

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND
Northern Division

SONYA TAYLOR, *et al.*,

Plaintiffs,

v.

ROBERT F. KENNEDY, JR., *et al.*,

Defendants.

Civ. Action No. 1:26-cv-03705-GLR

BRIEF OF *AMICI CURIAE* AMERICAN CANCER SOCIETY CANCER ACTION
NETWORK AND THIRTY-ONE ADDITIONAL ORGANIZATIONS IN SUPPORT OF
PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

AMERICAN CANCER SOCIETY
CANCER ACTION NETWORK
MARY ROUVELAS (*pro hac vice* pending)
AMERICAN CANCER SOCIETY
CANCER ACTION NETWORK
655 15th Street NW, Suite 503
Washington, DC 20005

*Attorney for the American Cancer Society
Cancer Action Network*

MORRISON & FOERSTER LLP
BRADLEY S. LUI (D. Md. Bar No. 30803)
JOSEPH R. PALMORE (*pro hac vice* pending)
MORRISON & FOERSTER LLP
2100 L Street NW, Suite 900
Washington, DC 20037
Telephone: (202) 887-8766
Facsimile: (202) 785-7574
BLui@mofo.com

HANNAH VESTER (*pro hac vice* pending)
MORRISON & FOERSTER LLP
250 West 55th Street
New York, NY 10019

Attorneys for Amici Curiae

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INTRODUCTION AND INTEREST OF *AMICI*

Since 1965, Congress has guaranteed critical medical assistance to low-income people with chronic and disabling conditions through the Medicaid program. *See* 42 U.S.C. § 1396-1. Medicaid has dramatically increased the resources available to these individuals for medical care, leading to improved access to treatment and ultimately better health outcomes for covered individuals.

In the One Big Beautiful Bill Act, Congress amended the Medicaid program by adding a work requirement for certain individuals eligible for Medicaid through the Affordable Care Act's Medicaid expansion. *Id.* § 1396a(xx) (amended by Pub. L. No. 119-21, § 71119, 139 Stat. 72, 306 (2025)). Congress, however, was careful to categorically exclude from this work requirement “medically frail” individuals and those with “special medical needs.” *Id.* § 1396a(xx)(9)(A)(ii)(V). The U.S. Department of Health and Human Services Interim Final Rule (“the Rule”) would unlawfully undo much of that mandated exclusion. In particular, the Rule would remove “medically frail” individuals from Medicaid unless they can show not just that they are “medically frail,” but also that their health condition “significantly impairs” their ability to meet the work requirement. 42 C.F.R. § 435.554(c)(5)(i).

The Rule improperly burdens individuals with “serious or complex medical condition[s],” 42 U.S.C. § 1396a(xx)(9)(A)(ii)(V), by erecting roadblocks between them and a work-requirement exclusion Congress provided. And, as *amici* explain, Congress excluded such individuals for good reason: people with serious or complex health conditions experience routine disruptions to their ability to work, making case-by-case evaluation unnecessary.

The upshot of the Rule will be loss of coverage for seriously ill Medicaid recipients. Indeed, many Medicaid recipients who unquestionably cannot work under any standard will

nonetheless lose coverage due to their inability to submit the paperwork required to meet the Rule's bureaucratic and confusing requirements.

Amici have a strong interest in avoiding that outcome and protecting Medicaid recipients from losing coverage. *Amici*, the 32 organizations listed in the appendix, are all non-profit organizations whose work is focused on promoting better outcomes for individuals with a variety of health-related needs. Protecting access to healthcare is critical to achieving that goal.

I. MEDICAID COVERAGE CRITICALLY AFFECTS HEALTH OUTCOMES

As of June 2026, 66 million individuals in the United States were enrolled in Medicaid. Ctrs. for Medicare & Medicaid Servs., *June 2026: Medicaid and CHIP Eligibility Operations and Enrollment Snapshot* (Sep. 25, 2026).¹ Around 20 million of those people were enrolled through the Affordable Care Act's Medicaid expansion. KFF, *Medicaid Expansion Enrollment* (last visited Oct. 22, 2026).²

Research into the effects of Medicaid is highly consistent: Medicaid has improved access to and use of medical services. A meta-review of over 600 studies conducted between 2014 and 2021 concluded that Medicaid expansion led to coverage gains and improvements in access to care. Madeline Guth et al., *The Effects of Medicaid Expansion Under the ACA: Studies from January 2014 to January 2020*, KFF (Mar. 17, 2020);³ Madeline Guth & Meghana Ammula, *Building on the Evidence Base: Studies on the Effects of Medicaid Expansion, February 2020 to*

¹ <https://www.medicaid.gov/resources-for-states/downloads/eligib-oper-and-enrol-snap-jun2026.pdf> [<https://perma.cc/2NUM-JM7Q>].

