

June 1, 2026

The Honorable Robert F. Kennedy, Jr.
Secretary
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Request for Information Regarding Medical Aid in Dying (MAID) (CMS-1851-P)
(RIN 0938-AV78)

Dear Secretary Kennedy:

We submit this comment as bipartisan, bicameral Members of Congress in response to the Department of Health and Human Services (HHS) and Centers for Medicare & Medicaid Services' (CMS) request for information regarding medical aid in dying (MAID), 91 Fed. Reg. 17338. Medically assisted suicide raises significant informed consent issues as well as concerns about disability and age discrimination. Since the vast majority of assisted suicide patients are enrolled in hospice—92% according to Oregon data and 90% according to Washington data¹—this is problematic for HHS and CMS' regulation of patient health and safety within the hospice program. We urge HHS and CMS to implement reporting requirements in the hospice program to monitor assisted suicide for discriminatory practices against vulnerable populations,² as well as ensure compliance with the Assisted Suicide Funding Restriction Act.³

In 1997, the U.S. Supreme Court unanimously upheld Washington's and New York's bans on assisted suicide in *Washington v. Glucksberg* and *Vacco v. Quill*.⁴ The majority opinions found that there is no right to assisted suicide under the Due Process or Equal Protection Clauses.⁵ Justice Sandra Day O'Connor concurred, joined by Justice Ruth Bader Ginsburg and Justice Stephen Breyer, expressing concern about "the risk that a dying patient's request for assistance in ending his or her life might not be truly voluntary."⁶ Nearly thirty years of assisted suicide practice in the United States has not alleviated that concern.

¹ *Oregon Death With Dignity Act: 2025 Data Summary (Oregon Report)*, Or. Health Auth. 1, 9 (Apr. 1, 2026), https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/1e8579_25.pdf; *2024 Death with Dignity (Washington Report)*, Wash. State Dep't Health 1, 1 (July 2025), <https://doh.wa.gov/sites/default/files/2026-02/422-109-DeathWithDignityAct2024.pdf>.

² See 42 U.S.C. § 1395x(dd)(2)(G) (directing hospice programs to "meet[] such other requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are provided care and services by such agency or organization").

³ See 42 U.S.C. §§ 14401 to 14408; see also 41 C.F.R. § 411.15 (q) (2025).

⁴ *Washington v. Glucksberg*, 521 U.S. 702 (1997); *Vacco v. Quill*, 521 U.S. 793 (1997).

⁵ *Glucksberg*, 521 U.S. at 735; *Vacco*, 521 U.S. at 808.

⁶ *Glucksberg*, 521 U.S. at 738.

Currently, thirteen states plus the District of Columbia permit assisted suicide.⁷ These laws permit certain medical practitioners to prescribe drugs at lethal dosages to a patient that is, among other criteria, eighteen years or older and “terminally ill” with a six month or less prognosis, with or without care, so that the patient may self-administer the drugs.⁸ Yet, as the National Council on Disability warns, under assisted suicide laws, “some people’s lives, particularly those of people with disabilities, will be ended without their fully informed and free consent, through mistakes, abuse, insufficient knowledge, and the unjust lack of better options.”⁹

There are grave informed consent issues within assisted suicide. Doctor shopping is rampant; Oregon data indicates the median patient-physician relationship is four weeks, with some relationships ranging as little as zero weeks.¹⁰ Mental health referrals are practically nonexistent, as only 0.5% of patients received them, even though many assisted suicide patients show signs of depression, which can impair the decision-making process.¹¹ On top of this, “it is common for medical prognoses of a short life expectancy to be wrong,” and under the definition of terminal illness in assisted suicide laws, “[t]here is no requirement that the doctors consider the likely impact of medical treatment, counseling, and other supports on survival.”¹²

Assisted suicide drugs are experimental. The Food and Drug Administration (FDA) does not approve compounded drugs,¹³ which are commonly used in assisted suicide,¹⁴ and the FDA could never approve drugs indicated for assisted suicide because they are not “safe” for purposes of the Federal Food, Drug, and Cosmetic Act.¹⁵ As *The Atlantic* reported in 2019, “[i]n states where the practice is legal, state governments provide guidance about which patients qualify, but say nothing about which drugs to prescribe.”¹⁶ With “no government-approved clinical drug trial, and no Institutional Review Board oversight,” assisted suicide drug prescribers are left to experiment directly on end-of-life patients.¹⁷

