

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

SONYA TAYLOR, et al.,

Plaintiffs,

v.

ROBERT F. KENNEDY, JR., in his official
capacity as Secretary of Health and Human
Services, et al.,

Defendants.

Case No. 1:26-cv-3705-GLR

**BRIEF OF AMICI CURIAE AMERICAN PUBLIC HEALTH
ASSOCIATION, GRANTMAKERS IN HEALTH, THE JACOBS
INSTITUTE OF WOMEN'S HEALTH, THE NATIONAL CENTER
FOR MEDICAL-LEGAL PARTNERSHIP, LIBERTY HEALTH
ALLIANCE, AND 167 DEANS, CHAIRS, AND PUBLIC HEALTH
AND HEALTH POLICY SCHOLARS IN SUPPORT OF
PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT**

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INTERESTS OF AMICI CURIAE

Amici curiae public health organizations are the American Public Health Association, Grantmakers in Health, the Jacobs Institute of Women’s Health, the National Center for Medical-Legal Partnership, the Liberty Health Alliance, and 167 distinguished deans, chairs, and scholars at the nation’s leading academic institutions and research universities in the fields of public health policy and law. Collectively, these organizations include tens of thousands of public health professionals and researchers across the country. The organizational and individual *amici* advance public health law and policy to improve health equity in the United States.

INTRODUCTION

In July 2025, Congress added a new requirement that low-income adults aged 19 to 64 whose eligibility is based on the Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. 119 (2010), show they work, volunteer, or are in school for at least 80 hours each month to be eligible for Medicaid. Aware that people with serious health conditions would face difficulties in satisfying this new “community engagement” requirement, Congress excluded those who are “medically frail or otherwise [have] special medical needs,” enumerating five categories of serious health conditions that per se qualify individuals as medically frail. App. 0593. Members of Congress repeatedly described the exclusion as applying categorically to these individuals without requiring individualized proof of their inability to work.

Rather than follow Congress’s directive, Defendants’ agency, the Centers for Medicare & Medicaid Services (CMS), has adopted an interim final rule (IFR) adding a requirement to the medical frailty exclusion found nowhere in the statute. Now, not only must individuals show they have one of the statutorily specified health conditions, but they must also show that their “physical, mental, or other behavioral health condition *significantly impairs* the *individual’s* ability to comply with the community engagement requirement,” Medicaid Program; Community Engagement

Requirement for Certain Individuals, 91 Fed. Reg. 33348, 33373 (June 3, 2026) (emphases added). On top of that, the IFR restricts what evidence can be used to show significant impairment and prohibits the use of medical claims data alone to make medical frailty determinations.

CMS’s adoption of this extra-statutory “significant impairment” requirement is paradigmatic arbitrary and capricious agency action. CMS ignored the overwhelming evidence available to it, including evidence from its own prior work requirement experiments, showing that its new requirement, along with the agency’s evidentiary restrictions, will impose substantial evidentiary and administrative burdens on working-age people who are in serious need of ongoing health care. As CMS was well aware, these burdens have repeatedly been shown to result in massive coverage loss among the very people Congress unequivocally intended to protect through the medical frailty exclusion. The IFR ignored those harms and that the loss of access to critical health care will have dire consequences on the health care system as a whole. CMS failed to consider the wealth of evidence available to it (including many of its own studies) demonstrating that the IFR will not increase workforce participation because many of the individuals who would qualify for the exclusion but for the IFR’s requirements already work as they can, even if fewer than 80 hours per month, and removing access to health care for individuals with serious health conditions will not improve their ability to work, but rather undermine it.

STATUTORY AND REGULATORY BACKGROUND

Medicaid provides health coverage for about one in five people in the United States. App. 0538 (fig. 2).¹ Enacted with Medicare in 1965, Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (1965), Medicaid’s stated purpose is “to furnish . . . medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals whose

¹ “App.” refers to the appendix containing the studies and other sources on which the *amici* rely in this brief.

income and resources are insufficient to meet the costs of necessary medical services.” 42 U.S.C. § 1396–1. It operates differently from other health insurance programs to promote coverage to people with serious health conditions who need it, when they need it. *Id.* § 1396a(a)(10). For example, Medicaid does not restrict enrollment to an open-enrollment period or specific qualifying events, and it makes coverage retroactive once a person is enrolled. *Id.* §§ 1396a(a)(8), (a)(34).

States’ Medicaid programs must include certain mandatory populations, e.g., low-income families, qualified pregnant women and children, and Supplemental Security Income recipients. *See id.* § 1396a(a)(10). In 2010, the ACA gave States the option to expand Medicaid eligibility to adults under 65 with incomes below 133% of the federal poverty line. *Nat’l Fed’n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 585 (2012). Hundreds of studies confirm that the ACA’s Medicaid expansion has led to healthier individuals, lower uncompensated care costs, and increased workforce participation. App. 0005, 0363, 0448, 0489–0490. Nearly half of expansion enrollees have at least one chronic condition, with more than 60% of those ages 50–64 having at least one. *Id.* at 0464.

In 2025, Congress enacted HR 1, including Section 71119, which imposes an 80-hour per month community engagement (i.e., work, community service, or education) requirement for Medicaid eligibility for certain groups, including the new adult eligibility group under the ACA’s expansion. Pub. L. No. 119-21, § 71119 (codified at 42 U.S.C. § 1396a(xx)). The statute excludes certain populations from the requirement, including, as relevant here, an individual who is:

medically frail or otherwise has special medical needs (as defined by the Secretary), including an individual (aa) who is blind or disabled (as defined in section 1382c of this title); (bb) with a substance use disorder; (cc) with a disabling mental disorder; (dd) with a physical, intellectual or developmental disability that significantly impairs their ability to perform 1 or more activities of daily living; or (ee) with a serious or complex medical condition.

42 U.S.C. § 1396a(xx)(9)(A)(ii)(V). Members of Congress explicitly stated at the time of passage that people with these serious health conditions would unequivocally be excluded from the

community engagement requirement, and that States could automatically verify that individuals qualify for the exclusion. App. 0784 (“We have reasonable exemptions for: . . . [i]ndividuals who are medically frail” and “[i]ndividuals who are blind, have [a] substance abuse disorder, a disabling mental disorder, a physical or intellectual disability that significantly impairs their ability to perform one or more activities of daily living or a serious, complex medical condition.” (third alteration in original)); *see also id.* at 0025–0030 (collecting quotes).

