House File 533 - Introduced

HOUSE FILE 533
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A BILL FOR

An Act relating to care and choices at the end of life, providing penalties, and including effective date provisions.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

Section 1. NEW SECTION. **142E.1 Findings.**

1. The state of Iowa has long recognized that mentally capable adult individuals have a fundamental right to determine their own medical treatment options in accordance with their own values, beliefs, or personal preferences.

2. It is important that the state of Iowa upholds both the highest standard of medical care and the full range of options for each individual, particularly at the end of life.

3. Terminally ill individuals may undergo unremitting pain, agonizing discomfort, and a sudden, continuing, and irreversible reduction in their quality of life at the end of life.

4. The availability of medical aid in dying provides an additional palliative care option for terminally ill individuals who seek to retain their autonomy and some level of control over the progression of the terminal disease as they near the end of life or to ease unnecessary pain and suffering.

5. Integration of medical aid in dying into standard end-of-life care has demonstrably improved end-of-life care by contributing to better conversations between providers and their patients, earlier and more appropriate enrollment in hospice care, and better palliative care training for providers.

6. The state of Iowa seeks to affirm that a provider who respects and honors the values and priorities of individuals with a terminal disease for their last days of life and prescribes or dispenses medication for any such qualified terminally ill individual who makes a request pursuant to this chapter is practicing lawful patient-centered and patient-directed care.

7. Patient-directed care differs from patient-centered care in that it is not only respectful of and responsive to individual patient decisions, preferences, needs, and values, but also ensures that patient values direct all clinical decisions and that patients are fully informed of and able to

access legal options they desire.

Sec. 2. NEW SECTION. **142E.2 Short title.**

This chapter shall be known and may be cited as the *"Iowa Our Care, Our Options Act"*.

Sec. 3. NEW SECTION. **142E.3 Definitions.**

As used in this chapter, unless the context otherwise requires:

1. *"Adult"* means an individual eighteen years of age or older.

2. *"Attending provider"* means the provider who has primary responsibility for the care of a patient and treatment of the patient's terminal disease.

3. *"Coercion or undue influence"* means the willful attempt, whether by deception, intimidation, or any other means, to do any of the following:

a. Cause a patient to request, obtain, or self-administer medication pursuant to this chapter with the intent to cause the death of the patient.

b. Prevent a qualified patient from obtaining or self-administration of medication pursuant to this chapter.

4. *"Consulting provider"* means a provider who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding a patient's disease.

5. *"Department"* means the department of health and human services.

6. *"Health care entity"* means a hospital licensed under chapter 135B, a nursing facility licensed under chapter 135C, an inpatient hospice program, a clinic, or any other facility licensed by the state wherein medical care is provided. *"Health care entity"* does not include a provider.

7. *"Informed decision"* means a decision by a medically capable requesting patient to request and obtain a prescription for medication pursuant to this chapter that the qualified patient may self-administer to bring about a peaceful death after being fully informed by the attending provider and

consulting provider of all of the following:

a. The requesting patient's diagnosis and prognosis.

b. The potential risk associated with taking the medication to be prescribed.

c. The probable result of taking the medication to be prescribed.

d. The feasible end-of-life care and treatment options for the requesting patient's terminal disease, including but not limited to comfort care, palliative care, hospice care, and pain control, and the risks and benefits of each.

e. The requesting patient's right to withdraw a request pursuant to this chapter or consent for any other treatment, at any time.

8. *"Licensed mental health provider"* means the same as a *"mental health professional"* as defined in section 228.1.

9. *"Medical aid in dying"* means the practice of evaluating a patient's request for medication, determining if a patient is qualified, performing the duties specified, and providing a prescription to a qualified patient, pursuant to this chapter.

10. *"Medical-aid-in-dying medication"* or *"medication"* means the medication prescribed and dispensed under this chapter to a qualified patient to bring about a peaceful death.

11. *"Medically confirmed"* means the attending provider's medical opinion that the patient is eligible to receive medication pursuant to this chapter has been confirmed by the consulting provider after performing a medical evaluation.

12. *"Mentally capable"* means that in the opinion of the provider or licensed mental health provider, if an opinion is required under this chapter, the requesting patient has the ability to make and communicate an informed decision.

13. *"Oral request"* means an affirmative statement that demonstrates a contemporaneous affirmatively stated desire by the requesting patient seeking medical aid in dying.

14. *"Patient"* means an adult who is under the care of a provider.