² <https://www.kff.org/medicaid/state-indicator/medicaid-expansion-enrollment/> [<https://perma.cc/3L6D-HLXD>].

³ <https://www.kff.org/report-section/the-effects-of-medicicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-report/> [<https://perma.cc/8S38-ZSPC>].

March 2021, KFF (May 6, 2021);⁴ see also U.S. Dep’t of Health & Hum. Servs., *Health Coverage Under the Affordable Care Act: Current Enrollment Trends and State Estimates* (Mar. 22, 2024).⁵ Among low-income parents, for example, Medicaid expansion increased insurance coverage by 13.4 percent and reduced cost-related barriers to care by 11.3 percent. Elena Andreyeva et al., *Examining the Impact of ACA Medicaid Expansion on Insurance Coverage, Access to Care and Health of Low-Income Parents*, 60 Health Servs. Rsch. (Oct. 2025).

Studies of states that have expanded Medicaid availability have found that coverage gains are especially pronounced among high-risk populations, such as those with cancer and other serious illnesses. See Guth et al., *supra*, at 5-6. In fact, socioeconomic disparities in health coverage among cancer patients have been nearly eliminated in states that expanded Medicaid coverage following the Affordable Care Act. Xuesong Han et al., *Comparison of Insurance Status and Diagnosis Stage Among Patients with Newly Diagnosed Cancer Before vs After Implementation of the Patient Protection and Affordable Care Act*, 4 JAMA Oncol. 1713 (Dec. 2018).

Increased health coverage through Medicaid has, in turn, improved access to and utilization of health services. Researchers studying the effects of Medicaid expansion under the Affordable Care Act found that Medicaid expansion is associated with “significant improvements” in access to care, including primary care, medications, preventive visits, screening tests, and self-reported health. Benjamin D. Sommers et al., *Three-Year Impacts of the Affordable Care Act: Improved*

⁴ <https://www.kff.org/report-section/building-on-the-evidence-base-studies-on-the-effects-of-medicaid-expansion-february-2020-to-march-2021-report/> [<https://perma.cc/KZ4F-LKEA>].

⁵ <https://aspe.hhs.gov/sites/default/files/documents/b07715d223280dc544cf26fcd19040fb/aspe-health-coverage-under-aca.pdf> [<https://perma.cc/CMG6-WKY8>].

Medical Care and Health Among Low-Income Adults, 36 Health Affs. 1119, 1124 (June 2017); *see also* Guth et al., *supra*, at 8-9. Research evaluating the effects of Medicaid coverage on health access prior to Medicaid expansion confirms these results. As compared with uninsured individuals, for example, individuals enrolled in Medicaid are more likely to regularly utilize outpatient care and to receive prescription medication. *See, e.g.*, Andrea S. Christopher et al., *Access to Care and Chronic Disease Outcomes Among Medicaid-Insured Persons Versus the Uninsured*, 106 Am. J. Pub. Health 63 (Jan. 2016) (individuals enrolled in Medicaid are more likely to have at least one outpatient physician visit annually); Katherine Baicker & Amy Finkelstein, *The Effects of Medicaid Coverage-Learning from the Oregon Experiment*, 365 NEJM 683 (July 2011) (Medicaid coverage raises the probability of using outpatient care by 35 percent and the probability of receiving prescription drugs by 15 percent).