CMS’s IFR amended the Medicaid expansion eligibility regulations to implement the community engagement requirement at 42 C.F.R. §§ 435.550–435.563. *See* IFR, 91 Fed. Reg. at 33353. In defining when a person is considered “medically frail,” CMS added an extra condition completely absent from the statute itself: proof that the “condition *significantly impairs the individual’s ability to comply* with the community engagement requirement.” *Id.* at 33373 (emphasis added). Furthermore, despite knowing that Medicaid claims often are slow to be fully processed by States, the IFR further restricts States from considering data more than 12 months old when making these determinations, and it permits enrollees to self-attest to their qualifying condition only once in a continuous enrollment period. *Id.* at 33393.

ARGUMENT

In adopting its novel, more restrictive definition of “medically frail,” CMS failed to consider the overwhelming evidence—including evidence from *CMS’s own* work requirement experiments—showing that the new standard will preclude millions of Americans from qualifying for the exclusion even though they demonstrably fall into a category Congress expressly identified as an excluded group based on their health conditions. The agency ignored the wealth of data and evidence before it, based its justifications on demonstrably flawed assumptions inconsistent with

the available evidence, and disregarded the severe harm its IFR will impose on a highly vulnerable population that Congress sought to protect, rendering the IFR arbitrary and capricious.

I. CMS IGNORED VAST EVIDENCE THAT ITS SIGNIFICANT-IMPAIRMENT TEST WILL CAUSE COVERAGE LOSSES FOR MILLIONS WHOM CONGRESS CHOSE TO PROTECT AND WEAKEN THE HEALTH CARE SYSTEM.

Congress stated that the community engagement requirement in HR 1 only applies to “able-bodied adults who are choosing not to work.” App. 0713. Aware that the requirement may lead to coverage losses, Congress categorically excluded certain categories of medically frail people who may struggle to meet the 80-hour a month requirement. *See* 42 U.S.C. § 1396a(xx)(9)(A)(ii)(V). CMS’s atextual requirement to qualify as medically frail upends that categorical protection, resulting in drastic coverage losses for a vulnerable population that Congress sought to shield and disruption to the health care system as a whole.

A. CMS Ignored Its Own Evidence Showing Its New Test Would Impose Substantial Coverage Losses Among Individuals with Serious Health Conditions.

CMS ignored the evidence available to it—including its own data and the research presented to it while it was developing the IFR—making clear that CMS’s significant-impairment test will result in substantial coverage losses among people with serious health conditions, the very population Congress sought to protect. As a result, CMS “failed to consider . . . important aspect[s] of the problem.” *Motor Vehicle Mfrs. Ass’n of the U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983). The IFR also “runs counter to the evidence before the agency,” *Defs. of Wildlife v. U.S. Dep’t of the Interior*, 931 F.3d 339, 351–52 (4th Cir. 2019), and “conflict[s] with the policy judgments that undergird the statutory scheme,” *Health Ins. Ass’n of Am., Inc. v. Shalala*, 23 F.3d 412, 416 (D.C. Cir. 1994). Accordingly, the IFR is arbitrary and capricious.

The IFR creates an extra-statutory step for medical frailty determinations—not only must States determine that an individual has a qualifying diagnosis, but they must determine whether

the health condition significantly impairs the individual’s ability to work or volunteer at least 80 hours per month. In adopting that test, CMS disregarded evidence, including its own research findings, showing that verifying whether a particular medical condition significantly impairs a specific individual’s ability to work or volunteer at least 80 hours per month, particularly given CMS’s evidentiary restrictions, will impose high administrative burdens on individuals and States. Those burdens, in turn, will lead to severe coverage losses among the very individuals Congress intended to exclude. App. 0514–0516 (explaining that a main contributor to expected coverage losses was “limited awareness among beneficiaries and low rates of reporting activities to the state”).

To be sure, the IFR instructs States to verify whether an individual qualifies as medically frail using *ex parte* data, suggesting that States could rely on their own automated systems to identify relevant data, such as Medicaid claims data, to make individual medical frailty determinations. IFR, 91 Fed. Reg. at 33405. But in reality, States will need to rely heavily on manual reporting by individuals to obtain documentation that is sufficient to determine whether their conditions significantly impair their ability to meet the community engagement requirement because State databases will not contain the data needed to make such determinations on an individualized basis.

Moreover, States lack the infrastructure to routinely conduct the types of functional assessments necessary to determine significant impairment on an individual basis—nor did Congress provide funding to create it. App. 0413. It will also be difficult to find a provider who can even furnish the necessary documentation, as health care records contain clinical evidence, not specialized occupational evidence necessary to show inability to work, which clinical health professionals rarely possess. *See, e.g., Mascio v. Colvin*, 780 F.3d 632, 635–36 (4th Cir. 2015) (recounting the multi-year process for disability determinations). CMS’s IFR compounds these burdens by restricting what data can be used to prove significant impairment. Under the IFR, States cannot rely on

diagnosis alone, 91 Fed. Reg. at 33373, cannot use claims data more than 12 months old, *id.* at 33393, and are limited in relying on self-attestations, *id.* at 33406.

CMS's failure to recognize the real-world implications of its new requirement is fatal to the rule because the evidence makes clear that manual reporting requirements create significant barriers to Medicaid coverage. These barriers mean that many applicants who qualify for Medicaid will not end up enrolled in the program, as CMS knows. For example, Georgia's Medicaid work requirement experiment similarly relies on a manual reporting system for documenting compliance with or an exclusion from the requirement. App. 0385–0388. As of July 2026, only 19,397 individuals have successfully enrolled in Georgia's Medicaid program out of an estimated 240,000 eligible people. App. 0620 & n.108. An interim evaluation of the demonstration found that the magnitude of difference between Georgia's projected and actual enrollment "suggests that many individuals who would be eligible . . . are not applying to the program" and that as many as 40% of people who started applications gave up and never submitted them. App. 0620.

Similarly, manual reporting requirements mean that many individuals who are currently enrolled in Medicaid and qualify for an exclusion under HR 1 will nevertheless ultimately lose coverage under the IFR. Studies show that manual reporting requirements result in substantially more people being deemed "noncompliant" and disenrolled compared to automated data-matching systems, App. 0385–0387 (noting a 98% noncompliance rate in Georgia), and that many of those who lose coverage should have qualified but were unable to provide the required documentation. App. 0619. Every added administrative hurdle increases the risk that an eligible individual will fail to obtain coverage or lose coverage solely due to administrative burdens unrelated to their eligibility. This is particularly true for low-income people with serious health conditions, who lack the means to secure the type of inability-to-work evaluations that the IFR demands. App. 0663.

CMS’s own data shows that States have long struggled to verify whether individuals qualify for a medical frailty exclusion, even without a significant-impairment test. In Georgia, for example, 22% of application denials and 30% of disenrollments from its community engagement experiment were due to procedural barriers, such as missing forms. App. 0033-0054; 0065-0070.