15. *"Prognosis of six months or less"* means the terminal disease of a patient will, within reasonable medical judgment, result in the patient's death within six months.

16. *a. "Provider"* means a person licensed, certified, or otherwise authorized or permitted by the law of this state to diagnose and treat medical conditions, and prescribe and dispense medication, including controlled substances. *"Provider"* includes all of the following:

(1) A physician licensed to practice medicine pursuant to chapter 148.

(2) An advanced registered nurse practitioner licensed under chapter 152 or an advanced practice registered nurse under chapter 152E.

(3) A physician assistant licensed under chapter 148C.

b. "Provider" does not include a health care entity.

17. *"Qualified patient"* means a mentally capable patient who has satisfied the requirements of this chapter in order to obtain a prescription for medication to bring about a peaceful death. A person shall not be considered a *"qualified patient"* under this chapter solely because of advanced age or disability.

18. *"Requesting patient"* means a patient with a terminal disease.

19. *"Self-administer"* or *"self-administration"* means a qualified patient's performance of an affirmative, conscious, voluntary act to ingest medication prescribed pursuant to this chapter to bring about the qualified patient's peaceful death. *"Self-administration"* does not include administration by parenteral injection or infusion.

20. *"Terminal disease"* means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.

Sec. 4. NEW SECTION. **142E.4 Informed consent.**

1. This chapter shall not be construed to limit the amount of information provided to a patient to ensure the patient can

make an informed decision.

2. An attending provider shall provide sufficient information to a patient regarding all appropriate end-of-life care options, including hospice and palliative care, and the foreseeable risks and benefits of each, so that the patient can make a voluntary and affirmative decision regarding the patient's end-of-life care.

3. An attending provider is deemed to fail to obtain informed consent for subsequent medical treatment if a requesting patient requests information about medical aid in dying and, within a reasonable time, the provider has failed, at a minimum, to do either of the following:

a. Provide information to the requesting patient about medical aid in dying and other legal end-of-life options.

b. Document the date of the requesting patient's request in the patient's medical record and upon request transfer the requesting patient's medical records to an alternative provider consistent with federal and state law.

4. If a requesting patient requests that the requesting patient's medical records be transferred to an alternative provider, the requesting patient's medical records shall be transferred within two business days.

Sec. 5. NEW SECTION. **142E.5 Standard of care.**

1. Care that complies with this chapter shall be deemed to meet the medical standard of care.

2. This chapter shall not be construed to exempt a provider or other medical personnel from meeting medical standards of care for a patient's treatment.

Sec. 6. NEW SECTION. **142E.6 Request for medical aid in dying.**

1. A mentally capable patient with a terminal disease may request a prescription for medication under this chapter. The requesting patient shall make an oral request and a written request and shall reiterate the oral request to the requesting patient's attending provider no less than forty-eight hours

after making the initial oral request. An oral request charted in the requesting patient's medical record by a provider other than the requesting patient's attending provider satisfies the oral request requirement under this section.

2. The attending and consulting providers of a qualified patient shall meet all requirements of sections 142E.8 and 142E.9.

3. Notwithstanding any provision to the contrary under subsection 1, if the requesting patient's attending provider has determined that the requesting patient will, based on reasonable medical judgment, die within forty-eight hours after making the initial oral request under this section, the requesting patient may satisfy the requirements under this section by reiterating the oral request to the attending provider at any time after making the initial oral request.

4. At the time the requesting patient makes the second oral request, the attending provider shall offer the requesting patient an opportunity to rescind the request.

5. Oral and written requests for the requesting patient must be made only by the requesting patient and shall not be made by the requesting patient's surrogate decision-maker, health care proxy, attorney-in-fact for health care, or via an advance health care directive.

6. If a requesting patient decides to transfer the requesting patient's care to an alternative provider, the custodian of the requesting patient's medical records shall transfer all relevant medical records including written documentation of the dates of any of the requesting patient's oral or written requests concerning medical aid in dying within two business days.

7. The transfer of care or medical records of a requesting patient does not toll or restart any waiting period under this section.

Sec. 7. NEW SECTION. **142E.7 Form of written request —— requirements.**

1. A written request for medication under this chapter shall be in substantially the following form, signed and dated by the requesting patient, and witnessed by at least one person who, in the presence of the requesting patient, attests that to the best of the witness's knowledge and belief the requesting patient is mentally capable, acting voluntarily, and is not being coerced nor unduly influenced to sign the request.

