Aging, Disability, and the Growing Risk of a Government Assisted Suicide Push for Cost Reasons

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Over the past several years, the push to legalize assisted suicide in the states had seemingly slowed, likely due to the repercussions of the COVID-19 pandemic on the healthcare system. However, the 2024 state legislative session has been unusually active, with assisted suicide proponents making a serious push in over half a dozen states, and even passing these dangerous bills in several state House chambers (HB 140[i] in Delaware and HB 1283[ii] in New Hampshire). At the time of this writing, there are a few states nearing the end of their sessions with active bills that could yet become law.

There have also been two alarming coinciding developments – the first of which is a newly introduced bill[iii] to repeal a decades old prohibition on federal funding of assisted suicide in Congress[iv], and the second being a trend to remove state residency requirements.

The United States is approaching a tipping point. While only a minority of states legalize the practice, federal funding of assisted suicide, coupled with enough states removing residency could lead down a foreseeable and dangerous path. The U.S. could easily be in a situation of nationwide promotion of assisted suicide to already vulnerable groups of people in the name of reducing healthcare costs.

Nine states and the District of Columbia (D.C.) now legalize physician-assisted suicide, including California, Colorado, Hawaii, Maine, New Jersey, New Mexico, Oregon, Washington, and Vermont[v].

Nearly every state criminalizes assisting in a suicide, but these sorts of laws carve out an exception for a healthcare provider to prescribe lethal drugs to end a patient's life if certain criteria are met.

While such laws are promoted as providing an "option" to patients, the data shows that nearly all of those utilizing these laws are doing so not out of being in pain, but for reasons that overlap with common fears associated with disability and aging.

One of the most important firewalls preventing these laws from being more heavily utilized, where legal, is the lack of federal promotion or federal funding.

The Growing Trend and Increasing Numbers

According to the most recent Oregon report, "Since the law was passed in 1997, a total of 4,274 people have received prescriptions under the [Death With Dignity

Act] and 2,847 people (67%) have died from ingesting the medications. During 2023, DWDA deaths accounted for an estimated 0.8% of total deaths in Oregon."[vi]

In California, the most recently issued report from 2022 shows that 1,270 people received lethal prescriptions, and 853 people died from ingesting them. They have lost at least 3,349 people in the mere 6 years this bill has been in effect.[vii] In these and the other states, the number of deaths has been on a nearly uniform trajectory of increasing year over year.

While these numbers are far too high, they pale in comparison to the statistics in Canada, where they have both a single-payer style system of healthcare, and government-funded Medical Aid in Dying (MAiD). Seven percent of ALL deaths in Canada are now done using MAiD.

Though the Canadian experiment with euthanasia is relatively recent, the results have been devastating.

As explained by a recent study, "The realities of medical assistance in dying in Canada":

> In 2015, the Canadian Supreme Court declared that an absolute Criminal Code prohibition on assisted suicide and euthanasia was unconstitutional. In response, the Canadian parliament enacted Bill C-14 in 2016 permitting assisted suicide and euthanasia for the end-of-life context, which it termed "Medical Assistance in Dying" (MAiD). In 2021, Bill C-7 expanded eligibility for MAiD to those with disabilities not approaching their natural death. By 2021, MAiD accounted for 3.3% of all deaths in Canada with some areas of Canada presently reporting MAiD death rates upward of 7%. In 2021, Canada had 10,064 deaths by MAiD, surpassing all jurisdictions for yearly reported assisted deaths.[viii]

Because the Canadian government pays for and promotes MAiD, their numbers have risen in astonishing fashion. Like Canada, the U.S. share of the government budget devoted to healthcare is extremely large, and growing.

The Financial Pressure to Reduce Healthcare Costs

According to the official government cost estimates from the Canadian C-7 legislation,

> The predicted gross reduction in health care costs amounts to $109.2 million while the cost of administering MAID is estimated at $22.3 million. Thus, the difference between the two represents a net cost reduction for provincial governments of $86.9 million.[ix]

While insurers can and do pay for assisted suicide in the states where legal, if the Federal government were to take an active role in promoting and paying for assisted suicide, we could expect numbers of deaths in the United States, with healthcare budgets far exceeding Canada, to rise dramatically.

