ETHICS AND PUBLIC POLICY CENTER

August 3, 2026

Via email (regsqna@health.ny.gov)

New York State Department of Health
Bureau of Program Counsel, Regulatory Affairs Unit
Corning Tower, Empire State Plaza, Rm. 2438
Albany, New York 12237-0031
Attention: Katherine Ceroalo

RE: Addition of Section 35.7 and Part 1008 to Title 10 NYCRR (Medical Aid in Dying Physician Reporting Requirements)

Dear Ms. Ceroalo:

We are scholars at the Ethics and Public Policy Center (EPPC). Eric Kniffin is an EPPC Fellow, a member of EPPC's Administrative State Accountability Project (ASAP), and a former attorney in the U.S. Department of Justice's Civil Rights Division. Rachel Morrison is an EPPC Fellow, Director of ASAP, and a former attorney with the Equal Employment Opportunity Commission. We are both experts on religious liberty law and health care conscience protection law.

We write to offer public comment in response to the New York State Department of Health's proposed "Addition of Section 35.7 and Part 1008 to Title 10 NYCRR (Medical Aid in Dying Physician Reporting Requirements)" ("Proposed Rule").[1] The Proposed Rule would establish reporting requirements for attending physicians participating in assisted suicide under New York's Medical Aid in Dying Act ("MAID Act"), codified at N.Y. Pub. Health Law § 2899-d et seq. The Proposed Rule would also establish a procedure for "correct[ing]" the death certificate of someone who died by assisted suicide to indicate the cause of death as "the underlying terminal illness or condition." Proposed Rule at 3 (proposed Section 35.7 of Title 10).

The Proposed Rule's Regulatory Impact Statement claims that "[t]he proposed rule does not overlap or conflict with any Federal legal requirements." Proposed Rule at 9. We believe that is incorrect. We write to bring the Department's attention to areas of federal and state law that we believe the Department must take into account before it finalizes its proposed regulations. Specifically, the MAID Act and its proposed regulations appear to violate: (1) federal law that protects health care workers' rights of conscience; (2) federal restrictions on assisted suicide; and (3) New York laws that protect the integrity of official records including certificates of death. As explained below, we believe the Department's proposed regulations fail to acknowledge and

[1] N.Y. State Dep't of Health, Addition of § 35.7 and Part 1008 to Title 10 NYCRR: Medical Aid in Dying Physician Reporting Requirements (proposed June 3, 2026), https://regs.health.ny.gov/sites/default/files/proposed-regulations/Medical%20Aid%20in%20Dying%20Physician%20Reporting%20Requirements.pdf.

provide guidance on these important conflicts. We urge the Department to take these concerns into account as it finalizes this proposal.

BACKGROUND

We begin with a brief summary of how the MAID Act works and how it interacts with New York's Palliative Care Information Act ("PCIA").

The MAID Act establishes a multi-step process under which a mentally capable, terminally ill adult resident may request, receive, and then self-administer a lethal dose of a death-causing drug. In brief: A patient must make both an oral and a written request to an attending physician, undergo evaluation and confirmation by an attending and a consulting physician, complete a mandatory mental-health assessment to confirm decision-making capacity, and, if all statutory criteria are met and the request is not rescinded, receive a prescription for lethal medication that the patient alone may use to commit suicide. N.Y. Pub. Health Law §§ 2899-e–2899-j (McKinney 2026). After the patient commits suicide, the certifying physician must fill out the death certificate as though the patient had died of his or her "underlying terminal illness or condition," and not as a direct result from ingesting a lethal drug cocktail. *Id*. § 2899-p(2).

The MAID Act overlays an earlier statute, the PCIA, which requires certain healthcare providers and facilities to inform some terminally ill patients of their options for end-of-life care, options that now include assisted suicide. *Id*. §§ 2997-c et seq. The PCIA mandates that physicians treating terminally ill patients offer information and counseling about the patient's "end-of-life options" and available "appropriate palliative care and end-of-life options," and, if they decline to provide the counseling themselves, make an effective referral to someone who will. *Id*. § 2997-d. The MAID Act cross-references this counseling obligation, requiring attending physicians who participate in MAID to provide the information required under the PCIA as part of the qualifying process. *Id*. §§ 2899-e(1)(f), 2899-f(1).