Thus, the IFR’s new test inevitably will result in millions of individuals with significant health conditions losing or being denied Medicaid coverage. Researchers have estimated that the IFR will cause nearly two million more people to lose Medicaid coverage than would lose coverage using HR 1’s categorical medical frailty exclusion. App. 0012–0023 (estimating coverage losses rising by nearly two million). And those who lose coverage will not be limited to individuals who “choose[] not to work,” as Congress intended. App. 0713. People who qualify for the exclusion under HR 1’s medical frailty exclusion will lose coverage under the IFR, and many who would meet even CMS’s significant-impairment test will also lose coverage simply because they cannot provide the necessary documentation to demonstrate their significant impairment. The inevitable coverage losses to individuals with serious health conditions that will result from the IFR cannot be squared with Congress’s intent to preserve Medicaid coverage for these very individuals when it designed the medically frail exclusion. *See Health Ins. Ass’n of Am., Inc.*, 23 F.3d at 416 (agency action is unreasonable if it “conflict[s] with the policy judgments that undergird the statutory scheme”); *Kennecott Utah Copper Corp. v. U.S. Dep’t of Interior*, 88 F.3d 1191, 1212 (D.C. Cir. 1996) (rejecting agency interpretation because it was “simply not a reasonable attribution of the intent of Congress”); *Page v. Pension Benefit Guar. Corp.*, 968 F.2d 1310, 1316 (D.C. Cir. 1992) (agency policy unreasonable where it “perpetuates the very weaknesses Congress sought to cure”).

Moreover, all the evidence showing that the significant-impairment test would cause substantial coverage losses among individuals with serious health conditions was indisputably

presented to the agency prior to its issuance of the IFR. *See, e.g.*, Administrative Record (AR) 4183–96 (explaining that States do not have processes to determine whether someone can work); AR 4330–34 (noting “the complexity of identifying people with mental health conditions” and other serious health conditions); AR 4462–67 (discussing physicians’ administrative burdens); AR 4723–30 (presenting data on how claims data can be used to identify someone as medically frail); AR 4784–87 (highlighting the harm that gaps in coverage could cause to people with serious health conditions). But the agency unreasonably failed to consider any of it when assessing the consequences of the IFR. *See Defs. of Wildlife*, 931 F.3d at 351 (holding that agency’s “nest density” estimates for a species of bees were unreasonable because the agency “ignored significant evidence that undermines the reasonableness of its estimates”); *District of Columbia v. U.S. Dep’t of Agric.*, 496 F. Supp. 3d 213, 226 (D.D.C. 2020) (rejecting rule because “the agency failed adequately to respond to the ‘considerable evidence’” weighing against its policy (citation omitted)).

Instead, CMS based its fanciful coverage-loss estimates on assumptions that are contradicted by the evidence. *See Defs. of Wildlife*, 931 F.3d at 351. CMS failed even to ask whether its significant-impairment test might cause more coverage losses than HR 1’s categorical approach. CMS estimated that 10% of individuals who would otherwise be subject to the community engagement requirement should qualify as medically frail, but this was based on a study that predated the IFR and did not address how CMS’s new test and evidentiary restrictions would impact that estimate. *Compare* IFR, 91 Fed. Reg. at 33458 *with* AR 3575–3615 *and* App. 0683. Even if that were not the case, CMS misrepresents the utility of that 10% figure because it did not, as CMS asserts, estimate the total number of people who would qualify as medically frail; rather, it measured only those who reported being unable to work *at all* over the prior year due to disability or

illness. App. 0699. Thus, the study does not account for the many medically frail individuals who work but are unable to work for 80 hours a month due to their health conditions. App. 0699.

The same is true for CMS's estimates of individuals who would be erroneously disenrolled or denied coverage for administrative reasons. The agency estimated the rate of those administrative errors to be approximately 7% of qualifying individuals. IFR, 91 Fed. Reg. at 33460. But it never explained how its new significant-impairment test or its restrictions on the evidence States can use to determine whether that test is met might affect procedural disenrollment rates. *Id.* And, again, the actual number of individuals who will be disenrolled or denied coverage for purely procedural reasons will be much higher than CMS estimates. *See* App. 0012 (predicting nearly two million more people will be denied coverage or disenrolled under the IFR).

Congress chose to categorically exclude people with serious health conditions from the community engagement requirement in HR 1 because it recognized the importance of continued access to essential health care, the challenges they face navigating barriers, and how health care is critical to helping them work if they are able. CMS's IFR ignores that choice and fails to reflect the vast evidence showing that the very population that Congress sought to protect will be harmed by the policies CMS adopted in its IFR. For those reasons, the IFR is arbitrary and capricious.

B. CMS Failed to Account for the Harms to the Entire Health Care System.

The costs of the coverage losses due to CMS's added requirement will fall not only on vulnerable Medicaid recipients but also on the health care system itself. The IFR will increase uncompensated care and administrative costs, which will be borne by physicians and providers, individuals seeking health care, and States. App. 0443–0446. These consequences will reduce access to services in underserved and rural areas, particularly among providers who serve a disproportionate number of poor and underserved adults on Medicaid with high health needs. *See* App.

0366–0382. CMS ignored evidence of these broader impacts from its own data, rendering the IFR arbitrary and capricious. *See Defs. of Wildlife*, 931 F.3d at 352 (agency’s prediction unreasonable because it was at odds with the agency’s own evidence).

As discussed, CMS’s significant-impairment test will cause individuals with serious health conditions to lose coverage. Meanwhile, a substantial body of evidence presented to, and in many cases created by, CMS shows the ACA’s Medicaid expansion increased coverage, improved population health, lowered uncompensated care costs to providers by more than 50%, and reduced costs to States. App. 0630–0631. It logically follows that coverage losses among that population will have the opposite effects; the greater the coverage losses, the greater the uncompensated medical care and the greater the burden on providers’ ability to provide critical services.