Request for Medication
to End My Life in
a Peaceful Manner

I, _____ am an adult of sound mind. I have been diagnosed with _____, and given a prognosis of six months or less to live.

I have been fully informed of the feasible alternatives, and the concurrent or additional treatment opportunities for my terminal disease, including but not limited to comfort care, palliative care, hospice care, or pain control, and the potential risks and benefits of each. I have been offered or received resources or referrals to pursue these alternative, or concurrent or additional treatment opportunities for my terminal disease.

I have been fully informed of the nature of the medication to be prescribed, including the risks and benefits, and understand that the likely outcome of self-administration of medication is death. I understand that I can rescind this request at any time, that I am under no obligation to fill the prescription once written nor to self-administer the medication if I obtain the medication.

I request that my attending provider furnish a prescription for medication that will end my life if I choose to self-administer it, and I authorize my attending provider to contact a pharmacist to dispense the prescription at a time of my choosing.

I make this request voluntarily, free from coercion or undue

influence.

_____ _____

Requesting Patient Signature Date

_____ _____

Witness Signature Date

2. The witness required under this section shall not be any of the following:

a. A relative of the requesting patient by blood, marriage, or adoption.

b. A person who at the time the request is signed would be entitled to any portion of the estate of the requesting patient upon death, under any will or by operation of law.

c. An owner, operator, or employee of a health care entity where the requesting patient is receiving medical treatment or is a resident.

d. The requesting patient's attending provider at the time the request is signed.

e. An interpreter for the requesting patient, if the requesting patient uses an interpreter.

Sec. 8. NEW SECTION. **142E.8 Attending provider responsibilities.**

The attending provider shall do all of the following:

1. Determine whether a requesting patient has a terminal disease with a prognosis of six months or less and is mentally capable.

2. Confirm that the requesting patient's request does not arise from coercion or undue influence.

3. Inform the requesting patient of all of the following:

a. The requesting patient's diagnosis and prognosis.

b. The potential risks, benefits, and probable result of self-administration of the prescribed medication to bring about a peaceful death.

c. The potential benefits and risks of feasible alternatives including but not limited to concurrent or additional treatment options for the requesting patient's terminal disease,

palliative care, comfort care, hospice care, and pain control.

d. The requesting patient's right to rescind the request for medication pursuant to this chapter at any time.

e. That there is no obligation to fill the prescription nor an obligation to self-administer the medication, if the medication is obtained.

4. Provide the requesting patient with a referral for comfort care, palliative care, hospice care, pain control, or other end-of-life treatment options as requested by the patient and as clinically indicated.

5. Refer the requesting patient to a consulting provider for medical confirmation that the requesting patient has a terminal disease with a prognosis of six months or less to live and is mentally capable.

6. Include the consulting provider's written determination in the requesting patient's medical record.

7. Refer the requesting patient to a licensed mental health provider if the attending provider observes signs that the requesting patient may not be capable of making an informed decision.

8. Include the licensed mental health provider's written determination in the requesting patient's medical record, if such determination was requested.

9. Inform the requesting patient of the benefits of notifying the next of kin of the requesting patient's decision to request medication pursuant to this chapter.

10. Fulfill the medical record documentation requirements under this chapter.

11. Ensure that all steps are carried out in accordance with this chapter before providing a prescription to a requesting patient for medication pursuant to this chapter including all of the following:

a. Confirming that the requesting patient has made an informed decision to obtain a prescription for medication pursuant to this chapter.

b. Offering the requesting patient an opportunity to rescind the request for medication pursuant to this chapter.

c. Educating the requesting patient on all of the following:

(1) The recommended procedure for self-administration of the medication to be prescribed.

(2) The safe-keeping and proper disposal of unused medication in accordance with state and federal law.

(3) The importance of having another individual present when the requesting patient self-administers the medication to be prescribed.

(4) Not taking the medication in a public place.

12. Once the requesting patient is determined to be a qualified patient, in accordance with state and federal law, do one of the following:

a. Deliver the prescription personally, by mail, or through an authorized electronic transmission to a licensed pharmacist who will dispense the medication including any ancillary medications to the attending provider, to the qualified patient, or to an individual expressly designated by the qualified patient in person or with a signature required on delivery, by mail service, or by messenger service.

b. If authorized by the federal drug enforcement agency, dispense the prescribed medication including any ancillary medications to the qualified patient or an individual designated in person by the qualified patient.