Together, these statutes move assisted suicide from something a patient might raise on request to something New York law expects physicians and institutions to affirmatively present as part of the required "end-of-life options" counseling for terminally ill patients.

ANALYSIS

I. The MAID Act and the proposed regulations conflict with federal and New York law.

A. The proposed regulations conflict with federal conscience protection laws.

The MAID Act and its regulations must comply with federal law that protects the conscience rights of physicians and other health care providers who object to participating in assisted suicide.[2] The Department is already well aware of such objections, which have been

[2] *See generally* U.S. Dep't of Health & Hum. Servs., Off. for Civ. Rts., Dear Colleague Letter on Safeguarding Federal Conscience and Related Protections in Health Care (Jan. 21, 2026),

brought to the State's attention through protests and testimony during the legislative process and an ongoing federal civil rights lawsuit brought by Catholic nuns.[3] As the Supreme Court has said in a similar context, "[i]f the Departments did not look to" federal religious freedom law or discuss it "when formulating their solution, they would certainly be susceptible to claims that the rules were arbitrary and capricious for failing to consider an important aspect of the problem." *Little Sisters of the Poor v. Pennsylvania*, 591 U.S. 657, 682 (2020). While *Little Sisters* involved a challenge to regulations that relied on the Religious Freedom Restoration Act (RFRA), which does not apply to the states, New York is subject to other federal civil rights laws and the Department must take these into account when regulating under the MAID Act. *See* N.Y. C.P.L.R. § 7803(3) (courts may consider whether a regulation is "arbitrary and capricious").

Section 1553 of the Affordable Care Act is one such law. 42 U.S.C. § 18113. Section 1553 prohibits any State that "receives Federal financial assistance under this Act" from discriminating against "an individual or institutional health care entity … on the basis that the entity does not provide 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." 42 U.S.C. § 18113(a).

New York receives federal financial assistance for health care and thus all New York laws and regulations related to assisted suicide are subject to Section 1553. A recent press release from the Department acknowledges that New York is receiving federal funding to keep 1.3 million people covered under the Essential Plan.[4] As such, the Department must take care to ensure that its regulations under the MAID Act do not discriminate against any health care entities—whether individual doctors and nurses, or facilities like hospitals and nursing homes—on the basis that they will not participate in assisted suicide.

The federal Church Amendments, 42 U.S.C. § 300a-7, do not apply to New York State as a whole, but will apply to individual New York institutions based on their funding. Subsection (c)(2) prohibits recipients of certain HHS grants or contracts for biomedical or behavioral research from discriminating in employment or staff privileges against physicians or health care personnel because the individual: (1) performed or assisted in the performance of a lawful health service or research activity, or (2) refused to perform or assist in such service or activity due to the individual's religious beliefs or moral convictions. It also prohibits discrimination against such personnel based on these same religious beliefs or moral convictions.

Subsection (d) of the Church Amendments is even broader, applying to "any part of a health service program or research activity funded in whole or in part under a program administered by the Secretary of Health and Human Services." *Id*. § 300a-7(d). Entities subject

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https://www.hhs.gov/sites/default/files/conscience-dcl.pdf (summarizing the principal federal health care conscience protection authorities enforced by the HHS Office for Civil Rights).

[3] *See* Timothy Fanning, *Catholic Providers Sue New York Over Medical Aid-in-Dying Law*, Times Union (July 20, 2026), https://www.timesunion.com/capitol/article/catholic-lawsuit-ny-aid-dying-22352840.php.

[4] Press Release, N.Y. State Dep't of Health, *New York State Department of Health Provides Update on Federal Approval to Preserve Health Coverage for 1.3 Million New Yorkers* (Mar. 23, 2026), https://info.nystateofhealth.ny.gov/news/press-release-new-york-state-department-health-provides-update-federal-approval-preserve.

to this subsection must not require any individual "to perform or assist in the performance" of any part of a funded program or activity if doing so "would be contrary to his religious beliefs or moral convictions." *Id*.