Disability issues arise in assisted suicide. An individual with terminal illness meets the definition of a physical disability under the Americans with Disabilities Act and the Rehabilitation

⁷ *Euthanasia*, Cornell L. Sch. Legal Info. Inst. (Oct. 2025), <https://www.law.cornell.edu/wex/euthanasia>; 410 Ill. Comp. Stat. 22/1 to /999 (2026) (eff. Sept. 12, 2026); N.Y. Pub. Health Law art. 28-F, §§ 2899-d to -s (McKinney 2026) (eff. Aug. 5, 2026).

⁸ *E.g.*, Or. Rev. Stat. §§ 127.800, 127.805 (2023).

⁹ Nat’l Council on Disability, *The Danger of Assisted Suicide Laws*, Bioethics & Disability Series 14–15 (2019).

¹⁰ *Oregon Report*, *supra* note 1, at 18.

¹¹ *See id.* at 15.

¹² Nat’l Council on Disability, *supra* note 9, at 21–22.

¹³ *Human Drug Compounding Laws*, U.S. Food & Drug Admin. (Dec. 17, 2024), <https://www.fda.gov/drugs/human-drug-compounding/human-drug-compounding-laws>.

¹⁴ *See Oregon Report*, *supra* note 1, at 22.

¹⁵ *See* 21 U.S.C. § 355(b)(1)(A)(i).

¹⁶ Jennie Dear, *The Doctors Who Invented a New Way to Help People Die*, *Atlantic* (Jan. 22, 2019), <https://www.theatlantic.com/health/archive/2019/01/medical-aid-in-dying-medications/580591/>.

¹⁷ *Id.*

Act.¹⁸ In fact, individuals with disabilities and disability rights groups have raised this argument and alleged assisted suicide laws violate federal disability rights laws in litigation across the country.¹⁹ Patients seeking assisted suicide commonly request assisted suicide, not due to pain or concerns about future pain, but for disability-related reasons, citing concerns about “loss of autonomy,” being “less able to engage in activities,” and “loss of dignity.”²⁰ Consequently, assisted suicide stigmatizes disabilities, and sends the message that the lives of persons with disabilities are less valued in society.

Age discrimination and elder abuse are also concerns within assisted suicide practices. Most assisted suicide patients are age 65 or older (88.3% under Oregon data and 86.2% under Washington data).²¹ Although assisted suicide laws require two witnesses to the lethal drug request, most states only require one witness to be disinterested, meaning, one of these witnesses may be a beneficiary to the patient’s will or life insurance policy.²² Assisted suicide laws do not require a prescriber or any witnesses to be present when the patient self-administers the drugs.²³ Especially with patient age and education demographics—most patients are well educated—these circumstances are “consistent with elder abuse” and possible financial exploitation.²⁴

Assisted suicide undermines America’s national posture of suicide prevention. America is facing an epidemic of suicide. In 2024, we lost more than 50,000 Americans to suicide and over 1.5 million Americans attempted suicide. Suicide is the eleventh leading cause of death in America and around 135 suicides occur every day on average. Additionally, over 14 million adults reported seriously considering suicide in 2024. Peer-reviewed data shows that where assisted suicide is legalized, rates of non-assisted suicide spike.²⁵ Additionally, each year the U.S. government invests hundreds of millions of taxpayer dollars annually in suicide prevention services. States and localities spend millions each year as well. A 2024 NIH report shows that the economic cost of suicide/self-harm is estimated at \$510 billion annually.²⁶ New data shows that people living with serious and potentially life-limiting health conditions are more than twice as likely to die by suicide compared with the general population.²⁷ Assisted suicide undermines suicide prevention services,

¹⁸ See 42 U.S.C. § 12102; 29 U.S.C. § 705(9).

¹⁹ *E.g.*, *United Spinal Ass’n v. California*, No. 24-2751 (9th Cir. argued Mar. 26, 2025).

²⁰ Nat’l Council on Disability, *supra* note 9, at 37.

²¹ *Oregon Report*, *supra* note 1, at 12; *Washington Report*, *supra* note 1, at 4.