13. Document in the qualified patient's medical record the qualified patient's diagnosis and prognosis, determination of mental capability, the date of any oral request, a copy of the written request, a notation that the requirements under this chapter have been completed, and identification of the medication and ancillary medications prescribed to the qualified patient pursuant to this chapter.

Sec. 9. NEW SECTION. **142E.9 Consulting provider responsibilities.**

A consulting provider shall do all of the following:

1. Evaluate the requesting patient and the requesting patient's relevant medical records.

2. Confirm all of the following to the attending provider regarding the requesting patient:

a. That the requesting patient has requested a prescription for medical-aid-in-dying medication.

b. That the requesting patient has a terminal disease with a prognosis of six months or less to live.

c. That the requesting patient is mentally capable, or provide documentation that the consulting provider has referred the requesting patient for further evaluation in accordance with section 142E.10.

d. That the requesting patient is acting voluntarily, free from coercion or undue influence.

Sec. 10. NEW SECTION. **142E.10 Referral — determination that requesting patient is mentally capable.**

1. If either the attending provider or the consulting provider doubts whether the requesting patient is mentally capable and is unable to confirm that the requesting patient is capable of making an informed decision, the attending provider or consulting provider shall refer the patient to a licensed mental health provider for a determination regarding the requesting patient's mental capability.

2. The licensed mental health provider who evaluates the requesting patient under this section shall submit to the attending provider or consulting provider who made the referral a written determination of whether the requesting patient is mentally capable.

3. If the licensed mental health provider determines the requesting patient is not mentally capable, the requesting patient shall not be deemed a qualified patient and the attending provider shall not prescribe medication to the requesting patient under this chapter.

Sec. 11. NEW SECTION. **142E.11 Death certificate.**

1. Unless otherwise prohibited by law, the attending

provider may sign the death certificate of a qualified patient who obtained and self-administered a prescription for medication pursuant to this chapter.

2. When a death has occurred in accordance with this chapter, the death shall be attributed to the underlying terminal disease, and all of the following shall apply:

a. A death following self-administration of medication under this chapter does not alone constitute a person's death that affects the public interest as described pursuant to section 331.802. If a death that occurs in accordance with this chapter is referred to the state medical examiner or a county medical examiner, the state medical examiner or county medical examiner may conduct a preliminary investigation to determine whether an individual received a prescription for medication under this chapter.

b. A death in accordance with this chapter shall not be designated a suicide or homicide.

c. A qualified patient's act of self-administration of medication prescribed pursuant to this chapter shall not be indicated on the death certificate.

Sec. 12. NEW SECTION. **142E.12 Reporting requirements — willful failure or refusal.**

1. The department shall create and make available to all attending providers a prescribing provider checklist form and prescribing provider follow-up form for the purposes of reporting the information as specified under this section to the department.

2. Within thirty calendar days of providing a prescription for medication pursuant to this chapter, the attending provider shall submit to the department an attending provider checklist form with all of the following information:

a. The qualifying patient's name and date of birth.

b. The qualifying patient's terminal diagnosis and prognosis.

c. Notice that the requirements under this chapter were

completed.

d. Notice that medication has been prescribed pursuant to this chapter.

3. Within sixty calendar days of notification of a qualified patient's death from self-administration of medication prescribed pursuant to this chapter, the attending provider shall submit to the department an attending provider follow-up form with all of the following information:

a. The qualified patient's name and date of birth.

b. The qualified patient's date of death.

c. A notation of whether or not the qualified patient was enrolled in hospice services at the time of the qualified patient's death.

4. The department shall annually review a sample of records pursuant to this chapter to ensure compliance and issue a public statistical report of nonidentifying information. The report shall be limited to all of the following:

a. The number of prescriptions for medication written pursuant to this chapter.

b. The number of attending providers who wrote prescriptions for medication pursuant to this chapter.

c. The number of qualified patients who died following self-administration of medication prescribed and dispensed pursuant to this chapter.

5. Except as otherwise required by law, the information collected by the department is not a public record and is not available for public inspection.

6. Willful failure or refusal by an attending provider to timely submit reports required under this section nullifies the protections provided under section 142E.16.

Sec. 13. NEW SECTION. **142E.13 Safe disposal of unused medications.**

A person who has custody or control of medication prescribed pursuant to this chapter after the qualified patient's death shall dispose of the medication by lawful means in accordance

with applicable state and federal guidelines.