We do not believe that the proposed Section 35.7 of Title 10 complies with the Department's obligations under Section 1553 or is sensitive to entities' obligations under the Church Amendments. That provision states that "[f]ailure to record the underlying terminal illness or condition as the cause of death on the New York State death certificate of an individual that self-administered medication for medical aid in dying shall be corrected by the medical provider responsible for the creation of the certificate upon notice from the commissioner of health." Proposed Rule at 3. It is likely that many medical professionals would object to certifying a death certificate that intentionally omits the immediate cause of the patient's death and fails to document what happened right before the patient died. Many medical providers may reasonably conclude that omitting such information amounts to "assisting" in an assisted suicide. As such, this aspect of the Proposed Rule fails to account for medical providers' rights under Section 1553 and the Church Amendments.

The Department may be tempted to argue that such an objection does not count as a legitimate moral or religious objection to participating in assisted suicide. The Department might believe that filling out paperwork after a patient commits suicide is too attenuated from the suicide itself and is therefore not a legitimate basis for a conscientious objection. But it is not the Department's place to dictate the contours of a medical professional's sincerely held moral or religious objection. Indeed, the First Amendment precludes the Department from making such a judgment. As the Supreme Court has cautioned, government must not "[a]ggregat[e]" to itself "the authority" to answer what is "a difficult and important question of religion and moral philosophy, namely, the circumstances under which it is wrong for a person to perform an act … that has the effect of enabling or facilitating the commission of an immoral act by another." *Burwell v. Hobby Lobby Stores, Inc.*, 573 U.S. 682, 723–24 (2014).

The proposed regulation would put physicians in a moral dilemma *even worse* than the scenario envisioned in *Hobby Lobby*. The Supreme Court held that government may not dismiss as too attenuated an employer's objection to including coverage for certain FDA-approved contraceptives, an act that the Supreme Court presumed for purpose of argument was "innocent in itself." *Id*. at 724. But here, the Department's proposed regulation would require medical professionals to attest to something the professional knows is false: that the patient died not from taking a fatal drug cocktail, but from an underlying terminal disease. Deliberately providing false information on a government form is clearly not an act innocent in itself.

The Department should amend the proposed regulations to clearly state that medical providers will not face discrimination, including disciplinary action, if they are unwilling or unable to certify MAID deaths as "natural" deaths because of their conscience or religious convictions.

B. The proposed regulations conflict with federal prohibitions on using federal funds for items and services connected with assisted suicide.

The Department must also consider federal restrictions on assisted suicide. For nearly three decades federal law has been clear: no federal funds can be used either directly or indirectly in connection with assisted suicide. The Assisted Suicide Funding Restriction Act of 1997 (ASFRA) prohibits federal funds from being used to provide or pay for any "assisted suicide, euthanasia, or mercy killing." 42 U.S.C. § 14402(a)(1).

Even without ASFRA, the United States Department of Health & Human Services (HHS) has determined that funding a patient's suicide is prohibited by § 1862(a)(1)(A) of the Social Security Act because suicide is neither an item nor a service "reasonable and necessary for the diagnosis or treatment of illness or injury." Two offices within HHS have reached this conclusion: the Centers for Medicare and Medicaid Services (CMS)[5] and the Health Care Financing Administration.[6] As CMS noted in a rule finalized today, CMS "expect[s] that hospice providers and staff are adhering" to this aspect of "Federal law,"[7] especially as these restrictions are so clear and well-established.

ASFRA articulates five main restrictions on federal funds and programs within healthcare. These comprise:

1. Prohibiting federal funds to provide any health care item or service for assisted suicide. Congress intended for this prohibition to include every activity relevant to providing assisted suicide, including "the provision of any assistance to obtain the means of death … the aid of a person or institution (such as physician or hospital), or the means to finance such a practice." It also intended to include the service of a "prescription for medication" as well as the medication itself. 42 U.S.C. § 14402(a)(1).

2. Prohibiting federal funds to pay for any health care item or service for assisted suicide. This would include direct payment programs like Medicaid. 42 U.S.C. § 14402(a)(2).

3. Prohibiting federal funds to pay for any health benefit coverage related to assisted suicide. 42 U.S.C. § 14402(a)(3). For state Medicaid, which is subsidized by the federal government, the state program must use exclusively state or private funds for procuring assisted suicide.

