specialist. [HSC §443.3]

4) Requires the attending physician to do the following before prescribing an aid-in-dying drug:

    a) Make the initial determination that the requesting adult has the capacity to make medical decisions; if indications of mental disorder, requires referral for a mental health specialist assessment, and prohibits an aid-in-dying drug to be prescribed until the mental health specialist determines that the individual has the capacity to make medical decisions and is not suffering from impaired judgement due to a mental disorder;
    b) Make the initial determination that the requesting adult has a terminal disease, has voluntarily made the request for an aid-in-dying drug pursuant to the law, is a qualified individual pursuant to the law, confirm that the individual is making an informed decision, as specified;
    c) Refer the individual to a consulting physician for medical confirmation of the diagnosis and prognosis, and for a determination that the individual has the capacity to make medical decisions and has complied with EOLA;
    d) Confirm that the qualified individual's request does not arise from coercion or undue influence by another person by discussing with the qualified individual, outside the presence of any other person, except for an interpreter, whether or not the qualified individual is feeling coerced or unduly influenced by another person; and,
    e) Counsel the qualified individual on 12 items, which includes the importance of having another person present when he or she ingests the aid-in-dying drug, not ingesting it in a public place, and, notifying next of kin of his or her request, but prohibits the denial of the request, if the qualified individual declines or is unable to notify next of kin.[HSC §443.5]

5) Prohibits a health care provider or professional organization or association from subjecting an individual to censure, discipline, suspension, loss of license, loss of privileges, loss of membership, or other penalty for participating in good faith compliance with EOLA or for refusing to participate in accordance with 7) and 8) below of existing law. [HSC §443.14]

6) Protects a health care provider from civil, criminal, administrative, disciplinary, employment, credentialing, professional discipline, contractual liability, or medical staff action sanction, or penalty or other liability for participating in EOLA, including, but not limited to, determining the diagnosis or prognosis of an individual, determining the capacity of an individual for purposes of qualifying for the EOLA, providing information to an individual regarding EOLA, and providing a referral to a physician who participates in the EOLA. [HSC §443.14]

7) Requires participation in activities authorized pursuant to EOLA to be voluntary. Permits a person or entity that elects, for reasons of conscience, morality, or ethics, not to engage in activities authorized pursuant to EOLA to not take any action in support of an individual's decision under EOLA. Prohibits a health care provider from being subject to civil, criminal, administrative, disciplinary, employment, credentialing, professional discipline, contractual liability, or medical staff action, sanction, or penalty or other liability for refusing to participate in activities authorized under EOLA, including, but not limited to, refusing to inform a patient regarding his or her rights under EOLA, and not referring an individual to a physician who participates in activities authorized under EOLA. [HSC §443.14]

8) Permits, if a health care provider is unable or unwilling to carry out a qualified individual's request under EOLA, and, the qualified individual transfers care to a new health care provider, the individual to request a copy of his or her medical records pursuant to law. [HSC §443.14

9) Permits a health care provider to prohibit its employees, independent contractors, or other persons or entities, including other health care providers, from participating in activities under EOLA while on premises owned or under the management or direct control of that prohibiting health care provider or while acting within the course and scope of any employment by, or contract with, the prohibiting health care provider. [HSC §443.15]

10) Requires a health care provider that elects to prohibit its employees, independent contractors, or other persons or entities, including health care providers, from participating in activities under EOLA, to first give notice of

the policy prohibiting participation to the individual or entity, and prohibits, a health care provider that fails to provide notice to an individual or entity from being entitled to enforce such a policy against that individual or entity. [HSC §443.15]

This bill:

1) Deletes the January 1, 2026 sunset on EOLA. Allows an individual to submit two oral requests within a minimum of 48 hours apart.

2) Permits an aid-in-dying drug request to be received by more than one attending physician and requires an attending physician to ensure the date of a request is documented in an individual's medical record. Prohibits an oral request documented in an individual's medical record from being disregarded by an attending physician solely because it was received by a prior attending physician.

3) Requires a physician to transfer all relevant medical records including written documentation and the dates of the individual's oral and written requests seeking to obtain a prescription for an aid-in-dying drug if the individual decides to transfer care to another physician.

4) Deletes the requirement that the attending physician give the qualified individual the final attestation form and deletes the final attestation form from the EOLA.

5) Adds health care facilities to the protections from civil, criminal, administrative, and other liabilities that apply to a health care provider who participates in EOLA. Defines "health care facility" as any clinic, health dispensary, or licensed health facility, including a general hospital, medical clinic, nursing home or in-patient hospice facility. A health care facility does not include an individual who is a health care provider or provider of health care.