Additional research confirms the critical importance of Medicaid availability for the early detection and timely treatment of serious illnesses. *See* Guth et al., *supra*, at 8-9. One reason for this is that increased Medicaid availability improves access to preventive and screening services, which are critical to detecting serious illnesses, such as cancer, at a time when treatment can be most effective. *See, e.g.*, Stacey A. Fedewa et al., *Changes in Breast and Colorectal Cancer Screening After Medicaid Expansion Under the Affordable Care Act*, 57 Am. J. Prev. Med. 3 (July 2019); *see also, e.g.*, Yoshiko Toyoda et al., *Affordable Care Act State-Specific Medicaid Expansion: Impact on Health Insurance Coverage and Breast Cancer Screening Rate*, 230 J. Am. Coll. Surg. 775 (May 2020) (Medicaid expansion states saw greater improvement in breast cancer screening rates among lower-income women as compared with non-expansion states); Nicolas Ajkay et al., *Early Impact of Medicaid Expansion and Quality of Breast Cancer Care in Kentucky*,

226 J. Am. Coll. Surg. 498 (Apr. 2018) (Medicaid expansion in Kentucky led to a higher incidence of early detection and treatment of breast cancer).

Medicaid is also vital for patients who have received a potentially life-threatening diagnosis because it improves access to timely and critical care. Medicaid expansion, for example, has been shown to facilitate access to medically recommended care for patients with a particularly aggressive type of breast cancer. Kewei Sylvia Shi et al., *Association of Medicaid Expansion with Timely Receipt of Treatment and Survival Among Patients with HR-Negative, HER2-Positive Breast Cancer*, 22 J. Nat'l Compr. Canc. Netw. 593 (Oct. 2024). Similar results have been found for patients newly diagnosed with non-small cell lung cancer. Jingxuan Zhao et al., *Medicaid Expansion and Stage at Diagnosis, Timely Initiation and Receipt of Guideline-Concordant Treatment, and Survival Among People with Non-Small Cell Lung Cancer*, 44 J. Clinical Oncol. 1296 (May 2026); *see also, e.g.*, Xuesong Han et al., *Medicaid Expansion Associated with Increase in Palliative Care for People with Advanced-Stage Cancers*, 42 Health Affs. 956 (July 2023) (Medicaid expansion associated with increased access to guideline-based palliative care for people with advanced cancers).

Finally, increased access to healthcare through Medicaid has improved health outcomes, particularly for patients with serious, life-threatening diseases. *See* Guth et al., *supra*, at 10-11; Guth & Ammula, *supra*, at 5-6. Multiple studies link Medicaid expansion to an overall decrease in mortality rates. *See, e.g.*, Mark Borgschulte & Jacob Vogler, *Did the ACA Medicaid Expansion Save Lives?*, 72 J. Health Econ. (July 2020); Sarah Miller et al., *Medicaid and Mortality: New Evidence from Linked Survey and Administrative Data*, 136 Q.J. Econ. 1783 (2021) (older adults in Medicaid expansion states experienced a substantial reduction in mortality compared to similar adults in non-expansion states). Additional research has likewise linked Medicaid expansion to

improved survival rates for individuals with specific health conditions. In particular, ample research demonstrates the positive impact Medicaid expansion has had on cancer survival rates for individuals with cancers in both early and late stages. *See, e.g.,* Jingxuan Zhao et al., *Association of State Medicaid Income Eligibility Limits and Long Term Survival After Cancer Diagnosis in the United States*, 18 JCO Oncol. Prac. (June 2022); Xuesong Han et al., *Association Between Medicaid Expansion Under the Affordable Care Act and Survival Among Newly Diagnosed Cancer Patients*, 114 J. Nat'l Canc. Inst. 1176 (Aug. 2022); Xu Ji et al., *Survival in Young Adults with Cancer Is Associated with Medicaid Expansion Through the Affordable Care Act*, 41 J. Clinical Oncol. 1909 (2023). These salutary effects extend even beyond the core Medicaid population to older adults who are dual-eligible for Medicare. *See* Kewei Sylvia Shi et al., *Spillover Effects of Medicaid Expansion on Insurance Coverage, Diagnosis, and Survival Among Low-Income Older Patients with Cancer*, 24 J. Nat'l Compr. Canc. Netw. 1522 (Sep. 2026).

By contrast, disruptions in Medicaid coverage, even for short periods of time, can undo these benefits, leading to devastating effects, particularly for patients with serious illness. *See* Sarah Sugar et al., U.S. Dep't of Health & Hum. Servs., *Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic* (Apr. 12, 2021)⁶ (disruptions in Medicaid coverage led to delays in care, less preventive care, decreased use of prescription medication, and increased hospitalizations). For example, interruptions in treatment can put individuals with cystic fibrosis—a genetic disease that can lead to life-threatening infections to the lungs and digestive systems—at risk of precipitous clinical decline and hospitalization. Aaron T. Trimble & Scott H. Donaldson, *Ivacaftor Withdrawal Syndrome in*

⁶ <https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf> [<https://perma.cc/UZ25-M9AC>].