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[5] CMS, Assisted Suicide Funding Restriction Act of 1997 (P.L. 105-12), MLN Matters No. SE20014 (Jan. 5, 2021), https://www.cms.gov/files/document/se20014.pdf.

[6] *See* H.R. Rep. No. 105-46, pt. 1 (1997) (on ASFRA) ("The Health Care Financing Administration (HCFA) has taken the position that: [T]he Medicare statute limits Medicare coverage to items and services that 'are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.' Physician assisted suicide, even if allowed under State law, does not meet these statutory criteria. As such, the program is prohibited from making payment for it." (alteration in original) (citing Letter from Debbie Chang, Dir., Off. of Legis. & Intergovernmental Affs., Health Care Fin. Admin. (May 1, 1996))).

[7] CMS, Medicare Program; FY 2027 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Program Requirements, 91 Fed. Reg. 49,118, 49,155 (Aug. 3, 2026), https://www.federalregister.gov/d/2026-15686.

4. Restricting any healthcare items and services furnished by a facility owned or operated by the federal government to be used for assisted suicide. 42 U.S.C. § 14402(c)(1). Notably, this would involve any healthcare facility directly administered by the federal government, including for instance veterans' homes and the Public Health Service, which includes the Indian Health Service.

5. Restricting any federal employees from providing any services for assisted suicide during the normal course of their employment. 42 U.S.C. § 14402(c)(2).

These restrictions on federal funds and programs are **widely known**. At the federal level, CMS's Medicare Provider Reimbursement Manual states repeatedly in *red italic print* that "*Items and services under ASFRA 1997*" are "nonreimbursable" and requires that such costs be reported on a separate line.[8]

Taken together, the MAID Act and the PCIA require covered institutions to perform activity that ASFRA prohibits federal healthcare dollars from funding. Covered providers must counsel terminally ill patients on their "end-of-life options," confirm patient eligibility through a qualifying process involving an attending physician, a consulting physician, and a mental health provider where indicated, and document a witnessed written request. N.Y. Pub. Health Law §§ 2899-b, 2899-d. But counseling, qualification workups, physician time spent confirming eligibility, and referral coordination are precisely the kind of "item or service" that ASFRA prohibits federal healthcare dollars from funding once furnished "for the purpose of causing, or assisting to cause," a patient's death. 42 U.S.C. § 14402(a)(1).

Hospices illustrate this acute conflict between the MAID Act and ASFRA. The MAID Act's definition of "health care facilities" expressly includes hospices, N.Y. Pub. Health Law § 2899-d(5). Hospices also tend to be heavily dependent on federal reimbursement, operating primarily on the Medicare hospice per diem benefit.[9] A hospice physician who visits a patient's home and completes a death certificate for a patient who has self-administered MAID medication must, under New York law, list the patient's underlying terminal illness—not the medication—as the cause of death, *id*. § 2899-p(2), regardless of any religious or moral objection to the inaccurate certification. This mandate applies even though the PCIA, which imposes the separate mandate that providers affirmatively counsel terminally ill patients on "end-of-life options," does not cover hospices at all. *Id*. § 2997-d(2). New York has thus built a scheme in which hospices are pulled into the MAID Act's death-certificate and qualifying obligations precisely where federal Medicare dollars are most concentrated, while remaining entirely outside the one statute that might otherwise have clarified the scope of any counseling obligation.

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[8] CMS, Medical Provider Reimbursement Manual, Part 2: Provider Cost Reporting Forms and Instructions, ch. 43, Transmittal 5 (CMS Pub. No. 15-2) (Feb. 25, 2022), https://www.cms.gov/files/document/r5p243i.pdf.

[9] Nat'l Partnership for Hospice Innovation, *Hospice Medicare Margins* at 8 (July 2019) ("Medicare is the primary payer for hospice services, covering more than 90% of hospice patient days…. Medicare pays hospices a daily rate for each patient-enrolled day that is intended to cover the costs of services identified in the patient's plan of care, regardless of the services actually provided to a patient on a specific day. There are four defined levels of hospice care with different per diem rates…."), https://www.nphihealth.org/wp-content/uploads/2020/05/Hospice_Medicare_Margins_NPHI_7-2019-1.pdf.

