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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY

STATE OF NEW JERSEY, Plaintiff, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, Defendant.	**COMPLAINT** Civil Action No.

The State of New Jersey hereby alleges as follows:

NATURE OF THE ACTION

1. On August 17, 2007, the Centers for Medicare & Medicaid Services (CMS), an agency within the United States Department of Health and Human Services (HHS), issued a letter (CMS Letter) which sets forth mandatory, rigid, and illegal benchmarks for state child health plans under the State Children's Health Insurance Program (SCHIP).

2. This is an action by the State of New Jersey seeking (1) a declaratory judgment that the CMS Letter (a) constitutes illegal rulemaking without notice and comment in violation of the

Administrative Procedure Act (APA), 5 U.S.C. § 553, (b) is an arbitrary and capricious exercise of the Secretary's authority in violation of the APA, 5 U.S.C. § 706(2)(A), (c) is an abuse of the Secretary's discretion under Title XXI of the Social Security Act, 42 U.S.C. § 1397aa et seq., and the regulations promulgated thereunder, in violation of the APA, 5 U.S.C. § 706(2)(A), (d) is contrary to Title XXI of the Social Security Act, 42 U.S.C. § 1397aa et seq., and the regulations promulgated thereunder, in violation of the APA, 5 U.S.C. § 706(2)(A), and therefore is without force and effect; and (2) an injunction barring CMS from reviewing New Jersey's state child health plan or plan amendments or pursuing any "corrective action" against New Jersey based upon a failure to meet the benchmarks set forth in the CMS Letter.

3. With approximately 6.6 million children enrolled in SCHIP programs nationwide, SCHIP has significantly reduced the number of children without access to quality medical care. The State of New Jersey provides health coverage to 124,000 previously uninsured, low-income children through its SCHIP program. The SCHIP program has thus enabled states like New Jersey to protect and improve the lives of the country's most vulnerable children.

4. The imposition of the illegal benchmarks set forth in the CMS letter would be devastating to the thousands of innocent children in New Jersey, and nationwide, who would lose or be denied health insurance coverage. New Jersey's SCHIP program has covered

children in families up to 350 percent of the federal poverty level since 1999, and has done so with repeated CMS approval. In fact, CMS has approved New Jersey's plan eight times. The CMS Letter is thus a sudden and unfounded reversal of long-standing federal policy and nine years of express federal approval of New Jersey's SCHIP programs and procedures. This reversal would eviscerate New Jersey's health insurance programs and result in the denial of coverage to thousands of children.

JURISDICTION AND VENUE

5. This action arises under Title XXI of the Social Security Act, 42 U.S.C. §§ 1397aa-jj; the Declaratory Judgment Act, 28 U.S.C. §§ 2201 and 2202; and the APA, 5 U.S.C. § 501-503, § 701 et seq. This Court has jurisdiction pursuant to 28 U.S.C. §§ 1331 and 1346(a)(2). Venue is proper pursuant to 28 U.S.C. § 1391(e).

PARTIES

6. Plaintiff, the State of New Jersey, through its Department of Human Services (DHS), operates NJ FamilyCare, which is New Jersey's SCHIP participating health insurance plan.

7. Defendant HHS is an executive branch agency of the United States of America. HHS, through CMS, is the federal agency responsible for administering SCHIP, which is authorized by Title XXI of the Social Security Act, 42 U.S.C. §§ 1397aa et seq.

STATEMENT OF FACTS

THE SCHIP PROGRAM

8. Enacted as Title XXI of the Social Security Act, SCHIP provides federal funding to states for the expansion of health insurance programs to uninsured children in families with incomes above Medicaid eligibility levels that are nonetheless unable to obtain or afford private coverage for their children.

9. Created in 1997, SCHIP is the largest federal expansion of health insurance coverage since the passage of Medicaid in 1965 and has significantly reduced the number of low-income children who are uninsured.

10. All states, territories, and the District of Columbia have established SCHIP programs. Approximately 6.6 million children are enrolled in SCHIP participating programs nationwide.