6) Requires a health care provider who is unwilling or unable to participate to inform the individual, document and transfer records, upon request. Prohibits a health care provider and a health care facility from engaging in false, misleading, or deceptive practices relating to a willingness to qualify an individual or provide a prescription to a qualified individual under EOLA.

7) Revises the permission of a health care provider to prohibit its employees, contractors or others from participating in EOLA, to, instead, permit only health care facilities to prohibit employees, contractors, or others from

prescribing aid-in-dying medication to a qualified individual who intends to self-administer the medication while on premises of a facility under the management or control of the facility, or, while acting within the course and scope of employment or contract with the facility.

8) Requires a health care facility to first give notice upon employment or other affiliation and thereafter annual notice of the policy described in 12) immediately above, and post on the facility's public website the facility's current policy governing medical aid in dying. Prohibits a health care facility from engaging in false, misleading, or deceptive practices relating to its policy concerning end-of-life care services or engage in coercion or undue influence under EOLA.

Comments

Author's statement. According to the author, EOLA will sunset on January 1, 2026. After the sunset date, terminally ill, capable adults who want the option of medical aid-in-dying will be denied access. Now is the time to remove the sunset, and address impediments to access while preserving essential safeguards. Currently, the law requires individuals and their healthcare team to comply with a lengthy and administratively burdensome multi-step process. While on paper it appears that a person can get through the process relatively quickly, in reality it takes a dying person several weeks to several months to get through the process, if they are able to complete it and obtain the prescription at all. The empirical and anecdotal data collected shows that the current process is unnecessarily cumbersome, with too many roadblocks for many dying patients to access the law. These burdens are heaviest for underserved communities in rural areas and individuals from diverse communities, consistent with the inequities experienced during the COVID-19 pandemic. The pandemic has placed a spotlight on the toll that lack of access to healthcare and administrative burdens exact in minority communities. While healthcare disparities are not new, the coronavirus pandemic has amplified persistent, systemic healthcare inequality. This bill will remove barriers, especially for underserved ethnic, racially diverse and rural communities, ensuring that all eligible terminally ill individuals are in charge of their end of life care while retaining the right to remain autonomous and die with dignity.

Concern and amendment request. CMA has concerns with the reduction of the time period between oral requests being decreased that period from 15 days to 48 hours. The majority of states in which physician aid-in-dying is legal require 15 days between the two oral requests. Exceptions include Hawai'i, which 20 days between requests and New Mexico, which recently decreased their 15 day waiting

period to 48 hours. CMA continues to offer what we see as a compromise, in agreeing to a five day waiting period, but at this time we do not believe California should be one of the first states to essentially remove what we see as a vital patient safeguard.

FISCAL EFFECT: Appropriation: No Fiscal Com.: Yes Local: Yes

According to the Senate Appropriations Committee:

- The California Department of Public Health (CDPH) reports the need for one new permanent position and a one-time IT cost for a total initial cost of $139,216 General Fund and $133,000 annually thereafter.

- CDPH currently uses the Health Statistics Special Fund (HSSF) (Fund 0099) to run the EOLA program. The projected increased workload would require CDPH to hire an additional staff member. Due to COVID, the revenues of the main funding source HSSP (Fund 0099) have been severely impacted and there are not available funds to support this new position. The estimated increase in reporting forms will require additional resources in the form of one new permanent full-time employee (FTE), and annually thereafter position. This new position will be filled by an Associate Governmental Program Analyst (AGPA) to fulfill the anticipated increase of EOLA forms submitted. The AGPA will also respond to the less complex inquiries. CDPH will need to seek funding from the General Fund, as the HSSF (Fund 0099) is fully allocated to other staffing positions in CHSI and would not be able to financially support the on-going costs of an AGPA. Additionally, a one-time cost of $6,216.00, provided by Information Technology Services Division, will be needed to remove the final attestation form from the Adobe Experience Manager web-based portal and update the Interpreter form with gender neutral language.

SUPPORT: (Verified 5/21/21)

Compassion & Choices Action Network (source)
Access TLC Hospice
American Nurses Association California
Americans United for Separation of Church & State - Orange County
Atheist United Los Angeles
Bloom in the Desert Ministries United Church of Christ
Brownie Mary Democratic Club of San Francisco
California Council for Advancement of Pharmacy
Compassion & Choices Latino Council
Dolores Huerta Foundation

End of Life Choices California
Good Grief Doula
Hemlock Society of San Diego
Hospice of Santa Cruz County
Integrated MD Care
Laguna Woods Democratic Club
Libertarian Party of California
Long Beach Gray Panthers
Mera Consulting
Older Women's League of San Francisco
Pilgrim United Church of Christ
Sonoma County Democratic Party
Southern California Secular Coalition
The Brittany Fund
Voyages
Woman For: Orange County
554 Individuals

OPPOSITION: (Verified 5/21/21)