Sec. 14. NEW SECTION. **142E.14 No duty to provide medical aid in dying — licensee discipline.**

1. A provider shall provide sufficient information to a patient with a terminal disease regarding available options, alternatives, and the foreseeable risks and benefits of each, so that the patient with a terminal disease is able to make informed decisions regarding the patient's end-of-life health care.

2. A provider may choose whether or not to practice medical aid in dying pursuant to this chapter.

3. If an attending provider is unable or unwilling to fulfill a requesting patient's request pursuant to this chapter, the attending provider shall do all of the following:

a. Document in the requesting patient's medical record the date of the requesting patient's oral or written request and the attending provider's notice to the requesting patient of the attending provider's inability or unwillingness to provide medical aid in dying.

b. Upon the requesting patient's request, transfer the requesting patient's medical records to an alternative provider, consistent with federal and state law.

4. An attending provider shall not engage in false, misleading, or deceptive practices relating to a willingness to qualify a requesting patient or to provide medical aid in dying. A provider who engages in such false, misleading, or deceptive practices is subject to licensee discipline by the applicable licensing board or entity.

Sec. 15. NEW SECTION. **142E.15 Health care entity — permissible prohibitions and duties — penalties — licensee discipline.**

1. A health care entity may prohibit providers from practicing medical aid in dying in the course of performing duties for the entity. A health care entity that prohibits the practice of medical aid in dying shall provide advance

notice in writing to providers and staff at the initial time of hiring, contracting, or privileging a provider, and on a yearly basis thereafter. A health care entity that fails to provide explicit, advance notice in writing to providers and staff that the health care entity prohibits providers from practicing medical aid in dying waives the right to enforce the prohibition.

2. If a requesting patient wishes to transfer care from a health care entity that prohibits the practice of medical aid in dying to another health care entity, the prohibiting entity shall coordinate a timely transfer of care including transfer of the requesting patient's medical records that includes a notation of the date the requesting patient first made an oral request or a written request concerning medical aid in dying within two business days of the request for transfer by the requesting patient.

3. A health care entity shall not prohibit a provider from fulfilling the requirements of informed consent and meeting the standard of medical care under this chapter by prohibiting the provider from doing any of the following:

a. Providing information to a patient regarding the patient's health status including but not limited to a diagnosis and prognosis, recommended treatment and treatment alternatives, and the risks and benefits of each.

b. Providing information regarding health care services available pursuant to this chapter, information about relevant community resources, and how to access those resources to obtain care of the patient's choice.

c. Practicing medical aid in dying outside the scope of the provider's employment or contract with the prohibiting entity and off the premises of the prohibiting entity.

d. Being present, if outside the scope of the provider's employment or contractual duties, when a qualified patient self-administers medication prescribed pursuant to this chapter or at the time of death of the qualified patient, if

requested by the qualified patient or the qualified patient's representative.

4. A prohibiting health care entity shall provide notice to the public by posting on the health care entity's internet site that the health care entity prohibits attending providers from qualifying patients for medical aid in dying and from prescribing and dispensing medication pursuant to this chapter while the provider is performing duties in the course of performing duties for the health care entity.

5. A health care entity shall not engage in false, misleading, or deceptive practices relating to the health care entity's policy regarding end-of-life care services, including whether the health care entity has a policy which prohibits affiliated providers from practicing medical aid in dying, or intentionally denying a requesting patient access to medication pursuant to this chapter by failing to transfer a requesting patient and the requesting patient's medical records to another provider in a timely manner. The intentional misleading of a patient or deploying of misinformation to obstruct access to services pursuant to this chapter by a health care entity constitutes coercion and undue influence which is an aggravated misdemeanor and also subjects the health care entity to licensee discipline.

6. If any portion of this section is found to be in conflict with federal requirements which are a prescribed condition to the receipt of federal funds, the conflicting part of this section is inoperative solely to the extent of the conflict with respect to the health care entity directly affected, and such finding or determination shall not affect the operation of the remainder of this section or this chapter.

Sec. 16. NEW SECTION. **142E.16 Immunities for actions in good faith —— prohibition against reprisals.**

1. A provider or health care entity shall not be subject to criminal liability, licensing sanctions, or other professional disciplinary action for actions taken in good-faith compliance

with this chapter.

2. A provider, health care entity, or professional organization or association shall not subject a provider or health care entity to censure, discipline, suspension, loss of license, loss of privileges, loss of membership, or any other penalty for engaging in good-faith compliance with this chapter or for refusing to participate in accordance with this chapter.