11. Like Medicaid, SCHIP is a partnership between the federal government and the states whereby states administer their individual SCHIP programs within the scope of broad federal guidelines, and the federal government matches state spending for SCHIP-eligible children. Under this program, the federal government makes matching funds available to states with approved SCHIP plans through capped allotments, based on a formula that takes into account the number of low-income children per state.

12. CMS has regulatory oversight of all state SCHIP

programs, activities and expenditures. 42 C.F.R. §§ 457.40, 457.50 and 457.60.

13. To be eligible for SCHIP funds under the program, each state must submit a child health plan to CMS, which it approves or disapproves in its entirety. 42 C.F.R. §§ 457.40(a), 457.50, 457.150(a). At any time subsequent to the approval of its state child health plan, a state may submit a plan amendment to amend the plan in whole or in part. 42 C.F.R. § 457.60.

14. While the state plans must be approved by CMS, the program was designed with bipartisan support to provide states with the tools and flexibility to address the distinct needs of each state's population.

15. The SCHIP statute and implementing regulations allow states broad flexibility in using SCHIP funds to provide health coverage to low-income children. The implementing regulations state that "[w]ithin *broad* federal rules, *each State decides* eligible groups, types and ranges of services, payment levels for benefit coverage, and administrative and operating procedures." 42 C.F.R. § 457.1 (emphasis added).

16. States are permitted to establish income eligibility thresholds in their SCHIP programs at 200 percent of the federal poverty level (FPL) or 50 percentage points above their existing Medicaid eligibility levels in 1997, the year SCHIP was enacted. 42 U.S.C. § 1397jj(b)(1).

17. The SCHIP statute gives the states broad discretion in determining how income is calculated. Under 42 U.S.C. § 1397bb(b), states may establish their own eligibility rules including those relating to income and resources. Nothing in the SCHIP statute or regulations limits the states' authority to decide how to calculate income.

18. The latitude granted to each state under Title XXI and its implementing regulations allows each state to incorporate cost of living and other factors that can affect a family's ability to afford health insurance for its children into its eligibility rules.

19. Numerous states operate plans with income eligibility thresholds above 200 percent of the FPL. These states have adopted SCHIP plans that are in accordance with the flexible income provisions afforded states under the statute and regulations and operate their SCHIP programs pursuant to state plans that have been approved by CMS.

20. Under SCHIP, state child health plans are required to include procedures intended to minimize the possibility that SCHIP insurance coverage will substitute for or "crowd-out" private health insurance coverage available under group health plans. Forty two C.F.R. § 457.805 requires that a state child health plan include "reasonable procedures to ensure that health benefits coverage provided under the State plan does not substitute for

coverage provided under group health plans."

21. Neither the SCHIP statute nor the regulations promulgated thereunder require specific crowd-out strategies. In fact, in promulgating the SCHIP's regulations, HHS specifically "opted not to propose specific procedures to limit substitution." 66 FR 2490. HHS stated that, "States have broad discretion to develop substitution prevention policies that best serve their particular populations." 66 FR 2490.

22. The states' child health plans include a variety of "reasonable procedures" to prevent substitution of coverage, each of which has been approved by CMS.

NEW JERSEY'S SCHIP PROGRAM: NJ FAMILYCARE

23. The State of New Jersey currently provides coverage to nearly 124,000 previously uninsured, low-income children through its SCHIP program, which is called NJ FamilyCare.

24. NJ FamilyCare provides coverage to uninsured children in families that are not otherwise eligible for Medicaid with gross incomes at or below 350 percent of the FPL.

25. New Jersey's initial State Plan was approved by CMS in February 1998 and originally included three separate insurance plans funded through SCHIP: (1) NJ FamilyCare Plan A, which covers children in families with gross incomes below 133 percent of the FPL; (2) NJ FamilyCare Plan B, which covers children in families with gross incomes between 133 percent and 150 percent of the FPL;

and (3) NJ FamilyCare Plan C, which covers children in families with gross incomes between 150 and 200 percent of the FPL.