The 2023 KFF issue brief, "What to Know about Medicare Spending and Financing" lays out the Medicare situation succinctly,

> Medicare, the federal health insurance program for 65 million people ages 65 and older and younger people with long-term disabilities, helps to pay for hospital and physician visits, prescription drugs, and other acute and post-acute care services.
>
> CBO projects that between 2021 and 2032, net Medicare spending—after subtracting premiums and other offsetting receipts—will grow as a share of both the federal budget, from 10.1% to 17.8%, and the nation's economy, from 3.1% to 4.3% of gross domestic product (GDP).
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> In 2021, Medicare benefit payments totaled $829 billion.[x]

"The last Centers for Medicare & Medicaid Services (CMS) report pegged national health spending at $4.5 trillion in 2022, and just over 17% of gross domestic product (GDP)."[xi]

With these enormous and mounting financial pressures on the healthcare system, there is an ongoing push to reduce these costs through a series of measures including the promotion of palliative care over treatment.

According to Holly Vossel's August 14, 2023 article, "How Palliative Care Generates Savings, Boosts Hospice Utilization"

> An analysis from the U.S. Centers for Medicare & Medicaid Services (CMS) of the program found that palliative care achieved some of the largest cost-savings during the last year of life…Patients that utilized community-based palliative care services were more likely to enroll in hospice further upstream, she indicated.
>
> During its demonstration period, the MCCM model reduced total Medicare spending among beneficiaries served by 14% according to a Center for Medicare & Medicaid Innovation's (CMMI) evaluation of the program.xii

If not for the federal ban on assisting suicide, the temptation to tap into assisted suicide to reduce pressure on federal healthcare spending on those enrolled in government programs would be enormous. Looking at the U.S. jurisdiction living

longest under legalized assisted suicide – Oregon –official state reports show that since 1998, 77 percent of all those who have died via the state-assisted suicide scheme have been over the age of 65.[xiii] This population is almost entirely enrolled in or eligible for the Medicare Program.

In every law being proposed as well as in every legalizing state, private and state-run insurers are able to cover the lethal drugs, which are relatively inexpensive as compared to ongoing treatment.

There have been well-documented, but still somewhat limited cases of direct interference from health insurers attempting to push people into early deaths in the name of cost savings.

According to a joint project of the Patient's Rights Action Fund and DREDF, a disability rights group, documenting several well-known cases,

> Financial pressures already play far too great a role in many, if not most, health care decisions. Direct coercion is not even necessary. If insurers deny, or even merely delay, approval of expensive, life-giving treatments that For example, patients Barbara Wagner and Randy Stroup, Oregonians with cancer, were both informed by the Oregon Health Plan that the Plan won't pay for their chemotherapy, but will pay for their assisted suicide. In California, Stephanie Packer and two patients of Dr. Brian Callister have encountered the same kind of problem.[xiv]

One study showed that 46% [of physicians] agreed that insurance companies would preferentially cover PAS over possible life-saving treatments if PAS was legalized nationally.[xv] Only 20% disagreed.

Because there is still a patchwork of state laws, and no federal funding, these laws have yet to be more heavily utilized. Nonetheless, the highest number of those receiving lethal drugs under the state laws includes both older populations, as well as those with disabilities.

The Age and Disability Factors and Risk

Data shows that the overwhelming majority of people applying for drugs are older, have disabilities, or often both. The sad reality of the pressures of age and disability are reflected in the reason that people are choosing assisted suicide. Spoiler alert, "pain" is not even cited as a top five reason.

Many pro-life groups, including National Right to Life (the oldest and largest pro-life organization in the United States) carry out their mission by promoting respect

for the worth and dignity of every individual human being, including persons with disabilities, older people, and other vulnerable people, especially those who cannot defend themselves.

Since the COVID-19 pandemic, existing hurdles to healthcare have become even higher. Factors including nationwide medical staff shortages, disparities in the access to services, and the lack of resources to enable more autonomous living have proven to be a threat to older persons. This threat is more profound in jurisdictions with legalized assisted suicide.

Looking at the U.S. jurisdiction living longest under legalized assisted suicide – Oregon –official state reports show that since 1998, 77 percent of all those who have died via the state-assisted suicide scheme have been over the age of 65. In Canada, the official annual government report states, "...similar to the trend reported in the three previous years, 95.5% of individuals receiving MAID in 2022 were age 56 and above, with 85% aged 65 and above."[xvi]

According to a recent UN report, "46 percent of older persons – those aged 60 years and over—have disabilities, and more than 250 million older people experience moderate to severe disability."[xvii]

As more states shift to legalize assisted suicide and populations age, the already existing danger these laws pose to older persons, and those with disabilities is sure to become a yet more significant problem.