3. A provider, health care entity, or professional organization or association shall not subject a provider to discharge, demotion, censure, discipline, suspension, loss of license, loss of privileges, loss of membership, discrimination, or any other penalty for providing medical aid in dying in accordance with the standard of care and in good faith under this chapter when the provider is engaged in the outside practice of medicine and not on the objecting provider's, health care entity's, or professional organization's or association's premises, or when the provider is providing scientific and accurate information about medical aid in dying to a patient when discussing end-of-life care options.

4. A provider is not subject to civil or criminal liability or professional discipline if, at the request of a qualified patient, the provider is present outside the scope of the provider's employment and not located on the health care entity's premises when the qualified patient self-administers medication pursuant to this chapter or at the time of the qualified patient's death.

5. A person who is present at the time of self-administration of medication pursuant to this chapter may, without civil or criminal liability, assist the qualified patient by preparing the medication prescribed pursuant to this chapter.

6. The request alone by a patient for medical aid in dying does not constitute grounds for neglect or elder abuse for any purpose of law, nor shall it be the sole basis for appointment

of a guardian or conservator for the requesting patient.

7. This section does not limit civil liability of a provider or a health care entity for an intentional or negligent violation of this chapter.

Sec. 17. NEW SECTION. **142E.17 Effect on construction of wills, contracts, or other agreements.**

1. A provision in a contract, will, or other agreement, whether written or oral, that would determine whether a patient may make or rescind a request for medical-aid-in-dying medication pursuant to this chapter is not valid.

2. An obligation owing under any currently existing contract shall not be conditioned or affected by a patient's act of making or rescinding a request for medical-aid-in-dying medication pursuant to this chapter.

3. It is unlawful for an insurer to deny or alter a health care benefit otherwise available to a patient with a terminal disease based on the availability of medical aid in dying or to otherwise attempt to coerce a patient with a terminal disease to make a request for medical-aid-in-dying medication.

Sec. 18. NEW SECTION. **142E.18 Insurance or annuity policies, plans, contracts, or other agreements.**

1. The sale, procurement, or issuance of a life, health, or accident insurance policy, plan, contract, or other agreement, or an annuity policy, plan, contract, or other agreement, or the rate charged for such policy, plan, contract, or other agreement shall not be conditioned upon or affected by a patient's act of making or rescinding a request for medical-aid-in-dying medication pursuant to this chapter.

2. A qualified patient's act of self-administration of medical-aid-in-dying medication pursuant to this chapter does not invalidate any part of a life, health, or accident insurance policy, plan, contract, or other agreement, or an annuity policy, plan, contract, or other agreement.

3. A carrier as defined in section 514C.13 shall not deny or alter benefits to a patient with a terminal disease

who is a covered beneficiary of the health benefit plan as defined in section 514C.13, based on the availability of medical-aid-in-dying medication, the patient's request for medical-aid-in-dying medication pursuant to this chapter, or the absence of a request by a patient for medical-aid-in-dying medication pursuant to this chapter. A person who violates this subsection is subject to regulation by the commissioner of insurance under Title XIII, subtitle 1.

Sec. 19. NEW SECTION. **142E.19 Liabilities and penalties.**

1. A person who intentionally or knowingly alters or forges a patient's request for medical-aid-in-dying medication pursuant to this chapter or who conceals or destroys a rescission of a patient's request for medical-aid-in-dying medication pursuant to this chapter is guilty of a class "A" felony.

2. A person who intentionally or knowingly coerces or exerts undue influence on a patient with a terminal disease to request medical-aid-in-dying medication pursuant to this chapter or to request or utilize medical-aid-in-dying medication pursuant to this chapter is guilty of a class "A" felony.

3. Nothing in this section shall limit civil liability or damages arising from negligent conduct or intentional misconduct by a provider or health care entity.

4. The penalties specified in this chapter shall not preclude application of criminal penalties applicable under other laws for conduct inconsistent with this chapter.

Sec. 20. NEW SECTION. **142E.20 Claims by governmental entity for costs incurred.**

A governmental entity that incurs costs resulting from a qualified patient's self-administration of medication prescribed under this chapter in a public place shall have a claim against the estate of the qualified patient to recover such costs and reasonable attorney fees related to enforcing the claim.