²² Margaret K. Dore, “*Death With Dignity*”: *A Recipe for Elder Abuse and Homicide (Albeit Not by Name)*, 11 Marq. Elder’s Advisor 387, 388 (2012).

²³ Nat’l Council on Disability, *supra* note 9, at 42.

²⁴ Dore, *supra* note 22, at 396; see also *About Abuse of Older Persons*, U.S. Ctrs. for Disease Control & Prevention (Nov. 7, 2024), <https://www.cdc.gov/elder-abuse/about/index.html>.

²⁵ <https://sma.org/southern-medical-journal/article/how-does-legalization-of-physician-assisted-suicide-affect-rates-of-suicide/>

²⁶ <https://pubmed.ncbi.nlm.nih.gov/38479565/>

²⁷ <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesamongpeoplediagnosedwithseverehealthconditionsengland/2017to2020>

normalizes premature death for vulnerable populations, undermines their sense of autonomy and dignity, and pushes society away from robust care, support, and the protection of life.

Congress has restricted federal funding for assisted suicide and protected conscientious objections to the practice. The Assisted Suicide Funding Restriction Act broadly limits federal funds from “paying (directly or indirectly)” for the provision of “any health care item or service furnished for the purpose of causing, or for the purpose of assisting in causing, the death of any individual, such as by assisted suicide, euthanasia, or mercy killing.”²⁸ This prohibition extends to a “pay[ment] . . . for such an item or service” and a “pay[ment] (in whole or in part) for health benefit coverage” related to the coverage or expenses of “such an item or service.”²⁹ The Affordable Care Act also provides anti-discrimination protections for an individual or institutional health care entity that does not participate in “assisted suicide, euthanasia, or mercy killing.”³⁰

As you consider the assisted suicide issue further, we recommend you use the statutory language, “assisted suicide, euthanasia, or mercy killing,” which is more precise than “MAID.”³¹ “MAID” includes both assisted suicide and euthanasia,³² even though no jurisdiction in the United States permits euthanasia.

We also request that you establish reporting requirements within hospice programs regarding assisted suicide. In doing so, please consider monitoring assisted suicide practices for the following:

- Discrimination against individuals with disabilities, older persons, and other vulnerable groups;
- Eligibility of patients solely due to an eating disorder;³³
- Proper disposal of unused medication and prevention of drug diversion;³⁴
- Insurance denials of life-sustaining medical care that offer to cover assisted suicide drugs instead;³⁵
- Drug complications;
- Experimentation of assisted suicide drug compounds;
- Compliance with federal restrictions on using funds, directly or indirectly, for health care items or services for assisted suicide.

²⁸ 42 U.S.C. § 14402(a)(1).

²⁹ *Id.* § 14402(a)(2) to (3).

³⁰ 42 U.S.C. § 18113(a).

³¹ 42 U.S.C. § 14402; 42 U.S.C. § 18113.

³² *See Medical Assistance in Dying: Overview*, Gov’t Can. (Aug. 27, 2025), <https://www.canada.ca/en/health-canada/services/health-services-benefits/medical-assistance-dying.html>.

³³ *See Chelsea Roth & Catherine Cook-Cottone, Assisted Death in Eating Disorders: A Systematic Review of Cases and Clinical Rationales*, *Frontiers Psychiatry*, July 31, 2024, at 1.

³⁴ *See Oregon Report*, *supra* note 1, at 4 (noting 400 people died by assisted suicide in 2025, but prescribers wrote 637 prescriptions).

³⁵ Nat’l Council on Disability, *supra* note 9, at 20–21.

As Senators and Members of Congress who are committed to the health and safety of hospice patients, especially those in vulnerable populations, we are grateful to see HHS and CMS consider how assisted suicide practices pose discrimination and informed consent issues. We urge HHS and CMS to establish reporting requirements to monitor assisted suicide for discriminatory practices and oversee compliance with federal funding restrictions within hospice programs. All hospice patients—regardless of physical disability, mental health, eating disorder, age, or financial means—deserve compassionate end-of-life care that is free of coercion and discrimination.

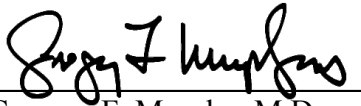
Sincerely,



James Lankford
United States Senator



J. Luis Correa
Member of Congress



Gregory F. Murphy, M.D.
Member of Congress