26. On August 3, 1999, CMS approved New Jersey's second amendment to its State Plan to include NJ FamilyCare Plan D, which expanded coverage to uninsured children in families with gross incomes between 200 and 350 percent of the FPL.

27. In expanding NJ FamilyCare to 350 percent of the FPL, New Jersey was able to take into account the higher cost of living in New Jersey and to address the distinct needs of the state.

28. With repeated CMS approval, New Jersey has adopted various strategies to prevent crowd-out, including a period of uninsurance and the imposition of cost-sharing on participants in Plans C and D. In accordance with federal regulations and CMS policy, New Jersey has also agreed to verify that applicants lack access to private insurance and to monitor the crowd-out effect of providing insurance to participants in Plan D.

29. Thus, in approving New Jersey's plan amendments, CMS has expressly found that New Jersey's state plan included "reasonable procedures" to prevent crowd-out in accordance with federal law.

30. CMS has approved New Jersey's state plan eight times.

NJ FamilyCare's Uninsurance Period

31. New Jersey's initial State Plan, approved in February 1998, required that applicants be uninsured for a 12-month period in order to be eligible for enrollment in NJ FamilyCare.

32. Shortly after plan implementation, however, DHS conducted an analysis of demographic data which indicated that the State could shorten the waiting period without "crowding-out" other privately provided health insurance coverage. DHS estimated that an additional 6,500 children who had been uninsured for more than six -- but less than twelve -- months could be covered without triggering any crowd-out effect. CMS approved this reduction.

33. In May 2005, New Jersey proposed an amendment to further reduce the period of uninsurance from six to three months. In approving this amendment, CMS asked the State to demonstrate how it would monitor and address substitution of private coverage by families eligible for NJ FamilyCare Plan D. In response, the State committed to performing file reviews to monitor the levels of substitution by applicants, and to return the waiting period to six months should monitoring reveal that more than ten percent of the applicants were voluntarily dropping coverage. CMS approved this amendment on November 22, 2005.

34. CMS has also repeatedly approved the State's use of certain exceptions to the six and then three-month waiting periods. In July 1999 and again in November 2005, CMS approved exceptions

for circumstances under which: (1) a child becomes ineligible for Medicaid and has no other coverage, (2) a child's prior coverage is lost because a parent's employer ceases operation, or (3) a child's prior coverage is lost because a parent has lost their employment and cannot afford private coverage.

NJ FamilyCare Cost Sharing Requirements

35. Plans C and D of NJ FamilyCare (which cover children in families with gross incomes between 150 and 350 percent of the FPL) require cost-sharing by plan beneficiaries in the form of premiums and co-payments.

36. In Plan C, qualifying families are assessed a single monthly premium, regardless of the number of eligible children in the family or the family's income, and fixed co-payments are assessed for practitioner visits and prescription medications.

37. The Plan D benefits package mirrors a commercial plan whereby families pay a sliding-scale monthly premium depending on gross income, and co-payments in the plan are higher than those in Plan C.

38. For any family subject to cost-sharing, an annual limit equal to five percent of the family income applies, above which no additional cost-sharing is required. To date, no beneficiary has ever reached the cap level.

THE AUGUST 17, 2007 LETTER

39. On August 17, 2007, CMS issued a letter to State

Health Officials, attached hereto as Exhibit A.

40. The CMS Letter requires states that extend eligibility under SCHIP to children in families with "effective family income levels" above 250 percent of the FPL to adopt specific procedures.

41. CMS asserts that the specific procedures mandated by the CMS Letter will prevent substitution of coverage and that they should be considered mandatory under the "reasonable procedures" provision of 42 C.F.R. § 457.805.

42. The CMS Letter imposes specific, rigid benchmarks that a State must meet in order to expand or maintain eligibility under SCHIP above 250 percent of the FPL.

43. The procedures set forth in the CMS Letter are different than those under which New Jersey currently operates, and has operated with full CMS approval, since 1999.