Sec. 21. NEW SECTION. **142E.21 Construction.**

1. Nothing in this chapter authorizes a provider or any other person, including a qualified patient, to end the qualified patient's life by lethal injection, lethal infusion, mercy killing, homicide, murder, manslaughter, euthanasia, or any other criminal act.

2. Actions taken in accordance with this chapter do not for any purpose constitute suicide, assisted suicide, euthanasia, mercy killing, homicide, murder, manslaughter, elder abuse or neglect, or any other civil or criminal violation under the law.

Sec. 22. NEW SECTION. **142E.22 Severability.**

If any provision of this chapter or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of this chapter which can be given effect without the invalid provision or application, and to this end the provisions of this chapter are severable.

Sec. 23. FORMS. Within forty-five days of enactment of this Act, the department of health and human services shall create an attending provider checklist form and an attending provider follow-up form to facilitate collection of the information described in this Act and shall post the forms on the department's internet site.

Sec. 24. EFFECTIVE DATE.

1. The following, being deemed of immediate importance, takes effect upon enactment:

The portion of the section of this Act enacting section 142E.12, relating to the department of health and human services creating and making available to all attending providers a prescribing provider checklist form and prescribing provider follow-up form for the purposes of reporting the information as specified under this Act to the department of health and human services. The department of health and human services shall comply with this section within forty-five days of the effective date of this subsection.

2. The remainder of this Act, not including the portion of section 142E.12 that is effective upon enactment under subsection 1, is effective forty-five days after the effective date of subsection 1.

EXPLANATION

The inclusion of this explanation does not constitute agreement with the explanation's substance by the members of the general assembly.

This bill creates a new Code chapter, the "Iowa Our Care, Our Options Act".

The bill provides findings and definitions used in the new Code chapter.

The bill includes provisions relating to informed consent relative to an adult patient making a decision about end-of-life care and in particular medical aid in dying which is defined as the practice of evaluating a patient's request for medication, determining if a patient is qualified, performing the duties specified, and providing a prescription to a qualified patient, pursuant to the new Code chapter.

The bill provides that care that complies with the new Code chapter meets the medical standard of care and shall not be construed to exempt a provider or other medical personnel from meeting the medical standards of care for a patient's treatment.

The bill provides the process for a mentally capable patient with a terminal disease to request a prescription for medical-aid-in-dying medication. A requesting patient shall make an oral request and a written request and shall reiterate the oral request to the requesting patient's attending provider no less than 48 hours after making the initial oral request. However, if the attending provider has determined that the requesting patient will, based on reasonable medical judgment, die within 48 hours after making the initial oral request, the requesting patient may reiterate the oral request to the attending provider at any time after making the initial oral request.

The bill specifies the form of the request for medical-aid-in-dying medication and the requirements for witnesses of the form under the new Code section.

The bill specifies the responsibilities of the attending provider including determining whether a requesting patient has a terminal disease with a prognosis of six months or less and is mentally capable, confirming that the requesting patient's request does not arise from coercion or undue influence, informing the requesting patient of certain information, providing the requesting patient with a referral for alternative end-of-life treatment options, referring the requesting patient to a consulting provider for medical confirmation that the requesting patient has a terminal disease with a prognosis of six months or less to live and is mentally capable, referring the requesting patient to a licensed mental health provider if the attending provider observes signs that the requesting patient may not be capable of making an informed decision, informing the requesting patient of the benefits of notifying the next of kin of the requesting patient's decision to request medication, following all other required steps before providing the medication including confirming that the requesting patient has made an informed decision, and educating the requesting patient on the recommended procedure and other details relating to administering the medication. Additionally, once the attending provider has determined that the requesting patient is a qualified patient, either deliver the prescription to a licensed pharmacist to dispense the medication to the qualified patient, or to an individual expressly designated by the qualified patient; or if authorized by the federal drug enforcement agency, dispense the prescribed medication to the qualified patient or an individual designated in person by the qualified patient.

The bill includes responsibilities of a consulting provider including evaluating the requesting patient and the requesting patient's relevant medical records, confirming

certain information about the requesting patient including that the requesting patient has a terminal disease, is acting voluntarily, is free from coercion or undue influence, and is mentally capable or if not mentally capable then provide documentation that the consulting provider has referred the requesting patient for further evaluation by a licensed mental health provider. The bill provides that if either the attending provider or the consulting provider doubts whether the requesting patient is mentally capable and is unable to confirm that the requesting patient is capable of making an informed decision, the attending provider or consulting provider shall refer the requesting patient to a licensed mental health provider for a determination regarding the requesting patient's mental capability. If the licensed mental health provider determines the requesting patient is not mentally capable, the requesting patient shall not be deemed a qualified patient and the attending provider shall not prescribe medication to the requesting patient under the new Code chapter.