Cystic Fibrosis Patients with the G551D Mutation, 17 J. Cystic Fibrosis (Mar. 2018). Similarly, a recent analysis of more than 24,000 individuals in the Cystic Fibrosis Foundation Patient Registry found that those with at least one gap in care of twelve months or more had significantly worse lung function at subsequent visits compared to those without such gaps. Edmund H. Sears, Jr. et al., *Gaps in Cystic Fibrosis Care Are Associated with Reduced Lung Function in the U.S. Cystic Fibrosis Foundation Patient Registry*, 20 Ann. Am. Thorac. Soc’y 1250 (Sep. 2023). These findings underscore that gaps in care are not merely administrative events; they can have measurable clinical consequences for people with cystic fibrosis and other serious illnesses.

Gaps in insurance coverage also put increased financial pressure on the healthcare system overall. Continuous coverage is essential to managing many chronic conditions. For diabetes, for example, interruptions in care can cause increasing reliance on higher-intensity therapies, which in turn cost Medicaid billions of dollars annually, primarily driven by expensive hospitalizations and other complications. See American Diabetes Association, Comment Letter on Community Engagement Requirement for Certain Individuals Interim Final Rule 5 (July 31, 2026).⁷ As a result, policies that increase the risk of coverage loss and administrative churn threaten not only access to care, but also long-term health outcomes for patients and the financial stability of the healthcare system.

⁷ <https://www.regulations.gov/comment/CMS-2026-2047-41361>.

II. THE INTERIM FINAL RULE IMPROPERLY BURDENS PATIENTS THAT CONGRESS INTENDED TO EXCLUDE FROM THE MEDICAID WORK REQUIREMENT

A. The Definition Of Medical Frailty Adopted By The Interim Final Rule Improperly Narrows The Work Requirement Exclusion For Medically Frail Individuals

When Congress adopted the new work requirement for Medicaid expansion enrollees, it chose to exclude certain vulnerable populations. To this end, Congress expressly excluded from the work requirement any individual “who is medically frail or otherwise has special medical needs.” 42 U.S.C. § 1396a(xx)(9)(A)(ii)(V). Congress defined “medically frail” individuals to include, among other things, those “with a serious or complex medical condition.” *Id.* Such individuals are “specified excluded individual[s],” and the work requirement does not apply to them. *Id.* § 1396a(xx)(1), (9)(A)(i) (making “community engagement” a condition of Medicaid eligibility for individuals other than “specified excluded individual[s]”).

The Rule, however, disregards Congress’s intent and improperly narrows the definition of medical frailty. Rather than exclude such individuals as a group, the Rule imposes the extra-textual requirement that “medically frail” individuals show that their condition “significantly impairs” their ability to comply with the work requirement. 42 C.F.R. § 435.554(c)(5)(i). This additional limitation has no basis in the statute, which does not require individuals with a “serious or complex medical condition”—or any of the other congressionally specified diagnoses—to make any additional showing of hardship. To the contrary, the statute explicitly excludes such individuals based on their diagnosis alone.

B. This Improperly Narrow Definition Of Medical Frailty Imposes A Serious Burden On Vulnerable Patients That Congress Intended To Protect

This improperly narrowed definition of medical frailty imposes a serious burden on the very vulnerable patients that Congress wanted to protect. When passing the bill, members of

Congress emphasized that it would “not take Medicaid away from . . . the medically frail,” 171 Cong. Rec. S4054 (daily ed. June 30, 2025) (statement of Sen. Crapo), and that “these work requirements apply only to able-bodied adults . . . who don’t have a disqualifying condition,” 171 Cong. Rec. H3048 (daily ed. July 2, 2025) (statement of Rep. Foxx). Congress recognized that many individuals with serious or complex medical conditions are unable to work or require significant modifications to their work due to their illness or to its treatment. By passing a categorical exclusion, Congress chose to exclude this group of patients from the work requirement altogether, rather than make them separately prove an inability to work.