44. The procedures set forth in the CMS Letter are contrary to the statute, regulations and guidance previously promulgated by CMS and utilized by New Jersey and numerous other states in the implementation of their SCHIP participating programs.

New Benchmark Requiring A Twelve-Month Waiting Period

45. The CMS Letter requires states to establish a minimum of a one-year period of uninsurance before a child may enroll in an SCHIP program. The CMS Letter does not allow states to employ any exceptions to this rule.

46. CMS never required New Jersey to establish a minimum of a one-year period of uninsurance. To the contrary, CMS approved New Jersey's State Plan Amendments seeking to reduce its SCHIP waiting period from twelve to six months in May 1999 and from six to three months in November 2005. In addition, CMS also approved the use of exceptions to the uninsurance period in 1999 and 2005.

47. Only two states have adopted twelve-month uninsurance periods. All other states have adopted shorter uninsurance periods, all of which have been approved by CMS. Moreover, all states employ exceptions to the period of uninsurance.

48. CMS has no rational basis for requiring New Jersey to establish a minimum one-year period of uninsurance. Indeed, the application of this new requirement would cause significant hardship as children in families where no insurance was available or affordable would be forced to wait up to a year for coverage.

49. CMS has no rational basis for this sudden and drastic reversal of prior policy, the policy under which New Jersey's state plan was approved for the past nine years.

50. Moreover, this twelve-month uninsurance requirement would contravene the clear intention of the SCHIP statute, which is to allow states flexibility in determining appropriate and "reasonable procedures" for their own state plans.

New Benchmark Regarding Enrollment of Low-Income Children

51. The CMS Letter requires states to assure that a state has enrolled at least 95 percent of the children in the state below 200 percent of the FPL who are eligible for SCHIP or Medicaid in one of the two programs. The 95 percent assurance serves as a precondition for continued expansion above 250 percent of the FPL.

52. When it approved New Jersey's Plan D expansion, CMS did not require New Jersey to assure CMS that it had enrolled at least 95 percent of the children in New Jersey below 200 percent of the FPL who are eligible for SCHIP or Medicaid in one of the State's health insurance programs.

53. In fact, CMS has never required New Jersey to assure that it has enrolled any minimum percentage of the children in New Jersey below 200 percent of the FPL who are eligible for SCHIP or Medicaid.

54. Even under Medicare, which has nearly universal eligibility and automatic enrollment, the participation rate is less than 95 percent.

55. CMS has no rational basis for requiring New Jersey to assure that it has enrolled at least 95 percent of the children in New Jersey below 200 percent of the FPL who are eligible for SCHIP or Medicaid.

56. The imposition of this requirement on NJ FamilyCare would have the practical effect of forcing New Jersey to cease the

operation of NJ FamilyCare Plan D as it would be impossible for New Jersey to make this assurance.

57. CMS has no rational basis for this sudden and drastic reversal of prior policy, the policy under which New Jersey's state plan was approved for the past nine years.

58. Moreover, this assurance would contravene the clear intention of the SCHIP statute, which is to allow states flexibility in establishing their own state plans.

New Benchmark Regarding Program Participant's Eligibility for Private Insurance

59. The CMS Letter requires states to assure that the number of children in the target population insured through private employers has not decreased by more than two percentage points over the prior five-year period.

60. CMS has never required New Jersey to assure that the number of children in the target population insured through private employers has not decreased by more than two percentage points over the prior five-year period.

61. CMS does not provide any explanation as to how this percentage is to be calculated. Moreover, a decline in employer-based coverage may be attributable to a variety of factors.

62. CMS has no rational basis for requiring New Jersey to assure that the number of children in the target population insured through private employers has not decreased by more than two percentage points over the prior five-year period.

63. CMS has no rational basis for this sudden and drastic reversal of prior policy, the policy under which New Jersey's state plan was approved for the past nine years.

64. Moreover, this required assurance would contravene the clear intention of the SCHIP statute, which is to allow states flexibility in determining appropriate and "reasonable procedures" for their own state plans.