Data citing the reasons people utilize assisted suicide reflect the overlapping concerns of those in the disability community and older people at large. The top five reasons are: "loss of autonomy" (90.9 percent), "less able to engage in activities" (90.2 percent), "loss of dignity" (73 percent), "burden on others" (48.3 percent), and "losing control of bodily functions" (43.7 percent).[xviii]

Governments should focus on the right to access long-term care programs to cover a broad range of long-term supports and services, such as personal care aides, home modifications, or assisted living costs.

Current law surrounding delivery of healthcare to older persons does provide for many basic services, but tremendous gaps remain. According to the Commonwealth Fund's analysis, "More than four in 10 community-living older adults experienced adverse consequences due to unmet [long-term services and supports of LTSS] needs. Older adults with dementia, greater LTSS needs, and low incomes were more likely to experience adverse consequences. Other factors associated with a higher likelihood of adverse consequences included the number of caregivers helping an older adult.[xix]

Between the national medical staff shortages and the lack of long-term support services for 4 in 10 Americans, euthanasia laws are not only inappropriate, but cannot be implemented where there are basic unmet health care needs.

The problem in Canada is being reported, but not widely enough. News reports about regarding people who ask for MAiD because they cannot secure housing or healthcare are becoming more frequent, but not officially logged.

> [N]arrative accounts are accumulating in the media about people applying and getting MAiD due to suffering associated with lack of access to medical, disability and social support, and often with intersecting components of disability and mental health issues. None of these cases or issues were identified by the Health Canada Annual Reports on MAiD." [internal citations omitted].[xx]

Nationwide medical staffing shortages and disparities in regional delivery remain an ongoing problem in the United States. The American Hospital Association in testimony before Congress in 2023 gave a stark assessment of what Americans are already acutely aware of: medical staffing shortages, particularly in marginalized and rural communities.

They explain,

> The result of these mounting pressures on the health care workforce has created a historic workforce crisis complete with real-time short-term staffing shortages and a daunting long-range picture of an unfulfilled talent pipeline. Just within the week of February 9, Department of Health and Human Services (HHS) data showed that 623 hospitals (or 16.7% of reporting hospitals) anticipated a critical staffing shortage. In addition, projections from the Bureau of Labor Statistics estimate U.S. health care organizations will have to fill more than 203,000 open nursing positions every year until 2031. There also are significant projected shortages of physicians and allied health and behavioral health care providers, which will likely be felt even more strongly in areas serving structurally marginalized urban and rural communities.[xxi]

When older people in particular cannot access healthcare in a meaningful way, assisted suicide will become a cheap and simpler option than trying to navigate finding appropriate health care providers.

Disability advocates have long expressed alarm over legislation that permits assisted suicide mainly based on the numerous biases and obstacles this group faces

in receiving healthcare. National Right to Life and other pro-life groups, which not always politically aligned, have worked alongside experts from numerous medical associations, disability advocacy groups, and legal organizations.

The non-partisan government organization summarizes an observation shared by all these disparate groups, the National Council on Disability.

In its 2019 report, they explained,

> Demoralization in people with disabilities is often based on internalized oppression, such as being conditioned to regard help as undignified and burdensome or to regard disability as an inherent impediment to quality of life. Demoralization can also result from the lack of options that people depend on. These problems can lead patients toward hastening their deaths—and doctors who conflate disability with terminal illness or poor quality of life are ready to help them. Moreover, most health professionals lack training and experience in working with people with disabilities, so they do not know how to recognize and intervene in this type of demoralization.[xxii]

Implementing assisted suicide laws in an impartial way as it relates to persons with disabilities and older persons has proved to be nearly impossible.

In the United States, Federal Law protects all citizens of any age from various types of discrimination, known as the Americans with Disabilities Act (ADA). Its passage in 1990 guaranteed that people with disabilities have the same opportunities as everyone else to enjoy employment, purchase goods and services, and participate in state and local government programs.