Congress’s adoption of a categorical exclusion for those with serious and complex medical conditions was empirically sound. For example, research shows that between 40 and 85 percent of individuals in cancer treatment stop working, with work absences ranging from 45 days to six months depending on the treatment. Angela G.E.M. de Boer et al., *Cancer Survivors and Unemployment: A Meta-analysis and Meta-regression*, 301 JAMA 753 (Feb. 2009). A recent survey of cancer patients and survivors conducted by *amicus* American Cancer Society Cancer Action Network (“ACS CAN”) produced similar results. Of those surveyed, an overwhelming majority (90%) reported that cancer treatment required them to miss work, school, or volunteering. Nearly three-quarters (72%) had to miss over a month of work or other activities; 42 percent had to miss thirteen weeks or more. *Survivor Views: Most Cancer Patients Would Not Be Able to Meet Work Requirements*, Am. Cancer Soc’y Cancer Action Network (July 2026) [hereinafter ACS CAN, *Survivor Views*].⁸

⁸ https://www.fightcancer.org/sites/default/files/national_documents/medicaid_work_req_survey_jul26.pdf [<https://perma.cc/Y5U5-G6GQ>].

Work disruptions are not limited to patients in active treatment for cancer. An individual's ability to work their normal hours or their normal job can be disrupted even before they have received a formal diagnosis. The process of reaching a diagnosis—whether for cancer or another serious or complex medical condition—is often urgent and time-consuming. It can involve multiple scans and procedures, including surgical procedures, as well as meetings with clinicians to discuss results and possible treatment plans.

Similarly, people who are beyond the active treatment phase of a serious illness can be left with long-term challenges to their ability to work. Cancer survivors, for example, can experience long-term work disruptions either due to the effects of the cancer or to the toxicity of its treatment. *See, e.g.,* Pamela Farley Short et al., *Employment Pathways in a Large Cohort of Adult Cancer Survivors*, 103 *Canc.* 1292 (Mar. 2005). This can include both physical and cognitive difficulties, as well as other related long-term medical conditions that require ongoing medical care and treatment. Recent cancer survivors will also often require frequent medical follow-up visits, and some patients will require indefinite active treatment, which can impact their ability to work for years after their diagnosis. Indeed, nearly a third of those surveyed by ACS CAN reported that disruptions to their ability to work continued after active cancer treatment was complete and into survivorship. ACS CAN, *Survivor Views*.

Because the work disruptions caused by complex medical conditions can be inconsistent and unpredictable, patients may struggle to meet the “significantly impairs” standard adopted by the Rule notwithstanding the burdens detailed above. For example, a seriously ill individual may be deemed able to work during the (re)verification period, but their disease may progress or they may experience sudden side effects, infections, or acute complications making it impossible to comply with the work requirement in a future period. Illustrating this point, over two-thirds (68%)

of respondents to the ACS CAN survey who reported being able to continue doing some work while in cancer treatment also reported that their ability to work fluctuated. Twenty-five percent reported that their ability to work changed month-by-month; 23 percent said it changed week-by-week; and 20 percent said it varied day-by-day. ACS CAN, *Survivor Views*.

Such fluctuations in a person's ability to work are not limited to cancer patients. Individuals with other serious or complex medical conditions often experience changes in the severity of the effects of their conditions. This is especially true of medical conditions that are, for many people, episodic in nature, such as cystic fibrosis, diabetes, lupus, or epilepsy. In fact, epilepsy is, in part, *defined* by its fluctuations: the approximately 1-in-26 Americans who develop the condition in their lifetimes experience seizures—sudden, abnormal bursts of electrical activity in the brain that can disrupt behavior, awareness, and bodily control. See Epilepsy Foundation of America, Comment Letter on Community Engagement Requirement for Certain Individuals Interim Final Rule 1-2 (July 31, 2026).⁹ These fluctuations in a person's condition can result in changes to that person's ability to meet the work requirement over time—changes that the Rule does not account for.

The variable course of many serious or complex medical conditions and their treatments is the very reason that Congress adopted a categorical exclusion from the work requirement for medically frail individuals. The Rule, however, disregards that intention at the expense of the very people Congress set out to protect.

⁹ <https://www.regulations.gov/comment/CMS-2026-2047-42575>.