New Benchmark Regarding Cost-Sharing Policies

65. The CMS Letter requires that the State Plan not be more favorable than any competing private plan by more than one percent of the family income, unless the public plan's cost sharing is set at the five percent family cap.

66. CMS has never required that New Jersey's State Plan not be more favorable than any competing private plan by more than one percent of family income.

67. In any event, the information needed by New Jersey to meet this requirement would be impossible to obtain, especially in light of the variety of existing and available private plans.

68. The result of the application of this cost-sharing requirement would be to require New Jersey to charge the full five percent of family income to participants in New Jersey's SCHIP program, which the State has never done.

69. The application of the cost-sharing requirement would, furthermore, obviate New Jersey's flexibility in

implementing its SCHIP program, as New Jersey will no longer be able to determine the appropriate level of costs to impose on families enrolled in NJ FamilyCare.

70. CMS provides no rational basis for requiring New Jersey to apply this cost-sharing requirement.

71. CMS has no rational basis for this sudden and drastic reversal of prior policy, the policy under which New Jersey's state plan was approved for the past nine years.

72. Moreover, this cost-sharing requirement would contravene the clear intention of the SCHIP statute, which is to allow states flexibility in determining appropriate and "reasonable procedures" for their own state plans.

COUNT I
VIOLATION OF APA RULEMAKING, 5 U.S.C. § 553

73. The CMS Letter imposes mandatory requirements on states that extend their SCHIP Programs to families with incomes above 250 percent of the FPL. The CMS letter sets forth new rules as defined by the APA, 5 U.S.C. § 551.

74. The requirements contained in the CMS Letter are not interpretive rules, general statements of policy, or rules of agency organization, procedure or practice. 5 U.S.C. § 553(b)(A).

75. The CMS Letter was subject to the rulemaking requirements of the APA. 5 U.S.C. § 553.

76. CMS did not publish a general notice of proposed

rulemaking in the Federal Register, nor did it provide states participating in SCHIP or other interested parties an opportunity to submit comments of any kind.

77. The requirements set forth in the CMS Letter are rules promulgated in violation of the APA's notice and comment provision, 5 U.S.C. § 553, and are thus without force and effect.

COUNT II
ARBITRARY AND CAPRICIOUS, 5 U.S.C. § 706(2)(A)

78. Plaintiff incorporates Paragraphs 1 through 72 as if set forth fully herein.

79. The CMS Letter establishes rigid benchmarks with specific standards.

80. There is no rational basis for the rigid benchmarks established by the CMS Letter.

81. CMS provides no rational basis for requiring New Jersey to establish a minimum of a one-year period of uninsurance for individuals prior to receiving coverage.

82. CMS provides no rational basis for requiring New Jersey to assure that it has enrolled at least 95 percent of the children in New Jersey below 200 percent of the FPL who are eligible for SCHIP or Medicaid as a condition of income expansion.

83. CMS provides no rational basis for requiring New Jersey to assure the number of children in the target population insured through private employers has not decreased by more than two percentage points over the prior five-year period.

84. CMS provides no rational basis for requiring that New Jersey's cost-sharing plan not be more favorable to the public plan by more than one percent of the family income.

85. Because they lack a rational basis, the requirements contained in the CMS Letter are arbitrary and capricious, in violation of the APA, 5 U.S.C. § 706(2)(A).

COUNT III
ABUSE OF DISCRETION, 5 U.S.C. § 706(2)(A)

86. Plaintiff incorporates Paragraphs 1 through 72 as if set forth fully herein.

87. The SCHIP Statute, 42 U.S.C. § 1397aa et seq., and the regulations promulgated thereunder, 42 C.F.R. § 457 et seq., neither compel nor authorize CMS to require a state to establish a minimum of a one-year period of uninsurance for individuals prior to receiving coverage.

88. The SCHIP Statute and regulations neither compel nor authorize CMS to require a State to assure that it has enrolled at least 95 percent of the children in New Jersey below 200 percent of FPL who are eligible for SCHIP or Medicaid.