CMS wholly ignored these impacts. For example, community health centers, which are primarily funded through Medicaid, are critically important to aging patients with significant health conditions, providing them with treatment and ongoing management of serious or complex health conditions. As Medicaid enrollees lose coverage due to the significant-impairment requirement, these centers will likely be forced to lay off staff or close entirely, App. 0445; 0631; *see also* AR 4737–4738; 4789, to the detriment of some of the nation’s most vulnerable patients.²

Other providers will similarly face increased uncompensated care costs, which will in turn reduce access to services as providers are forced to reduce staffing or even close. Providers’ administrative costs across the board will also go up due to the IFR’s new test. Providers will be forced to spend more time that would otherwise go to patient care completing paperwork because verifying medical frailty will require individualized documentation. App. 0631–0632; *see also id.*

² One estimate of the financial impact of HR 1 calculated that community health centers would lose \$16–\$32 billion in reimbursement over the next five years due to coverage losses; the actual impact under the IFR will likely be much higher. App. 0525–0533.

at 0594 (explaining that reporting requirements would “worsen physicians’ administrative burdens, take time away from direct patient care, drive up administrative costs, and contribute to physician burnout”); AR 4462. States too will experience increased costs, both from higher rates of uncompensated care at public hospitals and from processing and individually adjudicating every request for the medical frailty exclusion.

Notwithstanding this evidence, CMS did not consider these impacts on the health care system *at all*. CMS did not address the IFR’s adverse effects on safety-net providers, access to care, or States’ administrative burdens, even though these consequences will inevitably flow from the coverage losses caused by the IFR. *See Int’l Ladies’ Garment Workers’ Union v. Donovan*, 722 F.2d 795, 823 (D.C. Cir. 1983) (vacating rule because of agency’s failure to consider its “logical” consequences). As CMS acknowledged in the IFR, *see* 91 Fed. Reg. at 33406, access to care and costs to the health care system are of central importance to the Medicaid program. CMS’s failure to consider these “plain implications” of the IFR renders it arbitrary and capricious. *Defs. of Wildlife*, 931 F.3d at 351; *see also State Farm*, 463 U.S. at 43.

II. CMS FAILED TO CONTEND WITH THE EVIDENCE SHOWING THE ADDED TEST WILL MEAN LESS WORKFORCE PARTICIPATION, NOT MORE.

Another entirely predictable consequence of CMS’s significant-impairment test is that it will make it harder for people with disabilities and serious health conditions to work, directly contrary to Congress’s goal in HR 1. CMS again ignored the vast evidence available to it—including its own data—and instead baselessly assumed that taking health care away from individuals with serious health conditions would somehow increase their workforce participation. App. 0686. This core misassumption renders the IFR arbitrary and capricious. *See District of Columbia*, 496 F. Supp. 3d at 226 (arbitrary and capricious to fail to adequately respond to “considerable evidence” weighing against the policy (citation omitted)).

Experts have produced over 700 studies from 2014 to 2026—all available to CMS—showing the positive health and economic impacts of expanded Medicaid coverage to low-income individuals and society overall. App. 0072–0360, 0627, 0658–0659. Studies show that Medicaid coverage enables people to work and leads to greater workforce participation, particularly among people with chronic or complex medical or mental health conditions. The evidence shows that those who gained coverage through Medicaid expansion found it easier to look for work, to perform better at work, and to continue working once employed. App. 0626 (explaining that nearly 70% of enrollees in Michigan who were already working said Medicaid coverage made it easier for them to do their jobs). This is especially true among disabled individuals who can work *because* their Medicaid coverage gives them access to essential health care. App. 0626. In fact, Medicaid expansion *increased* the number of disabled individuals in the workforce from 41% to 47% between 2013 and 2017 and *decreased* the number of disabled individuals who could not work because of their disability from 32% to 27% over that same period. *Id.* at 0626-0627. It is common sense that access to health care makes people with serious health conditions more capable of physical and mental activity and that a lack of access makes them less so.

Despite that evidence, CMS assumed that its significant-impairment test would help individuals with serious medical or mental health conditions become more self-sufficient. Based on a handful of cherry-picked and irrelevant studies, none of which are about work requirements in Medicaid programs, that found a correlation between work and health, CMS concluded that “[e]mployment is recognized as an important factor in long-term beneficiary health and welfare” and that “the relationship between health and employment is intrinsic—and bidirectional in nature.” IFR, 91 Fed. Reg. at 33451. It then speculated that “participating in community engagement activities . . . could potentially help [individuals with serious or complex medical conditions]

escape isolation and dependency, build confidence, achieve self-sufficiency and prosperity, and improve health.” *Id.* at 33376. But the evidence, including CMS’s own data from the Arkansas and Georgia experiments, shows the opposite about work requirements: they do not significantly increase employment or incomes, but they do cause coverage losses among disabled individuals who will become unable to work without Medicaid coverage. *See* App. 0686–0690, 0725–0781. Indeed, CMS’s projected increase in workforce participation “is far larger than the current pace of overall job growth in the economy.” App. 0686.

Congress crafted the community engagement requirement in HR 1 to require “able-bodied adults who are choosing not to work” to work or volunteer to maintain Medicaid coverage, while preserving Medicaid coverage for those who most need it. App. 0713. A key committee leader assured the public that “our bill couldn’t be clearer” by including a “long list of exempted individuals,” which “includes anyone who’s blind, disabled, battling a chronic substance-use disorder or living with a serious and complex medical condition like cancer.” App. 0603. Congress made clear in the statutory text and the legislative history that it did not intend for the community engagement requirement to apply to individuals with serious health conditions, many of whom already work even if unable to work 80 hours every month. Congress understood that it added this requirement to a program with a unique public health feature not found in any other type of health insurance. Unlike other insurers that must guard against adverse selection, Medicaid allows people to qualify for coverage at a moment of great health need. CMS’s decision to impose an additional requirement on individuals with serious health conditions is thus unreasonable as a matter of law and directly undermines Congress’s goal of increasing community engagement when possible while at the same time protecting people who are already too sick to work 80 hours per month from losing coverage. App. 0699 (citing App. 0579–0589). CMS’s decision to adopt such a policy that

so clearly frustrates what Congress sought to accomplish with HR 1 is quintessentially arbitrary and capricious agency action. *See Health Ins. Ass'n of Am., Inc.*, 23 F.3d at 416; *Page*, 968 F.2d at 1316; *Kennecott Utah Copper Corp.*, 88 F.3d at 1212.

CONCLUSION

In adopting its IFR, CMS ignored the wealth of data available to it showing its policy would lead to millions of vulnerable people with serious health conditions losing coverage, despite Congress's intent to exclude these individuals from the community engagement requirement. It failed to consider the adverse consequences its policy will have on the health care system as a whole. And CMS's assumptions that its policy will increase workforce participation are misguided and contradicted by available evidence, including its very own data. Thus, CMS's IFR is arbitrary and capricious, and the Court should grant Plaintiffs' motion for summary judgment.