III. BUREAUCRATIC BARRIERS AND PATIENT CONFUSION FLOWING FROM THE INTERIM FINAL RULE WILL RESULT IN COVERAGE LOSSES

The Rule's extra-textual definition of medical frailty also burdens vulnerable patients by imposing additional bureaucratic barriers and increasing the likelihood that medically frail individuals will lose Medicaid coverage. This includes those who unquestionably cannot work. Under the Rule's "significantly impairs" standard, it is not enough for a patient to provide proof of a diagnosis. That patient must provide separate documentation, not contemplated by the statute, proving that their diagnosis "significantly impairs" their ability to comply with the work requirement. 42 C.F.R. § 435.554(c)(5)(i).

This adds unnecessary and onerous red tape for patients in desperate need of health coverage and needlessly complicates the eligibility verification process. Many people undergoing cancer treatment or treatment for another serious illness are likely to struggle to satisfy the additional paperwork requirement, given the already-significant demands placed on them by their health condition and treatment. Eighty-one percent of surveyed cancer patients, for example, report feeling overwhelmed by the many tasks essential to their survival, and three-quarters report that cancer symptoms and the side effects of treatment make tasks like submitting paperwork very challenging. Surveyed patients also report struggling with keeping track of important tasks (50%) and paperwork (41%), placing phone calls to doctor's offices and insurance providers (35%), regularly checking and processing email (31%), and meeting administrative deadlines (29%). *See ACS CAN, Survivor Views.*

The additional documentation required by the Rule will also place a significant burden on patient care providers, which may further complicate patients' ability to obtain the necessary documentation. The Rule's "significantly impairs" standard requires providers to make a determination outside the typical scope of medical diagnosis and treatment. This threatens to

further burden already severely overburdened clinicians and will force doctors to spend precious clinical hours filling out non-clinical compliance paperwork instead of engaging in face-to-face patient care.

The opaque and non-medical nature of the “significantly impairs” standard will also pose an impediment to many patients who may struggle to understand how the new work requirements apply to them. Indeed, in qualitative research conducted with Medicaid enrollees in 2026, CMS itself noted that many could not determine if they qualified for an exclusion from the work requirement under the new law. Ctrs. for Medicare & Medicaid Servs., *Medicaid Community Engagement Requirements: Qualitative Research Communication Summary* (2026).¹⁰

These additional administrative burdens will lead to a loss in coverage. Numerous studies have shown that increasing required paperwork dramatically increases the likelihood of procedural denials in Medicaid coverage. After Arkansas and New Hampshire imposed work requirements as part of their Medicaid programs, for example, many people lost or were poised to lose Medicaid coverage, including individuals who were actually working or who should have been exempt from the work requirements. See MaryBeth Musumeci, *Disability and Technical Issues Were Key Barriers to Meeting Arkansas’ Medicaid Work and Reporting Requirements in 2018*, KFF (June 11, 2019);¹¹ Ian Hill et al., *New Hampshire’s Experiences with Medicaid Work Requirements: New Strategies, Similar Results*, Urban Inst. (Feb. 10, 2020);¹² see also, e.g., Leah

¹⁰ <https://www.medicaid.gov/resources-for-states/working-families-tax-cut-legislation/community-engagement/resources/Community-Engagement-messaging.pdf> [https://perma.cc/5D3Y-WMG8].

¹¹ <https://www.kff.org/medicaid/disability-and-technical-issues-were-key-barriers-to-meeting-arkansas-medicaid-work-and-reporting-requirements-in-2018> [https://perma.cc/2W7S-LCEE].

¹² <https://www.urban.org/research/publication/new-hampshires-experiences-medicaid-work-requirements-new-strategies-similar-results> [https://perma.cc/P9HJ-ZGSG].

Chan, *Pathways to Coverage: Looking Back Two Years and into the Future*, Ga. Budget & Pol’y Inst. (Oct. 13, 2025) (concluding that paperwork was a major reason for coverage loss after Georgia imposed Medicaid work requirement).¹³ Similarly, a 2020 study of three states that had implemented or were about to implement Medicaid work requirements concluded that the introduction of additional red tape posed a significant risk of coverage loss even for individuals who were working and for those with serious health needs who were eligible for an exception under those states’ rules. Jennifer Wagner & Jessica Schubel, *States’ Experiences Confirm Harmful Effects of Medicaid Work Requirements*, Ctr. on Budget & Pol’y Priorities (Nov. 18, 2020).¹⁴ The Rule’s medical frailty definition similarly introduces additional red tape into the evaluation of Medicaid eligibility for individuals with serious or complex medical conditions and threatens to deprive vulnerable patients of coverage based on procedural reasons alone.