A hospital or hospice operating on Medicare and Medicaid reimbursement (as nearly every covered institution in New York does) cannot lawfully bill federal programs for the qualifying and counseling activity the state now compels it to perform. Yet the MAID Act and the proposed regulations provide no mechanism for isolating that activity from an institution's ordinary, federally reimbursed operations. The Department's proposed regulations do nothing to alert medical professionals and institutions to this conflict.

C. The proposed regulations conflict with New York laws that prohibit physicians from providing false information on government forms.

The proposed regulations also fail to acknowledge and take account of New York laws that make it unlawful for physicians to give false certifications on government forms.

As noted above, the MAID Act requires that the death certificate of someone who kills himself or herself under the law's provisions "will" state that the "cause of death" was the patient's "underlying terminal illness or condition." N.Y. Pub. Health Law § 2899-p. The Department's proposed Section 35.7 to Title 10 underscores this requirement and states that a death certificate "shall be corrected by the medical provider" if it fails "to record the underlying terminal illness or condition as the cause of death." Proposed Rule at 3. We believe these provisions conflict with physicians' duties under New York law.

A physician's charge when completing a certificate of death is clear. The CDC's Standard Certificate of Death[10] and New York City's Certificate of Death Worksheet[11] require the signatory to document the "immediate cause" of death and explicitly distinguish that cause from the "disease or injury that initiated the events resulting in death" (CDC) or the "underlying cause which began the chain of events" leading to death (NYC). New York City's form requires a certifying physician to certify that, "To the best of my knowledge, death occurred due to the cause(s) and manner stated."[12]

Several New York laws separately prohibit making knowingly false statements on vital records and official documents:

- Under Public Health Law § 4102, it is unlawful to "willfully alter" or "falsify any certificate of birth or death."

- Under Penal Law § 175.30, it is a class A misdemeanor when a person, "knowing that a written instrument contains a false statement or false information," presents it to a public

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[10] CDC, U.S. Standard Certificate of Death (Rev. 11/2003), https://www.cdc.gov/nchs/data/dvs/death11-03final-acc.pdf; CDC, Instructions for Completing the Cause-of-Death Section of the Death Certificate, https://www.cdc.gov/nchs/data/dvs/blue_form.pdf.

[11] New York City, Dep't of Health and Mental Hygiene, Certificate of Death Worksheet (Rev. 1/12), https://www.nyc.gov/assets/doh/downloads/pdf/vs/vs-death-worksheet.pdf. NYC's worksheet refers physicians to the CDC's *Physicians' Handbook on Medical Certification of Death*, http://www.cdc.gov/nchs/data/misc/hb_cod.pdf, which defines the "immediate cause of death" as "the final disease, injury, or complication directly causing the death." *Id*. at 13.

[12] CDC, U.S. Standard Certificate of Death (Rev. 11/2003), https://www.cdc.gov/nchs/data/dvs/death11-03final-acc.pdf.

office or public servant "with the knowledge or belief that it will be filed with, registered or recorded in or otherwise become a part of the records" of that office.

- Under Penal Law § 175.35, it is a class E felony, punishable by up to 4 years in prison, when the same conduct is done "with intent to defraud the state or any political subdivision, public authority or public benefit corporation."

- Section 3.19 of New York City's own Health Code independently states, "No person shall make a false, untrue or misleading statement or forge the signature of another on a certificate, application, registration, report or other document ... required to be submitted or filed with the Department."

The MAID Act and proposed regulations also conflict with a more specific provision in New York law that states that, when "a death is caused by an opioid overdose, such information *shall be indicated* on the certificate, including, if known to the person completing the death certificate, the specific opioid that caused the death of the decedent." N.Y. Pub. Health Law § 4141 (emphasis added). Assisted suicide protocols in the United States virtually always include a high-dose opioid, usually morphine.[13]

The MAID Act and the Department's proposed Section 35.7 violate all of these norms and state law requirements. There is no doubt that someone who kills himself or herself under the MAID Act intends to commit suicide. The law itself makes this plain. Section 2899-e states that the patient must make a written request "to self-administer medication for the purpose of ending such patient's life." The proposed form detailed in the MAID Act reads, in part, "I request ... medication that will end my life."