Dated: October 27, 2026

Respectfully submitted,

/s/ Edward R. McNicholas

Edward R. McNicholas (Bar No. 24833)

Stephanie A. Webster (*pro hac vice* pending)

Chetan A. Patil (*pro hac vice* pending)

ROPES & GRAY LLP

2099 Pennsylvania Avenue, NW

Washington, D.C. 20006-6807

t: (202) 508-4779

Edward.McNicholas@ropesgray.com

Counsel for Amici Curiae

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LIST OF PROPOSED AMICI PUBLIC HEALTH DEANS AND SCHOLARS

A. Public Health Deans

1. Chandler, G. Thomas, MS, PhD, Distinguished Dean Emeritus, Professor, Environmental Health Sciences, Arnold School of Public Health, University of South Carolina
2. Ettner, Susan L., PhD, Dean Emerita of Graduate Education, Distinguished Professor, David Geffen School of Medicine, Division of General Internal Medicine and Health Services Research, Distinguished Professor, Fielding School of Public Health, University of California, Los Angeles
3. Fields, Sheldon D., PhD, RN, CRNP, FNP-BC, AACRN, FAANP, FNAP, FADLN, FAAN, Associate Dean for Equity and Inclusion, Research Professor, Ross and Carol Nese College of Nursing, The Pennsylvania State University, President, National Black Nurses Association
4. Gusmano, Michael K., PhD, Iacocca Chair, Professor of Health Policy, Associate Dean of Academic Affairs, College of Health, Lehigh University
5. Jain, Atul, MD, MS, Chair, Division of General Internal Medicine, Mayo Clinic in Arizona, Associate Dean, Mayo Clinic School of Continuous Professional Development, Director of Education Initiatives, Mayo Clinic and Arizona State University Alliance for Healthcare
6. LaVeist, Thomas A., PhD, Dean and Weatherhead Presidential Chair in Health Equity, Professor, Tulane University School of Public Health and Tropical Medicine
7. Marsit, Carmen J., PhD, Executive Associate Dean for Faculty Affairs and Research Strategy, Rollins Distinguished Professor, Gangarosa Department of Environmental Health, Rollins School of Public Health, Emory University
8. McDonald, Katherine E., PhD, Associate Vice President for Research, Professor, Public Health, Syracuse University
9. Thorpe, Jane, JD, Professor and Sr. Associate Dean for Academic, Student & Faculty Affairs, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University
10. Trapido, Edward, ScD, FACE, Dean, LSU School of Public Health – New Orleans
11. Vermund, Sten H., MD, PhD, Dean, Distinguished University Health Professor of Public Health and Pediatrics, College of Public Health, University of South Florida

B. Public Health, Health Law, and Policy Scholars

12. Abernathy, Alice, MD, MSHP, Assistant Professor of Obstetrics & Gynecology and Medical Ethics & Health Policy, Perelman School of Medicine, Senior Fellow, Leonard Davis Institute of Health Economics, University of Pennsylvania
13. Ahmed, Aziza, JD, MS, Professor of Law, Boston University School of Law
14. Akman, Jeffrey S., MD, Leon M. Yochelson Professor and Chair, Department of Psychiatry and Behavioral Health, School of Medicine and Health Sciences, The George Washington University
15. Bae, Jean, JD, MPH, Clinical Associate Professor, Department of Public Health Policy and Management, School of Global Public Health, New York University
16. Barkoff, Alison, JD, Harold and Jane Hirsh Associate Professor of Health Law and Policy, Director, Hirsh Health Law and Policy Program, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University
17. Beckerman, Julia Zoe, JD, MPH, Teaching Professor and Vice Chair for Academics, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University
18. Bender Ignacio, Rachel, MD, MPH, Associate Professor of Infectious Diseases, Department of Medicine; Adjunct Associate Professor of Epidemiology, University of Washington
19. Berlin-Lowe, Michelle, MD, MPH, Professor Emerita, Obstetrics & Gynecology, Oregon Health & Science University, Director (Former), Oregon Health & Science University Center for Women's Health
20. Bernard, Caitlin, MD, MSCI, Assistant Clinical Professor, Indiana University School of Medicine, Department of Obstetrics and Gynecology
21. Bettigole, Cheryl, MD, MPH, MA, Professor of Clinical Family Medicine and Community Health, Professor of Medical Ethics and Health Policy, and Executive Director, Center for Public Health, Perelman School of Medicine, University of Pennsylvania
22. Bhagat, Santi, MD, MPH, Founder and President, Physician-Parent Caregivers, The Invisible Wave
23. Blanchard, Janice, MD, PhD, Professor, Chief of Health Policy Section, Department of Emergency Medicine, School of Medicine and Health Sciences, The George Washington University

24. Boris, Eileen, PhD, MA, Distinguished Professor Emerita, Department of Feminist Studies, University of California, Santa Barbara
25. Braaten, Kari P., MD, MPH, Assistant Professor of Obstetrics and Gynecology, Harvard Medical School, Mass General Brigham
26. Bratcher Goodwin, Michele, JD, LLM, SJD, Linda D. & Timothy J. O'Neill Professor of Constitutional Law and Global Health Policy, Faculty Director, O'Neill Institute for National and Global Health Law, Georgetown University Law Center
27. Brindis, Claire D., DrPH, Distinguished Professor of Health Policy, Emerita Director, Phillip R. Lee Institute for Health Policy Studies, Department of Pediatrics, School of Medicine, University of California, San Francisco
28. Brown, Benjamin P., MD, MS, Mimi Pichey Assistant Professor of Obstetrics and Gynecology, Assistant Professor of Health Services, Policy, and Practice, Clinician Educator, Warren Alpert Medical School and School of Public Health, Brown University
29. Burke, Taylor, JD, LLM, Adjunct Professor of Health Law and Policy, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University
30. Burris, Scott, JD, James E. Beasley Professor of Law, Center for Public Health Law Research, Temple University Beasley School of Law
31. Byrnes, Maureen, MPA, Teaching Instructor, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University
32. Calhoon, Claudia, DPH, MPH, Assistant Professor of Community and Public Health, Department of Health and Human Performance, York College of the City College of New York
33. Cartwright-Smith, Lara, JD, MPH, Associate Professor, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University
34. Casoni, Maria, MPH, MSL, Research Scientist, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University
35. Charo, R. Alta, JD, Knowles Professor Emerita of Law and Bioethics, University of Wisconsin Law and Medical Schools; Principal, Alta Charo Consulting LLC
36. Chavkin, Wendy, MD, MPH, Professor Emerita of Population and Family Health and Obstetrics-Gynecology, Mailman School of Public Health and Vagelos College of Physicians and Surgeons, Columbia University