Alliance of Catholic Health Care, Inc.
American Academy of Medical Ethics
American College of Pediatricians
California Catholic Conference
California Family Council
California Foundation for Independent Living Centers
California Hospital Association
California League of United Latin American Citizens
California Prolife Council and Right to Life Federation
Disability Rights Education and Defense Fund
Pacific Justice Institute
Patients Rights Action Fund
The Church of Jesus Christ of Latter-day Saints
One Individual

ARGUMENTS IN SUPPORT: Compassion & Choices Action Network, the sponsor of this bill, writes that this bill removes unnecessary regulatory roadblocks in the law, while maintaining the core eligibility requirements. According to the sponsor, a study by Kaiser Southern California demonstrates that a third of eligible patients die unable to make it through the waiting period. This bill removes unnecessary regulatory roadblocks, as Oregon has done, while keeping intact the

same basic eligibility requirements and core safeguards that have always protected vulnerable patients. Compassion & Choices sees firsthand the need for greater transparency around the implementation of the California EOLA so that patients know whether or not providers and health systems are willing to support them in accessing the law; clarification and flexibility with the waiting period so that it does not become an unnecessary suffering period; and several small, but important changes to the law to improve access without compromising patient safety, such as authorizing licensed clinical social workers to participate and clarifying the medical aid in dying may be self-administered in a healthcare facility.

The Dolores Huerta Foundation writes that this compassionate law will sunset on January 1, 2026, and terminally ill California adults who want the option of medical aid in dying will be denied access to it. Some provisions of the law intended as safeguards have actually have become roadblocks, making it sometimes impossible for dying Californians to access the law. We must act now to permanently reauthorize EOLA and include improvements to the existing law to address the impediments to access, while we preserve its essential safeguards. Currently, this law requires individuals and their healthcare team to comply with a lengthy and administratively burdensome 13-step process. People who are dying do not have time to navigate the difficult process.

The Chief Executive Officer of Hospice of Santa Cruz County writes, that while the number of patients choosing the EOLA at Hospice of Santa Cruz County remains small, I have witnessed the comfort and relief that patients receive from having this option. It is affirming to witness the dignity that patients feel by gaining some control at a time when they often feel like their bodies are failing them. We have also seen how comforted family members can be by knowing that their loved one died on their own terms. For a variety of reasons, too many suffering terminally ill Californians have been unable to access their end of life options.

ARGUMENTS IN OPPOSITION: The California League of United Latin American Citizens (LULAC) strongly believes that assisted suicide does not constitute health care and is a dangerous risk to Latino communities, who are struggling to attain any option of basic care. LULAC firmly believes that assisted suicide is not about choice when so many people of color lack access to sufficient medical care. Latinos face a myriad of health disparities due to inequities of our socio-economic systems and now amidst the Covid-19 pandemic are experiencing greater rates of infection and mortality due to lack of access to health care. Our Latino communities desperately need an option that ends suffering through actual medical care, not assistance with their suicides by medicine and the state, which is

just an opportunity for commodity-based, profit-driven health systems to cop out of care by providing the ever-cheap "option to die." This is the time for racial equity in access to medical care and options for healthy living, not broadening access to capacity to kill oneself.

The Disability Rights Education and Defense Fund writes that the disability community is full of individuals who have been misdiagnosed as terminally ill, but gone on to live full lives after that initial scare. A bad day should not be a death sentence a few hours later. This bill removes other important protections for patients: requiring more medical professionals, with more training, to judge a patient's prognosis and assess their decision-making capacity. This Act has extraordinarily little monitoring, data, and investigation of abuse—there's not even a phone number to call if concerned family members or friends fear their loved one is being coerced. It's almost as if the law is set up to avoid finding problems. The annual statistical reports are very minimal for such an important public policy. One example is that assisted suicide laws in Oregon and Washington State require that these states at least make public doctor-reported data on why their patients chose to hasten their death. Might it have been the economic pressures so rampant in our broken, profit-driven health care system? But in California, there is no requirement to report such data on patient reasons. And such important data is therefore missing from the California reports.

The California Hospital Association (CHA) writes that this bill, as amended on April 5, proposes changes to the EOLA that clarify language, address certain implementation issues, reasonably simplify its application, and ensure that prospective patients can be aware of a health care facility's policy on medical aid in dying. CHA has no objection to the changes made in Sections 1-5, inclusive, of the bill. However, certain language in Sections 6 and 7 severely restricts the ability of health care facilities to have and enforce a policy prohibiting participation in the EOLA—carving back protections that exist in current law. Consequently, CHA opposes this bill unless it is amended to correct these issues.

Prepared by: Teri Boughton / HEALTH / (916) 651-4111
5/22/21 14:37:40

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