Yet Section 2899-n claims that this same person—the patient who has expressly requested "medication that will end my life"—"shall not, because of that request, be considered to be a person who is suicidal." Section 2899-p(2) and the Department's proposed Section 35.7 require a medical provider to *omit* this information from the patient's official death certificate, even though CDC guidance, NYC's forms, and New York law require that the "immediate cause" of death be recorded accurately. Nothing in the Proposed Rule acknowledges this conflict.

D. The Proposed Rule also conflicts with generally accepted standards for certifying deaths and New York's own medicolegal framework.

The false-certification problem identified above is not limited to the certifying physician's own liability: because the Proposed Rule requires that every MAID death be recorded as

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[13] *See* Lonny Shavelson & Carol Parrot, *Adding Phenobarbital to the D-DMA and DDMA Medication Protocols for Medical Aid in Dying*, Am. Clinicians Acad. on Med. Aid in Dying (Jan. 12, 2021), https://www.aadm.org/wp-content/uploads/2024/11/1-12-21-Adding-phenobarbital-to-DDMA-protocols.pdf (collecting information on medication regimes in California, Washington, Oregon, New Jersey, and Washington); Or. Health Auth., Pub. Health Div., Oregon Death with Dignity Act: 2019 Data Summary (Feb. 25, 2020), https://www.oregon.gov/oha/ph/providerpartnerresources/evaluationresearch/deathwithdignityact/documents/year22.pdf ("over 90% of assisted suicides in Oregon involve one of two drug combinations," DDMA or DDMP, each which involves opioids).

"natural," it also forecloses the independent role that New York law assigns to medical examiners and coroners, who have a separate statutory duty to investigate deaths that are, under generally accepted forensic standards, unnatural.

According to the National Association of Medical Examiners' *Guide for Manner of Death Classification*, a national standard reference, "In most states, the acceptable options for manner-of-death classification are: Natural; Accident; Suicide; Homicide; or Undetermined (or 'Could not be Determined.')"[14] Natural deaths are deaths "due solely or nearly totally to disease and/or the aging process." *Id*. at 5. In determining "whether a death should be classified as natural or non-natural," certifiers of death are encouraged to apply the "but-for" principle: "But-for the injury (or hostile environment), would the person have died when he/she did?" *Id*. at 7. When there is an "intermingling of natural and non-natural factors," "the manner of death is unnatural when injury hastened the death of one already vulnerable to significant or even life-threatening disease." *Id*.

New York's own medicolegal framework treats suicide as an "unnatural" death. Medical examiners are directed to "make inquiry into unnatural deaths" in their counties, N.Y. Cty L. § 671(a), and to investigate any death falling within the jurisdictional categories listed in § 673—including "a violent death, whether by criminal violence, suicide, or casualty." *Id*. § 673(a); *see also* § 674(1)–(2) (requiring full investigation of deaths described in § 673). At least one New York county makes this connection explicit, defining a "natural" death as one that occurs "when there is no trauma, injury (including drugs), or suspicion of foul play."[15] Every MAID death is a death by drugs, and thus excluded under this definition as a "natural" death.

While the MAID Act asserts that what is by all accounts a suicide is not to be treated as such, the National Association of Medical Examiners advises certifiers of death to specifically "avoid, to the extent possible, interpretation of specific statutes as they may apply to a specific case in question."[16] For example,

> … if a state defines a fatal vehicular hit-and-run incident as a type of "vehicular homicide," the certifier may classify manner as accident if the fatal injury seems to have been unintentional without clear intent to harm or cause death…. This principle minimizes the need for the certifier to rely upon reported … information….

Id. at 6. The National Association of Medical Examiners' *Guide* thus instructs certifiers to classify manner of death based on the facts of the case and standard forensic criteria, rather than bending medical judgment to fit statutory labels.