Indeed, independent experts have predicted that the Rule will lead to staggering losses in medical coverage. See Patricia M. Boozang et al., *CMS’ Medicaid Work Requirements Rule: A 50-State Analysis of Additional Coverage Losses, FFY 2027-2034*, Manatt (July 16, 2026) (predicting that 1.8 million people will lose Medicaid coverage annually as a result of the Rule);¹⁵ see also, e.g., Am. Diabetes Ass’n, *Impact of Recent Medicaid and Affordable Care Act Policy Changes on Health Insurance Coverage and Cost-Sharing for Americans with Diabetes* (July 2026) (changes to Medicaid enacted by the One Big Beautiful Bill Act, including as a result of the

¹³ <https://gbpi.org/pathways-to-coverage-looking-back-two-years-and-into-the-future> [<https://perma.cc/JH5V-5AD7>].

¹⁴ <https://www.cbpp.org/research/health/states-experiences-confirm-harmful-effects-of-medicaid-work-requirements> [<https://perma.cc/KTT6-WABH>].

¹⁵ <https://www.manatt.com/insights/white-papers/2026/cms-medicaid-work-requirements-rule-a-50-state-analysis-of-additional-coverage-losses-ffy-2027-2034> [<https://perma.cc/9TZQ-C7A2>].

new work requirement, will result in the loss of healthcare coverage for nearly 500,000 Medicaid beneficiaries with diabetes).¹⁶ The impact of a loss in coverage, especially for patients with life-threatening diseases, is significant. Patients with serious conditions who rely on Medicaid will either have to forgo lifesaving treatment or take on significant debt to receive it. Even short gaps in coverage can put patients at serious risk. This upends Medicaid's benefits and undermines Congress's purpose in excluding such individuals from the new work requirement.

CONCLUSION

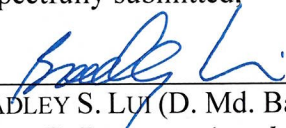
The Court should grant plaintiffs' motion for summary judgment.

Dated: October 27, 2026

MARY ROUVELAS (*pro hac vice* pending)
AMERICAN CANCER SOCIETY
CANCER ACTION NETWORK
655 15th Street NW, Suite 503
Washington, DC 20005

*Attorney for the American Cancer Society
Cancer Action Network*

Respectfully submitted,


BRADLEY S. LUI (D. Md. Bar No. 30803)
JOSEPH R. PALMORE (*pro hac vice* pending)
MORRISON & FOERSTER LLP
2100 L Street NW, Suite 900
Washington, DC 20037
Telephone: (202) 887-8766
Facsimile: (202) 785-7574
BLui@mofo.com

HANNAH VESTER (*pro hac vice* pending)
MORRISON & FOERSTER LLP
250 West 55th Street
New York, NY 10019

Attorneys for Amici Curiae

¹⁶ <https://diabetes.org/sites/default/files/2026-07/Affordable%20Care%20White%20Paper%20FINAL.pdf> [<https://perma.cc/9L3G-RWXQ>].

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND
Northern Division**

SONYA TAYLOR, *et al.*,

Plaintiffs,

v.

ROBERT F. KENNEDY, JR., *et al.*,

Defendants.

Civ. Action No. 1:26-cv-03705-GLR

APPENDIX: LIST OF *AMICI*

<i>Amici</i>	
American Cancer Society Cancer Action Network	Cystic Fibrosis Foundation
American Cancer Society	Disability Rights Education and Defense Fund
Access Ready Inc.	Epilepsy Foundation of America
American Diabetes Association	Judge David L. Bazelon Center for Mental Health Law
American Heart Association	Justice in Aging
American Network of Community Options and Resources	Legal Action Center
American Society of Clinical Oncology	Lupus Foundation of America
Arthritis Foundation	Muscular Dystrophy Association
Autistic Self Advocacy Network	National Academy of Elder Law Attorneys
Autistic Women & Nonbinary Network	National Bleeding Disorders Foundation
Blood Cancer United	National Multiple Sclerosis Society
CancerCare	National Organization for Rare Disorders
Cancer Nation	Southern Poverty Law Center
Cancer Support Community	Susan G. Komen Breast Cancer Foundation
CommunicationFIRST	The AIDS Institute
Crohn's & Colitis Foundation	ZERO Prostate Cancer