The bill includes provisions relating to the death certificate of a qualified patient who obtained and self-administered a prescription for medication under the new Code chapter. The bill requires the department of health and human services (HHS) to create and make available to all attending providers a prescribing provider checklist form and prescribing provider follow-up form for the purposes of reporting specified information about a qualifying patient within specified time periods. Willful failure or refusal by an attending provider to timely submit the reports nullifies the immunity protections provided under the new Code chapter.

The bill provides that a person who has custody or control of medication prescribed under the new Code chapter after the qualified patient's death shall dispose of the medication by lawful means in accordance with applicable state and federal guidelines.

The bill provides that a provider or health care entity may choose whether or not to provide medical aid in dying, but requires those that prohibit or refuse to provide medical aid in dying to comply with certain notifications to patients and providers. Under the new Code chapter, the intentional misleading of a patient or deploying of misinformation to obstruct access to medical-aid-in-dying services by a health care entity constitutes coercion and undue influence which is an aggravated misdemeanor and subjects the health care entity to licensee discipline. The bill provides that a provider or health care entity shall not be subject to criminal liability, licensing sanctions, or other professional disciplinary action for actions taken in good-faith compliance with the new Code chapter. Additionally, a provider, health care entity, or professional organization or association is prohibited from certain actions against a provider or health care entity for engaging in good-faith compliance with or for refusing to participate in accordance with the new Code chapter.

A provider, health care entity, or professional organization or association is prohibited from subjecting a provider to certain penalties for providing medical aid in dying in accordance with the standard of care and in good faith under the new Code chapter when the provider is engaged in the outside practice of medicine and not on the objecting provider's, health care entity's, or professional organization's or association's premises, or when the provider is providing scientific and accurate information about medical aid in dying to a patient when discussing end-of-life care options. A provider is not subject to civil or criminal liability or professional discipline if at the request of a qualified patient the provider is present outside the scope of the provider's employment and not located on the health care entity's premises when the qualified patient self-administers medication pursuant to the new Code chapter or at the time of the qualified patient's death.

A person who is present at the time of self-administration of medication may, without civil or criminal liability, assist the qualified patient by preparing the medication prescribed pursuant to the new Code chapter.

The request alone by a patient for medical aid in dying does not constitute grounds for neglect or elder abuse for any purpose of law, nor shall it be the sole basis for appointment of a guardian or conservator for the requesting patient. However, the immunity provisions do not limit civil liability of a provider or a health care entity for an intentional or negligent violation of the new Code chapter.

The bill includes provisions relating to the effect of the new Code chapter on the construction of wills, contracts, or other agreements and on insurance and annuity policies, plans, contracts, and other agreements.

The bill provides that a person who intentionally or knowingly alters or forges a patient's request for medical-aid-in-dying medication or who conceals or destroys a rescission of a patient's request for medical-aid-in-dying medication pursuant to the new Code chapter is guilty of a class "A" felony. A class "A" felony is punishable by confinement for life without possibility of parole. Additionally, a person who intentionally or knowingly coerces or exerts undue influence on a patient with a terminal disease to request medical-aid-in-dying medication or to request or utilize medical-aid-in-dying medication is guilty of a class "A" felony.

The bill provides that a governmental entity that incurs costs resulting from a qualified patient self-administering medication prescribed under the new Code chapter in a public place shall have a claim against the estate of the qualified individual to recover such costs and reasonable attorney fees related to enforcing the claim.

The construction provisions of the new Code chapter provide that nothing in the Code chapter authorizes a provider or

any other person, including the qualified patient, to end the qualified patient's life by lethal injection, lethal infusion, mercy killing, homicide, murder, manslaughter, euthanasia, or any other criminal act. Additionally, actions taken in accordance with the new Code chapter do not for any purpose constitute suicide, assisted suicide, euthanasia, mercy killing, homicide, murder, manslaughter, elder abuse or neglect, or any other civil or criminal violation under the law.

The bill includes a severability provision. The bill provides that the provision requiring HHS to create and make available the attending provider checklist form and follow-up form takes effect upon enactment and requires the completion of this requirement within 45 days of the effective date of the bill.

The remainder of the bill takes effect 45 days after the effective date of the form requirement.