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[14] Nat'l Ass'n of Med. Examiners, *A Guide for Manner of Death Classification* 4 (2002), available at https://www.aclu-md.org/app/uploads/2023/11/black_et_al_v_webster_et_al_-_2023-09-08_ex_2_name_guide_for_manner_of_death_classification.pdf.

[15] Onondaga Cty., NY, *Guide to Death Notification and Certification* at 7, https://onondaga.gov/health-meo/wp-content/uploads/sites/198/2020/12/DeathNotification.pdf.

[16] Nat'l Ass'n of Med. Examiners, *supra* at 6.

This national standard reference and New York law point in the same direction. Under the common-sense "but for" test, a MAID death is both a drug-induced death and a suicide: but for the ingestion of the prescribed lethal medication, the patient would not have died when he or she did. Either designation renders a MAID death "unnatural" under this framework, and state law states that a coroner or medical examiner "shall" investigate such deaths. In deciding whether she has a legal duty to investigate a MAID death, a well-informed coroner will be caught between the MAID Act itself, which asserts that a drug-induced suicide is not a suicide, and her professional training, which instructs her to do her job according to the plain facts and standard forensic criteria, rather than on legal wordplay.

Neither the MAID Act nor the Department's proposed regulations address, let alone reconcile themselves with, this forensic framework. They do not redefine "natural" death, alter the operational criteria medical examiners use to classify manner of death, or explain why a death that plainly qualifies as a suicide should nonetheless be certified as "natural." They simply command physicians to write "natural" and the underlying illness as the cause, without acknowledging that this instruction runs directly counter to the classification standards New York medical examiners and coroners otherwise apply to deaths in their jurisdictions. The Department should confront this contradiction and do more to help physicians and other certifiers of death carry out their ethical and legal duties.

II. Neither the MAID Act nor the proposed regulations advise New York medical providers on how to manage these conflicts.

As explained above, the MAID Act and proposed regulations create serious conflicts with relevant federal and New York law. But neither the MAID Act nor the Proposed Rule provides guidance on how medical providers are expected to navigate these conflicting legal requirements. As explained below, New York is out of step with guidance from other states and the MAID Act's opt-out and severability provisions do not resolve these conflicts.

A. New York is doing less than other pro-assisted suicide states to give medical provider guidance.

Several states that have legalized assisted suicide have recognized that ASFRA compliance cannot be left to guesswork and have issued explicit administrative guidance instructing providers how to keep state-authorized activity walled off from federal healthcare dollars. Consider the following examples.

New Mexico's Human Services Department, Medical Assistance Division, published a dedicated billing supplement for its End-of-Life Options Act, instructing clinicians and pharmacists in unambiguous terms that from the initial MAID assessment through the lethal prescription, "MAID Claims are *not* billed to Medicare, Managed Care Organizations, or commercial health plans."[17]

[17] N.M. Hum. Servs. Dep't, Med. Assistance Div., Enacting the End-of-Life Options Act, Medical Aid in Dying Billing and Guidance, Supp. No. 23-11, at 4 (Nov. 6, 2023), https://www.hsd.state.nm.us/wp-content/uploads/SUPPLEMENT-23-11-Medical-Aid-in-Dying-MAID-1.pdf.

Oregon's Medicaid program likewise directs that "death with dignity" services are to be covered exclusively through state funds, "except for those facilities limited by [ASFRA]."[18] Oregon has thus built the federal firewall directly into its provider billing framework rather than leaving providers to interpret the statute themselves.

California's Department of Health Care Services instructs assisted-suicide clinicians through its Medi-Cal Provider Manual that "Medicare does not provide coverage for aid-in-dying drugs or for medical services related to prescribing of these drugs," giving providers a clear administrative line to observe.[19]

Hawaii has likewise issued guidance that confirms the same principle in FAQ form, clarifying that "federal law prohibits all health insurers … from paying for medical aid-in-dying services or medications with funds from the federal government," and that the "Hawaii Medicaid program will cover the medications of Medicaid recipient[s] … under our Fee-For-Service program utilizing 100% State funds."[20]

While we are not opining on the merits of this guidance, these states' actions at least acknowledge an important tension between state and federal law that medical providers need to be aware of and navigate. **But New York, by contrast, has issued *no comparable guidance.*** The Proposed Rule addresses physician reporting requirements but fails to provide guidance on funding compliance or cost segregation. The result is that New York's covered providers currently have markedly less guidance on this point than medical providers in New Mexico, Oregon, California, or Hawaii.