Many legal scholars have observed that assisted suicide laws violate Section 504 of the Rehabilitation Act of the ADA because people with disabilities and only people with disabilities can be eligible for assisted suicide. Everyone else gets mandated suicide prevention. While litigation is ongoing in at least one jurisdiction, the outcome is many months or years away.[xxiii] In the meantime, no further jurisdiction should enact assisted suicide laws, and others should strongly consider administratively pausing or repealing theirs.

The Federal Bill to Pay for Assisted Suicide

Before any state law was yet to take effect, National Right to Life was instrumental in the enactment of the Federal-level Assisted Suicide Funding Restriction Act of 1997 (ASFRA) to bar federal funds from being used to aid in assisting in suicide.

This bill was passed with sweeping majorities in the House (398 – 16) and Senate (99-0).[xxiv]

On April 26, 2024, Reps. Brittany Pettersen (D-CO) and Rep. Scott Peters (D-CA) introduced H.R.8137, "To provide for an exception to the restrictions described in the Assisted Suicide Funding Restriction Act of 1997 with respect to certain States."

While this bill is unlikely to move in the 118th Congress, this is a dangerous bill that, if enacted, would have the effect of causing assisted suicide to increase exponentially for the reasons described above. What is more alarming is the push to remove residency requirements, enabling the whole of the United States to be able to receive assisted suicide in other states.

Alarming Trend on Residency and Telemedicine

In the over 25 years it has been in effect, the Oregon law had required that only residents could obtain lethal drugs to end their life. But Oregon has abandoned that basic requirement in 2022. [xxv] Vermont joined them the following year.

The abandonment of the residency requirement will not only set up a dangerous scenario where people from other states can travel to Oregon and Vermont to die, but proponents announced that they will push ahead to try and eliminate the residency requirements in other states where the practice is legal. [xxvi]

What is also alarming to many legal observers is not only the lack of civil or criminal accountability in Oregon, but the impact this will have on residents of other jurisdictions where assisting a suicide is legal. In 2022, 3 people traveled to Oregon to avail themselves of the suicide law, and that number jumped to 23 in 2023.[xxvii]

During the COVID-19 pandemic, the Drug Enforcement Administration (DEA) permitted controlled substances— some of which are also used in assisted suicide — to be prescribed after a virtual visit. While the DEA reasoned that people could keep safe at home, there is a growing concern that opiods were being prescribed from doctors who had never seen a patient in person. Now, the DEA is looking to restore some patient protections but has delayed action.[xxviii] The proposed rule is not specific to assisted suicide, but only to certain categories of drugs.

Since all of the drugs currently used in assisted suicide (legal in 9 states plus D.C.) are Schedule II drugs, assisted suicide activists are opposing this rule.

Vermont in particular permits assisted suicide by telemedicine, meaning non-residents could be prescribed lethal drugs virtually on the basis of a single virtual

visit. The proposed DEA rule would at least restore some measure of protection, requiring an in-person visit with a provider.

The abandonment of the residency requirement will set up a dangerous scenario where people from other states can travel to Oregon and Vermont to die, or take these drugs, unmonitored, out of the state. Numerous legal observers have sounded the alarm not only in regards to the lack of civil or criminal accountability in these states, but the impact this will have on residents of other jurisdictions where assisting a suicide is not legal.

Longtime euthanasia commentator Wesley Smith writing on the assisted suicide advocate's opposition of the DEA rule,

> So why oppose a reasonable rule that will prevent inappropriate prescribing of potent substances and protect patients involved in legitimate medical treatments far more often than assisted suicide? Here's the answer: Unregulated telemedicine opens the door to unrestricted assisted suicide.[xxix]

Conclusion

With the pressures of cost, age and disability outline above, the United States cannot continue to pass and must repeal assisted suicide laws. Any effort to federalize assisted suicide must be swiftly stopped.

The study "The realities of medical assistance in dying in Canada" reflecting on their disastrous experience with MAiD sums it up well,

> The fact that providing state facilitated death is more cost-effective than providing supported health-care and community support to facilitate living well raises concerns about conflicting interests: any country facing financial pressures ought to be concerned about perverse cost-cutting incentives that are built into a health-care system.[xxx]

[i] https://legis.delaware.gov/BillDetail?LegislationId=130281

[ii] https://www.gencourt.state.nh.us/house/legislation/billinfo.aspx?id=1136&sy=

[iii] H.R.8137 - 118th Congress (2023-2024): To provide for an exception to the restrictions described in the Assisted Suicide Funding Restriction Act of 1997 with respect to certain States, 118th Cong. (2024), https://www.congress.gov/bill/118th-congress/house-bill/8137.