37. Cohen, Alan B., ScD, Research Professor (Retired), Markets, Public Policy and Law, Boston University Questrom School of Business, and Professor of Health Law, Policy, and Management (Retired), Boston University School of Public Health
38. Collins, Sara R., PhD, Senior Scholar and Vice President, Health Care Coverage and Access and Tracking Health Systems Performance, The Commonwealth Fund
39. Crays, Allyson, JD, Public Health Law and Policy Analyst, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University
40. Crossley, Mary, JD, John E. Murray Faculty Scholar and Professor of Law, University of Pittsburgh School of Law
41. Crowley, Jeffrey, MPH, Distinguished Scholar & Director, Center for HIV and Infectious Disease Policy, O'Neill Institute for National and Global Health Law, Georgetown University Law Center
42. Cuello, Leonardo, JD, Research Professor, Center for Children and Families, Georgetown University McCourt School of Public Policy
43. Daniel, Clare, PhD, Senior Professor of Practice and Director of Research, Newcomb Institute of Tulane University
44. Dankwa-Mullan, Irene, MD, MPH, Adjunct Professor, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University
45. Deeb-Sossa, Natalia, Professor, Chicana/o/x Studies, University of California, Davis
46. Degutis, Linda C., DrPH, MSN, Lecturer, Department of Chronic Disease Epidemiology, Yale School of Public Health, Past President, APHA, Former Director, National Center for Injury Prevention and Control, CDC
47. Delgado, Ana, CNM, MS, Clinical Professor and Midwife, Department of Obstetrics, Gynecology and Reproductive Sciences, University of California, San Francisco School of Nursing
48. Doan, Alesha, PhD, Professor, School of Public Affairs & Administration, University of Kansas
49. Dorfman, Doron, JSD, JSM, LLM, LLB, Professor of Law, Seton Hall University School of Law
50. Dutta, Elizabeth Arend, DrPH, MPH, Professorial Lecturer, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

51. Ecker, Jeffrey L., MD, Joe V. Meigs Professor of Obstetrics, Gynecology and Reproductive Biology, Harvard Medical School, Chair Emeritus, Department of Obstetrics and Gynecology, Massachusetts General Hospital
52. Eisenberg, David L., MD, MPH, FACOG, Professor and Chief, Division of Complex Family Planning and Gynecology, Department of Obstetrics & Gynecology, Washington University in St. Louis School of Medicine
53. Eskenazi, Brenda, MA, PhD, Jennifer and Brian Maxwell Distinguished Professor Emeritus of Maternal and Child Health and Epidemiology, School of Public Health, University of California, Berkeley
54. Field, Robert I., JD, MPH, PhD, Professor of Law Emeritus, Thomas R. Kline School of Law, Professor of Health Management and Policy Emeritus, Dornsife School of Public Health, Drexel University
55. Finkel, Adam M., ScD, CIH, Clinical Professor of Environmental Health Sciences, University of Michigan School of Public Health
56. Fleisher, Jonah, MD, MPH, FACOG, Associate Professor, Clinical Obstetrics and Gynecology, Director, Center for Reproductive Health, University of Illinois Chicago
57. Frankford, David M., JD, Professor of Law, Rutgers Law School, Faculty Director at Camden, Center for State Health Policy, Rutgers University and Faculty, Institute for Health, Health Care Policy, and Aging Research, Rutgers University
58. Fredrick, Beth, Senior Associate, Population, Family and Reproductive Health Department, Johns Hopkins Bloomberg School of Public Health
59. Freed, Salama, PhD, Assistant Professor, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University
60. Friedman, Leonard H., PhD, MPH, FACHE, Professor and Director, MHA@GW Program, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University
61. Gaba, Nancy D., MD, FACOG, Oscar I. and Mildred S. Dodek Professor and Chair, Department of Obstetrics and Gynecology, School of Medicine and Health Sciences, The George Washington University
62. Gable, Lance, JD, MPH, Interim Dean and Professor of Law, Wayne State University Law School
63. Ghosh, Mimi, PhD, MS, Associate Professor, Department of Epidemiology, Milken Institute School of Public Health, The George Washington University

64. Glied, Sherry, PhD, MA, Professor, Robert F. Wagner Graduate School of Public Service, New York University
65. Godfrey, Emily M., MD, MPH, FAAFP, Professor, Department of Family Medicine, University of Washington School of Medicine
66. Godzich, Micaela, MD, Clinical Professor, Residency Program Director, Vice Chair of Education, Department of Family and Community Medicine, UC Davis Health
67. Goldberg, Randy, MD, MPH, FACP, FHM, Assistant Professor of Clinical Medicine, New York Medical College; Hospitalist and Chair of Clinical Ethics, Westchester Medical Center
68. Goldstein, Melissa M., JD, Professor, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University
69. Gordon, Sarah H., PhD, MS, Associate Professor, Health Law, Policy, and Management, Co-Director, BU Medicaid Policy Lab, Boston University School of Public Health
70. Gray, Elizabeth A., JD, MHA, Teaching Assistant Professor, Department of Health Policy and Management, Director, Undergraduate Public Health Program, Milken Institute School of Public Health, The George Washington University
71. Handler, Arden, DrPH, Professor Emeritus, Community Health Sciences, University of Illinois Chicago School of Public Health
72. Harrington, Amy R., MD, Associate Professor, Obstetrics & Gynecology, URM Family Planning, University of Rochester Medical Center
73. Harris, Eva, PhD, Professor, Division of Infectious Diseases, Chair, Infectious Disease and Immunity Graduate Group, School of Public Health, Director, Center for Global Public Health, University of California, Berkeley
74. Heinrich, Janet, DrPH, RN, FAAN, Research Professor, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University
75. Heled, Yaniv, JSD, Professor of Law, Center for Law, Health & Society, Georgia State University College of Law
76. Hermer, Laura, JD, LLM, Professor of Law, James E. Kelley Chair in Tort Law, Mitchell Hamline School of Law
77. Herring, Jordan, PhD, Assistant Professor, Department of Health Services Policy and Management, Arnold School of Public Health, University of South Carolina