B. The MAID Act's limited opt-out does not resolve these conflicts.

The MAID Act does contain an opt-out provision, but it is limited and does not resolve the tension the law has created with both federal and state law. The opt-out reaches only two of the MAID Act's four steps—prescribing and self-administration—leaving counseling and qualifying (the two steps that actually consume physician time and institutional resources) mandatory regardless of an institution's objection. *Id*. § 2899-d(2). Even an institution that qualifies for the opt-out must therefore still permit its physicians to perform qualification exams, obtain consulting-physician and mental-health sign-off, and, where the PCIA applies, provide counseling—the very activity that creates federal billing exposure in the first place. The opt-out is available at all only to hospitals and nursing homes (or entities they jointly own) that document a religious or moral objection "central to operations"; institutions outside that category, including many hospices and independent facilities, have no opt-out from any step of the process. *Id*. §§ 2899-d(2), 2899-l.

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[18] Or. Admin. R. 410-142-0380 (2024), https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=234122.

[19] Cal. Dep't of Health Care Servs., End of Life Option Act Services, Medi-Cal Provider Manual pt. 2, at 9 (rev. Aug. 2020), https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/3AB29106-6C52-405A-973F-62DF9FFEEDC0/eloa.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO.

[20] Haw. Med. Serv. Ass'n, *Our Care, Our Choice Act*, HMSA Provider Resource Center, https://prc.hmsa.com/s/article/Our-Care-Our-Choice-Act-prc (last visited Aug. 3, 2026).

C. The MAID Act's severability provision does not resolve these conflicts.

The MAID Act contains a generic severability clause providing that if any provision "is held to be invalid, or to violate or be inconsistent with any federal law or regulation, that shall not affect the validity or effectiveness of any other provision." N.Y. Pub. Health Law § 2899-s. This provision may protect other aspects of the law if and when a court confirms that one or more aspects of the MAID Act are unlawful. But it provides no guidance to medical practitioners or hospital administrators on how to navigate the legal conflicts that the MAID Act creates. *It gives a hospital compliance officer, hospice administrator, or general counsel no forward-looking instruction* today on how to structure billing, cost-accounting, or staff-time allocation to avoid violating ASFRA while carrying out the counseling, qualifying, and referral steps the MAID Act and the PCIA require. A severability clause tells a court what to do if the statute is later challenged; *it does not tell a provider what to do now.*

Conclusion

Thank you for the opportunity to provide public comment. We urge the Department to ensure that its MAID Act regulations comply with the federal and state laws identified above—laws that protect conscience rights, regulate assisted suicide, and protect the integrity of official documents including certificates of death. As it finalizes the rule, we specifically urge the Department to consider the following questions:

- Has the Department taken account of its duty under *Little Sisters of the Poor v. Pennsylvania* and other relevant authorities, to respect religious liberty, conscience rights, and related accommodations?

- Does the Department believe that its proposed regulations, in light of the issues raised in this comment, would survive "arbitrary and capricious" review?

- Will the Department clarify whether providers may opt out of the MAID Act specifically to comply with the federal funding ban under ASFRA?

- Will the Department provide guidance to New York physicians on how they should manage the conflict between the MAID Act and other New York laws that prohibit them from providing false information on certificates of death?

- Will the Department require or permit financial and staff-time segregation for MAID-related activity, consistent with the guidance provided by other states, including New Mexico, Oregon, and Hawaii?

- Does the Department's conclusion that "the new reporting requirements will impose a de minimis cost" on "physicians" take into account the potential civil and criminal penalties under New York law for knowingly certifying to false information in certificates of death?

Please let us know if the Department has any questions regarding this comment or if we may be of any assistance to the Department as it finalizes the proposed regulations.

Sincerely,

Eric Kniffin, J.D.
Fellow
Administrative State Accountability Project
Ethics & Public Policy Center

Rachel N. Morrison, J.D.
Fellow and Director
Administrative State Accountability Project
Ethics & Public Policy Center