



CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

October 2, 1998

S. 2151

Lethal Drug Abuse Prevention Act of 1998

As reported by the Senate Committee on the Judiciary on September 24, 1998

SUMMARY

S. 2151 would make it a violation of the Controlled Substances Act of 1970 to distribute or dispense a controlled substance to assist in suicide or euthanasia. Persons who violate the bill's provisions could face revocation of their license to prescribe controlled substances. The legislation would direct the Secretary of Health and Human Services, in consultation with the Attorney General, to establish the Medical Advisory Board on Pain Relief to assist in resolving disputes over the dispensing of controlled substances in certain instances of assisted suicide or euthanasia.

CBO estimates that implementing S. 2151 would not result in any significant cost to the federal government. Because enactment of S. 2151 could affect direct spending and receipts, pay-as-you-go procedures would apply to the bill; however, CBO estimates that the amounts involved would be less than \$500,000 a year.

S. 2151 contains no intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA) and would have no impact on the budgets of state, local, or tribal governments. The bill would impose a new private-sector mandate as defined in UMRA, but the direct costs imposed by the mandate would fall well below the statutory threshold established in UMRA (\$100 million in 1996, adjusted annually for inflation).

ESTIMATED COST TO THE FEDERAL GOVERNMENT

Enacting the bill would increase administrative costs of the Drug Enforcement Administration (DEA) and the Department of Health and Human Services in cases of assisted suicide or euthanasia that involve controlled substances. Under the bill's provisions, any such costs, including those relating to the Medical Advisory Board on Pain Relief, would be funded from user fees that are deposited into the diversion control fee account. Such outlays

would constitute direct spending. CBO anticipates very few of these cases, however, so the amount of additional spending would be negligible.

If an individual's license to dispense controlled substances is revoked, the DEA could seize any such substances in his or her possession. Thus, enacting S. 2151 could lead to the seizure of more assets and their forfeiture to the United States, but we estimate that any such increase would be less than \$500,000 annually in value. Proceeds from the sale of any such assets would be deposited as revenues into the assets forfeiture fund of the Department of Justice and spent from that fund in the same year. Thus, the change in direct spending from the assets forfeiture fund would match any increase in revenues to that fund.

PAY-AS-YOU-GO CONSIDERATIONS

The Balanced Budget and Emergency Deficit Control Act sets up pay-as-you-go procedures for legislation affecting direct spending or receipts. Enacting S. 2151 could affect both direct spending and receipts, but CBO estimates that any such effects would be less than \$500,000 a year.

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

S. 2151 contains no intergovernmental mandates as defined in UMRA and would have no impact on the budgets of state, local, or tribal governments. Although Oregon citizens voted to legalize doctor-assisted suicide for terminally ill patients, S. 2151 would not preempt that law. It would, however, make it illegal for doctors to assist in suicide or euthanasia using drugs governed by the federal Controlled Substances Act.

ESTIMATED IMPACT ON THE PRIVATE SECTOR

S. 2151 would impose a new private-sector mandate, as defined in UMRA. The bill would prohibit medical practitioners from intentionally dispensing or prescribing controlled substances for the purpose of assisting the suicide or euthanasia of an individual.

Under current law, medical practitioners who are licensed by state medical boards must also register with the Attorney General through the DEA if they intend to dispense or prescribe controlled substances. Practitioners may now lose their federal registration to dispense those substances if the Attorney General, after considering specific factors, determines that the registration would not be in the public interest. Intentionally dispensing or prescribing

controlled substances to assist or facilitate a suicide or euthanasia is not included in that list of factors, but under the provisions of S. 2151, it would be grounds for suspending or revoking a practitioner's federal license. In addition, controlled substances possessed by practitioners whose licenses have been revoked or suspended based on the bill's provisions would be subject to government seizure.

CBO estimates that the direct costs of the mandate on federally registered practitioners would fall well below the statutory threshold in UMRA. In all states except Oregon, medical practitioners may not legally assist in the suicide or euthanasia of an individual. Moreover, one recent study indicates that only a small percentage of physicians who provide care for dying patients—about 6 percent—have actively helped patients die. Thus, the number of medical practitioners potentially affected by the prohibition would be small.

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