

Congress of the United States
Washington, DC 20515

July 9, 2026

The Honorable Robert F. Kennedy, Jr.
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

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

We write to you 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, also medically termed physician-assisted suicide. Physician-assisted suicide raises significant informed consent issues as well as concerns about disability and age discrimination. The vast majority of patients receiving physician-assisted suicide are enrolled in hospice—90% in Washington.¹ This poses challenges 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 physician-assisted suicide for discriminatory practices against vulnerable populations,² as well as to 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 physician-assisted suicide in *Washington v. Glucksberg* and *Vacco v. Quill*.⁴ The majority opinions found that there is no right to physician-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

¹ *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.

request for assistance in ending his or her life might not be truly voluntary.”⁶ Nearly thirty years of physician-assisted suicide in the United States has not alleviated that concern.

Currently, thirteen states plus the District of Columbia permit physician-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, an independent, bi-partisan federal agency, warns, under physician-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 physician-assisted suicide. Patients spend little time with the physician providing physician-assisted suicide relative to the course of their disease.¹⁰ Only 0.5% of patients received mental health referrals, even though many physician-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 physician-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

Physician-assisted suicide drugs are not approved for the purpose of ending human life. The Food and Drug Administration (FDA) has not approved drugs indicated for physician-assisted suicide. These drugs would not meet the criteria as “safe” for purposes of the Federal Food, Drug, and Cosmetic Act.¹³ Instead, medical practitioners prescribe drugs approved for other indications to be used “off-label” for physician-assisted suicide. 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.”¹⁴ With “no government-approved clinical drug trial,

⁶ *Glucksberg*, 521 U.S. at 738.

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 *See* 21 U.S.C. § 355(b)(1)(A)(i).

¹⁴ 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/>.

and no Institutional Review Board oversight,” physician-assisted suicide drug prescribers are left with little oversight in assisting end-of-life patients.¹⁵

Disability issues also arise in physician-assisted suicide. An individual with terminal illness meets the definition of a disability under the Americans with Disabilities Act and the Rehabilitation Act of 1973.¹⁶ In fact, individuals with disabilities and disability civil rights groups have raised this argument and alleged physician-assisted suicide laws violate federal disability rights laws in litigation across the country.¹⁷ Annual state reports have shown that patients seeking assistance in ending their lives commonly do so, 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.”¹⁸ Consequently, many individuals with disabilities warn that states legalizing physician-assisted suicide send the message that the lives of persons with disabilities are less valued in society.

Age discrimination and elder abuse are also concerns within physician-assisted suicide practices. Most physician-assisted suicide patients are age 65 or older (86.2% in Washington).¹⁹ Although physician-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 or a disaffected caregiver.²⁰ Physician-assisted suicide laws do not require a prescriber or any witnesses to be present when the patient self-administers the drugs.²¹ These circumstances enable the possibility of financial exploitation.²²

Physician-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

¹⁵ *Id.*

¹⁶ See 42 U.S.C. § 12102; 29 U.S.C. § 705(9).

¹⁷ *E.g., United Spinal Ass’n v. California*, No. 24-2751 (9th Cir. argued Mar. 26, 2025).

¹⁸ Nat’l Council on Disability, *supra* note 9, at 37.

¹⁹ *Washington Report*, *supra* note 1, at 4.

²⁰ 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).

²¹ Nat’l Council on Disability, *supra* note 9, at 42.

²² 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>.

physician-assisted suicide is legalized, rates of suicide increase.²³ Additionally, each year the U.S. government, states, and localities invest millions of taxpayer dollars in suicide prevention services. A 2024 National Institutes of Health report shows that the economic cost of suicide/self-harm is estimated at \$510 billion annually.²⁴ 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.²⁵ Physician-assisted suicide undermines suicide prevention services, normalizes premature death for vulnerable populations, and pushes society away from robust care, support, and the protection of life.

Congress has restricted federal funding for physician-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.”²⁶ 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.”²⁷ 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.”²⁸

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

- Discrimination against individuals with disabilities, older adults, and other vulnerable populations;
- Proper disposal of unused medication and prevention of drug diversion;²⁹
- Insurance denials of life-sustaining medical care that offer to cover physician-assisted suicide drugs instead;³⁰

²³ <https://sma.org/southern-medical-journal/article/how-does-legalization-of-physician-assisted-suicide-affect-ratesof-suicide/>

²⁴ <https://pubmed.ncbi.nlm.nih.gov/38479565/>

²⁵ <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesamongpeoplediagnosedwithseverehealthconditionsengland/2017to2020>

²⁶ 42 U.S.C. § 14402(a)(1).

²⁷ *Id.* § 14402(a)(2) to (3).

²⁸ 42 U.S.C. § 18113(a).

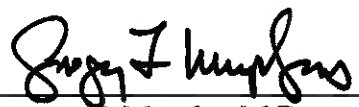
²⁹ See *Oregon Report*, *supra* note 1, at 4 (noting 400 people died by assisted suicide in 2025, but prescribers wrote 637 prescriptions).

³⁰ Nat’l Council on Disability, *supra* note 9, at 20–21.

- Drug complications;
- Consistency of drugs prescribed “off-label” for use in physician-assisted suicide;
- Compliance with federal restrictions on using funds, directly or indirectly, for health care items or services for physician-assisted suicide.

As bipartisan, bicameral 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 physician-assisted suicide practices may pose discrimination and informed consent issues. We urge HHS and CMS to establish reporting requirements to monitor physician-assisted suicide for discriminatory practices and oversee compliance with federal funding restrictions within hospice programs. All hospice patients—regardless of disability, age or financial means—deserve compassionate end-of-life care that is free of coercion and discrimination.

Sincerely,


James Lankford
United States Senator
Gregory F. Murphy, M.D.
Member of Congress
Tim Kaine
United States Senator
J. Luis Correa
Member of Congress

cc: Dr. Mehmet Oz, Administrator, Centers for Medicare and Medicaid Services