78. Hodder, Lucy C., JD, Director, Health and Life Sciences Law Programs, Distinguished Visiting Professor of Law, UNH Franklin Pierce School of Law, University of New Hampshire
79. Hoffman, Allison K., JD, William Maul Measey Professor of Law and Health Sciences, Carey Law School, Professor of Medical Ethics & Health Policy, Perelman School of Medicine, University of Pennsylvania
80. Hoffman, Sharona, JD, LLM, SJD, Distinguished University Professor, Professor of Bioethics, Edgar A. Hahn Professor of Jurisprudence, Co-Director, Law-Medicine Center, Case Western Reserve University School of Law
81. Hoffmann, Diane E., JD, Jacob A. France Professor of Health Law, Director, Law & Health Care Program, University of Maryland Francis King Carey School of Law
82. Holtz, Timothy H., MD, MPH, FACP, FACPM, RDML (ret) US PHS, Redstone Chair & Director, Sumner M. Redstone Global Center for Prevention and Wellness, Professor, Department of Global Health & Department of Epidemiology, Milken Institute School of Public Health, The George Washington University
83. Horton, Katherine, RN, MPH, JD, Research Professor, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University
84. Huberfeld, Nicole, Edward R. Utley Professor of Health Law, Co-Director, BU Program on Reproductive Justice, Chair, BU Health Law Program, Boston University School of Law and School of Public Health
85. Ivey, Susan L., MD, MHSA, Adjunct Professor, Community Health Sciences, School of Public Health, Co-PI, Health Research for Action, University of California, Berkeley
86. Jacobs, Feygele, DrPH, MS, MPH, Professor and Director, Geiger Gibson Program in Community Health, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University
87. Jordan, Jeanne A., PhD, HCLD(ABB), MT(ASCP), Professor Emerita, Department of Epidemiology, Milken Institute School of Public Health, The George Washington University
88. Jost, Timothy Stoltzfus, JD, Professor Emeritus, Washington and Lee University School of Law
89. Kalfoglou, Andrea, PhD, Associate Professor, Health Administration and Policy Program, Department of Sociology, Anthropology, & Health Admin and Policy, University of Maryland, Baltimore County

90. Kapadia, Farzana, PhD, MPH, Professor of Epidemiology and Population, Deputy Editor, AJPH, New York University School of Global Public Health, New York University Grossman School of Medicine
91. Keating, Nancy L., MD, MPH, Professor of Health Care Policy and Medicine, Department of Health Care Policy, Harvard Medical School
92. Kershner, Stacie, JD, Deputy Director, Center for Law, Health & Society, Georgia State University College of Law
93. Krieger, Nancy, PhD, Professor of Social Epidemiology, American Cancer Society Clinical Research Professor, Department of Social and Behavioral Sciences, Harvard T.H. Chan School of Public Health
94. Ku, Leighton, PhD, MPH, Professor, Department of Health Policy and Management, Director, Center for Health Policy Research, Milken Institute School of Public Health, The George Washington University
95. Kuhn, Randall, PhD, MA, Professor, Department of Community Health Sciences, University of California, Los Angeles Fielding School of Public Health
96. Lang, Valerie J., MD, MHPE, Professor of Medicine, Associate Chair for Medical Education Research and Scholarship, Department of Medicine, University of Rochester School of Medicine & Dentistry
97. Lantz, Paula M., PhD, MS, Professor Emerita, School of Public Policy and School of Public Health, University of Michigan
98. Law, Sylvia A., JD, Elizabeth K. Dollard Professor Emerita of Law, Medicine and Psychiatry, New York University School of Law
99. Levi, Jeffrey, PhD, Professor Emeritus, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University
100. Leyser-Whalen, Ophra, PhD, Associate Professor, Sociology and Director of Women's Studies, The University of Texas at El Paso
101. Lillie-Blanton, Marsha, DrPH, Adjunct Professor, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University
102. Magnus, Many, PhD, MPH, Professor and Chair, Department of Epidemiology, Milken Institute School of Public Health, The George Washington University
103. Markus, Anne R., PhD, MHS, JD, Professor and Chair, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

104. Mason, Diana J., RN, PhD, FAAN, Senior Policy Service Professor, Center for Health Policy and Media Engagement, School of Nursing, The George Washington University
105. Mason, Katy Ramsey, JD, MA, Associate Professor of Law, Director of Experiential Learning, Director, Medical-Legal Partnership Clinic, Cecil C. Humphreys School of Law, The University of Memphis
106. McConnell, K. John, PhD, Director, Center for Health Systems Effectiveness, Professor, Department of Emergency Medicine, Oregon Health & Science University
107. McDonnell, Karen A., PhD, Associate Professor, Department of Prevention and Community Health, Milken Institute School of Public Health, The George Washington University
108. McLemore, Monica R., RN, MPH, PhD, Professor and School of Nursing Endowed Chair for Health Promotion Professorship, University of Washington, Professor, New York University
109. McNulty, Molly, JD, Associate Professor of Public Health Law and Policy, Undergraduate Program in Public Health, School of Arts and Sciences, University of Rochester; Department of Public Health Sciences, University of Rochester School of Medicine & Dentistry
110. Meckstroth, Karen, MD, MPH, Clinical Professor, Department of Obstetrics, Gynecology & Reproductive Sciences, University of California, San Francisco
111. Michaels, David, PhD, MPH, Professor, Department of Environmental and Occupational Health, Milken Institute School of Public Health, The George Washington University
112. Miller, Velvet G., PhD, FAAN, Adjunct Assistant Professor Ret., Obstetrics and Gynecology Department, Indiana University School of Medicine
113. Monahan, John T., JD, Professor, Department of Medicine, Senior Fellow, McCourt School of Public Policy, Senior Lecturer, Georgetown University Law Center,
114. Morello-Frosch, Rachel, PhD, MPH, Professor, Environmental Health Sciences, Community Health Sciences, Department of Environmental Science, Policy and Management, School of Public Health, University of California, Berkeley
115. Morrison, Jill C., JD, LLM, Visiting Professor of Law, Director, Women's Law and Public Policy Fellowship Program, Georgetown University Law Center
116. Murphy, Caitlin, MPP, Research Scientist, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

117. Musumeci, MaryBeth, JD, Associate Teaching Professor, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University
118. Nelson, Hilary, PhD, MPH, FNAP, FCPP, Director, MPH Program; Associate Professor of Biochemistry & Biophysics and Associate Professor of Family Medicine & Community Health, Perelman School of Medicine; Associate Professor of Pathobiology, School of Veterinary Medicine, University of Pennsylvania
119. Nicholas, Lauren Hersch, PhD, MPP, Professor, Department of Medicine, University of Colorado
120. Paltiel, A. David, PhD, Professor of Health Policy and Management, Yale School of Public Health
121. Perreira, Krista M., PhD, Professor, Department of Social Medicine, University of North Carolina School of Medicine
122. Peterson, Mark A., PhD, Professor of Public Policy, Political Science, Health Policy and Management, and Law, Meyer and Renee Luskin School of Public Affairs; Senior Fellow, Center for Health Policy Research, University of California, Los Angeles
123. Pittman, Patricia, PhD, Professor of Health Policy and Management, Director of Health Workforce Research Center, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University
124. Poteat, Tonia, PhD, MPH, PA-C, Ruby L. Wilson Distinguished Professor, Duke University School of Nursing
125. Randall, Vernellia R., JD, MSN, Professor Emerita of Law, University of Dayton School of Law
126. Regenstein, Marsha, PhD, Professor, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University
127. Reiss, Dorit R., PhD, LLB, Professor of Law, James Edgar Hervey Chair in Litigation, UC Law San Francisco
128. Rempe, Shannon, JD, MPH, Program Director, Advancing Public Health and Health Equity in the Courts, Center for Health Policy & Law, Northeastern University
129. Rocco, Philip, PhD, Associate Professor of Political Science, Marquette University
130. Rooke-Ley, Hayden, Assistant Professor, Associate Director, Health Law and Policy Lab, Brown University School of Public Health