[iv] Assisted Suicide Funding restriction Act Pub. L. No 105-12, 111 Stat.23 (1997).

[v] While not legalizing the practice, a Montana Supreme Court decision found that a physician would be able to raise the defense that the patient consented if sued. *Baxter v. State*, 224 P.3d 1211, 2009 M.T. 449, 354 Mont. 234 (2009).

[vi] Oregon Death with Dignity Act, 2023 Data Summary, accessed May 13, 2024, https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year26.pdf

[vii] California End of Life Option Act 2022 Data Report, accessed May 13, 2024, https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/CDPH_End_of_Life%20_Option_Act_Report_2022_FINAL.pdf

[viii] Coelho, Ramona, et al. "The realities of medical assistance in dying in Canada." *Palliative & supportive care* 21.5 (2023): 871-878.

[ix] Parliamentary Budget Officer (2021) Cost Estimates for Bill C-7 MAiD, accessed May 13, 2024, https://www.pbo-dpb.gc.ca/web/default/files/Documents/Reports/RP2021-025-M/RP-2021-025-M_en.pdf

[x] Juliette Cubanski and Tricia Neuman, Jan 19, 2023, https://www.kff.org/medicare/issue-brief/what-to-know-about-medicare-spending-and-financing/#Overview_of_Medicare_Spending

[xi] https://www.kff.org/from-drew-altman/the-two-health-care-cost-crises/

[xii] https://hospicenews.com/2023/08/14/how-palliative-care-generates-savings-boosts-hospice-utilization/

[xiii] Oregon Death with Dignity Act, 2023 Data Summary, accessed May 13, 2024, https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year26.pdf

[xiv] A Primer on Assisted Suicide Laws, accessed May 13, 2024, https://dredf.org/wp-content/uploads/2017/04/a-primer-on-assisted-suicide-laws.pdf

[xv] Hetzler III, P. T., Nie, J., Zhou, A., & Dugdale, L. S. (2019). Focus: Death: A Report of Physicians' Beliefs about Physician-Assisted Suicide: A National Study. The Yale journal of biology and medicine, 92(4), 575

[xvi] https://www.canada.ca/content/dam/hc-sc/documents/services/medical-assistance-dying/annual-report-2022/annual-report-2022.pdf

[xvii] https://www.un.org/development/desa/disabilities/disability-and-ageing.html

[xviii] Oregon Death with Dignity Act, 2023 Data Summary, accessed May 13, 2024, https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year26.pdf

[xix] https://www.commonwealthfund.org/publications/issue-briefs/2021/oct/community-based-long-term-services-and-supports-are-needs-older#:~:text=In%20the%20United%20States%2C%207.7%20million%20community-living%20older,consequence%20due%20to%20unmet%20LTSS%20needs%20%28Exhibit%201%29.

[xx] Coelho, Ramona, et al. "The realities of medical assistance in dying in Canada." *Palliative & supportive care* 21.5 (2023): 871-878.

[xxi] https://www.aha.org/testimony/2023-02-15-aha-senate-statement-examining-health-care-workforce-shortages-where-do-we-go-here

[xxii] National Council on Disability. "The Danger of Assisted Suicide Laws." (2019).https://ncd.gov/sites/default/files/NCD_Assisted_Suicide_Report_508.pdf

[xxiii] United Spinal, et al. v. State of California, et al. Case No. 2:23-cv-03107 (C.D. Cal. 2023) https://endassistedsuicide.org/wp-content/uploads/2023/04/Complaint_Accessible.pdf

[xxiv] https://www.congress.gov/bill/105th-congress/house-bill/1003/all-actions

[xxv] https://compassionandchoices.org/docs/default-source/legal/rec-doc-20-1-exhibit-wm.pdf

[xxvi] https://apnews.com/article/business-health-oregon-lawsuits-portland-3cf31cb519d84a47e2d3cb70e8f0bce7

[xxvii] Oregon Death with Dignity Act, 2023 Data Summary, accessed May 13, 2024, https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year26.pdf

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