89. The SCHIP Statute and regulations neither compels nor authorizes CMS to require a State to assure that the number of children in the target population insured through private employers has not decreased by more than two percentage points over the prior five-year period.

90. The SCHIP Statute and regulations neither compel nor

authorize CMS to require that a State plan not be more favorable to the public plan by more than one percent of the family income, unless the public plan's cost-sharing is set at the five percent family cap.

91. In violation of the APA, 5 U.S.C. § 706(2)(A), the requirements set forth in the CMS Letter are an abuse of CMS' discretion and authority in implementing the SCHIP Program.

COUNT IV
ABUSE OF DISCRETION, 5 U.S.C. § 706(2)(A)

92. Plaintiff incorporates paragraphs 1 through 72 as if set forth fully herein.

93. The SCHIP Statute and the regulations implementing the SCHIP Program were designed to provide each state with the flexibility to implement its individual SCHIP Program as best fit the needs of that state and its specific population.

94. The rigid benchmarks established by the CMS Letter are contrary to the Statute and its implementing regulations.

95. Because its rigid benchmarks and standards are contrary to the SCHIP statute and its implementing regulations, the CMS Letter is an abuse of CMS' discretion in implementing the SCHIP Program in violation of the APA, 5 U.S.C. § 706(2)(A).

COUNT V
NOT IN ACCORDANCE WITH LAW, 5 U.S.C. § 706(2)(A)

96. Plaintiff incorporates paragraphs 1 through 72 as if set forth fully herein.

97. The SCHIP Statute and the regulations implementing the SCHIP Program were designed to provide each state with the flexibility to implement its individual SCHIP Program as best fit the needs of that state and its specific population.

98. The rigid benchmarks established by the CMS Letter are contrary to the Statute and its implementing regulations.

99. The CMS Letter constitutes agency action which is contrary to the SCHIP Statute and the regulations implementing the SCHIP Program and therefore is in violation of the APA, 5 U.S.C. § 706(2)(A).

WHEREFORE, Plaintiff State of New Jersey respectfully requests that this court:

1. Issue a declaratory judgment that:

a. The August 17, 2007 letter issued by CMS to State Health Officials constituted rulemaking subject to the public notice and comment requirements of the Administrative Procedure Act, 5 U.S.C. § 553;

b. In issuing the August 17, 2007 letter, CMS failed to comply with the public notice and comment requirements of the Administrative Procedure Act, 5 U.S.C. § 553(b);

c. The August 17, 2007 letter issued by CMS to State Health Officials is invalid under the Administrative Procedure Act and therefore is without force or effect;

d. The rigid and mandatory benchmarks established in the August 17, 2007 letter issued by CMS to State Health Officials have no rational basis;

e. The rigid and mandatory benchmarks established in the August 17, 2007 letter issued by CMS to State Health Officials are arbitrary and capricious and thus in violation of the Administrative Procedure Act, 5 U.S.C. § 706(2)(A);

f. The rigid and mandatory benchmarks established in

the August 17, 2007 letter issued by CMS to State Officials is contrary to Title XXI of the Social Security Act, 42 U.S.C. §§ 1397aa to jj, and thus in violation of the Administrative Procedure Act, 5 U.S.C. § 706(2)(C);

g. The rigid and mandatory benchmarks established in the August 17, 2007 letter issued by CMS to State Officials is contrary to the regulations promulgated under Title XXI of the Social Security Act, 42 C.F.R. § 457;

2. Issue an Order granting injunctive relief precluding CMS from reviewing New Jersey's plan or plan amendment or pursuing any "corrective action" against New Jersey based upon a failure to meet the newly stated benchmarks required by the CMS Letter; and

3. Award any other relief this Court deems appropriate.

Respectfully submitted,

ANNE MILGRAM
ATTORNEY GENERAL OF NEW JERSEY

By: _____
Megan Lewis
Deputy Attorney General

Dated: Trenton, New Jersey
October 1, 2007