131. Rosenbaum, Sara, JD, Professor Emerita, Health Law and Policy, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University
132. Russo, Jennefer, MD, MPH, Associate Clinical Professor, UCLA, Section Chief, Complex Family Planning, Harbor-UCLA Medical Center
133. Satz, Ani B., JD, PhD, Professor of Law and Public Health, Director, Project on Health Law, Policy and Ethics, Affiliated Professor of Business, Senior Faculty Fellow, Center for Ethics, Faculty Fellow, Emory Global Health Initiative, Emory University
134. Sawicki, Nadia N., JD, M. Bioethics, Georgia Reithal Professor of Law, Beazley Chair in Health Law, Beazley Institute for Health Law and Policy, Loyola University Chicago School of Law
135. Schaler-Haynes, Magda, JD, MPH, Professor, Department of Health Policy and Management, Department of Population and Family Health, Mailman School of Public Health, Columbia University
136. Schneider, Andy, JD, Research Professor of the Practice, Center for Children and Families, McCourt School of Public Policy, Georgetown University
137. Schwartz, Jason L., PhD, Associate Professor, Department of Health Policy and Management, Yale School of Public Health
138. Seidman, Dominika, MD, MA, Assistant Professor, Department of Obstetrics, Gynecology & Reproductive Sciences, University of California, San Francisco
139. Seiler, Naomi, JD, Professor, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University
140. Shachar, Carmel, JD, MPH, Assistant Clinical Professor of Law and Faculty Director of the Health Law and Policy Clinic, Center for Health Law and Policy Innovation, Harvard Law School
141. Shafer, Paul, PhD, Associate Professor, Department of Health Law, Policy, and Management, Boston University School of Public Health, Co-Director, Medicaid Policy Lab
142. Sharfstein, Joshua M., MD, Distinguished Professor of the Practice, Department of Health Policy and Management, Johns Hopkins Bloomberg School of Public Health
143. Silverman, Hannah, MPH, Senior Research Associate, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University

144. Sinha, Michael S., MD, JD, MPH, FCLM, Associate Professor of Law, Center for Health Law Studies, Saint Louis University School of Law
145. Skinner, Daniel, PhD, Professor of Health Policy, Department of Social Medicine, Ohio University
146. Skuster, Patty, JD, MPP, Associate Director of Accreditation and Core Teaching Faculty, MPH Program, University of Pennsylvania Perelman School of Medicine
147. Squires, Allison, PhD, RN, FAAN, Professor, Rory Meyers College of Nursing, Research Associate Professor, Grossman School of Medicine, New York University
148. Strasser, Julia, DrPH, MPH, Director, Reproductive Health Workforce & Policy Research Center, Assistant Research Professor, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University
149. Suski, Emily, JD, LLM, MSW, Willoughby Professor of Advocacy and Public Justice & Faculty Director of the Carolina Health Advocacy Medico-Legal Partnership (CHAMPS), Joseph F. Rice School of Law, University of South Carolina
150. Swartz, Katherine, PhD, MS, Professor of Health Policy and Management, Emerita, Harvard T.H. Chan School of Public Health, Harvard University
151. Swartzberg, John, MD, FACP, Emeritus Professor, Division of Infectious Diseases and Vaccinology, Chair, University of California, Berkeley
152. Swenor, Bonnielin, PhD, MPH, Director, Disability Health Research Center, Endowed Professor of Disability Health and Justice, Johns Hopkins University
153. Thompson-Lastad, Ariana, PhD, Associate Professor, Bixby Center for Global Reproductive Health & Department of Family and Community Medicine, University of California, San Francisco
154. Vertinsky, Liza, PhD, JD, Professor of Law, University of Maryland Francis King Carey School of Law
155. Vichare, Anushree, PhD, MBBS, MPH, Assistant Professor, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University
156. Volmar, Karen, JD, MPH, Professor and Associate Chair for Academic Programs, Department of Health Policy and Management, The University of North Carolina at Chapel Hill
157. Waldman, Ronald, MD, MPH, Professor Emeritus of Global Health, Milken Institute School of Public Health, The George Washington University

158. Wallace, Maeve, PhD, MPH, Associate Professor, Department of Health Promotion Sciences, Mel and Enid Zuckerman College of Public Health, University of Arizona
159. Wasserman, Alan G., MD, MACP, Eugene Meyer Emeritus Professor of Medicine, Department of Medicine, School of Medicine and Health Sciences, The George Washington University
160. Watson, Sidney D., JD, Jane and Bruce Robert Professor of Law and Scholar in Residence, Center for Health Law Studies, Saint Louis University School of Law
161. Westmoreland, Timothy M., JD, Professor from Practice, Emeritus, Georgetown University Law Center
162. Wheatley, Catherine, MD, FACOG, Associate Professor of Obstetrics and Gynecology, Obstetrics and Gynecology Residency Program Director, Department of Obstetrics and Gynecology, College of Medicine, University of Illinois Chicago
163. Winch, Peter, MD, MPH, Professor, Social and Behavioral Intervention Program, Department of International Health, Johns Hopkins Bloomberg School of Public Health
164. Wisner, Katherine L., MD, MS, DLFAPA, Professor of Psychiatry and Pediatrics, Developing Brain Institute, Children's National Hospital, Professor of Obstetrics and Gynecology, School of Medicine and Health Sciences, The George Washington University
165. Wynia, Matthew, MD, MPH, FACP, Professor, University of Colorado School of Medicine and Colorado School of Public Health, Director, Center for Bioethics and Humanities, University of Colorado Anschutz Medical Campus
166. Yang, Y. Tony, DSc, LL.M, MPH, Endowed Professor of Health Policy, The George Washington University
167. Young, Heather A., PhD, MPH, Vice Chair and Professor, Department of Epidemiology, Milken Institute School of Public Health, The George Washington University