UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY
TRENTON VICINIGE

STATE OF NEW JERSEY, Plaintiff, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, Defendant.	:	HON. JOEL A. PISANO Civ. Action No. 07-04698 (JAP) (JJH)

AMICI CURIAE BRIEF OF THE STATES OF CONNECTICUT AND MASSACHUSETTS IN SUPPORT OF PLAINTIFF'S OPPOSITION TO DEFENDANT'S MOTION TO DISMISS AND IN SUPPORT OF PLAINTIFF'S MOTION FOR PARTIAL SUMMARY JUDGMENT

RICHARD BLUMENTHAL
ATTORNEY GENERAL
STATE OF CONNECTICUT

Hugh Barber
Assistant Attorney General
55 Elm Street
P.O. Box 120
Hartford, CT 06141-0120

MARTHA COAKLEY
ATTORNEY GENERAL
COMMONWEALTH OF MASSACHUSETTS

Emily R. Paradise
Quentin A. Palfrey
Assistant Attorneys General
One Ashburton Place
Boston, MA 02108-1598

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The State of Connecticut and the Commonwealth of Massachusetts file this brief amici curiae in opposition to the defendant U.S. Department of Health and Human Services' (HHS) motion to dismiss and in support of plaintiff State of New Jersey's cross-motion for partial summary judgment. The amici states, as administrators of their State Children's Health Insurance Programs (SCHIP), wish to advise the Court of the significant harm that will result from implementation of the August 17, 2007 letter issued by HHS concerning administration of state children's health insurance programs. HHS' letter violates the Administrative Procedure Act and creates onerous, ultra vires restrictions on state SCHIP programs that effectively undermine the states' ability to provide health coverage to thousands of low-income children.

STATEMENT OF INTEREST OF THE AMICI

For the past ten years, the State of Connecticut and the Commonwealth of Massachusetts have provided health insurance to thousands of needy children through their SCHIP programs. Throughout this period, HHS has consistently approved the manner in which Connecticut and

Massachusetts have administered their programs, and the states have consistently complied with the agency's requests. At present, both Connecticut and Massachusetts provide health insurance to children in their states who live in families with incomes up to 300 percent of the federal poverty level (FPL).

On August 17, 2007, with no advance warning or opportunity for comment, HHS' Centers for Medicare & Medicaid Services (CMS) issued a letter to state health officials that fundamentally altered the rules governing the SCHIP program. While the new policy purported simply to "clarify" the rules governing coverage of children who live "in families with effective family income levels above 250 percent of the Federal poverty level," the letter's practical effect is to raise insurmountable obstacles to state coverage of these low-income children by imposing restrictions that are wholly inconsistent with the spirit and the letter of the law. Where the statute and HHS' own regulations contemplate discretion on the part of the states, CMS' letter takes it away. Where Congress' intent was to encourage expansive coverage, CMS' letter limits it. Had CMS adhered to the rulemaking requirements of the Administrative Procedure Act before issuing this letter, states would have had the opportunity to comment on the proposal and share their concern that the new requirements are so onerous that they will effectively undermine the states' efforts to provide health care to some of their most vulnerable citizens. As it stands, CMS engaged in unlawful rulemaking, far beyond the scope of existing statutory and regulatory requirements.

The State of Connecticut and the Commonwealth of Massachusetts, acting by and through their Attorneys General on behalf of the administrators of each state's SCHIP program, have a critical interest in ensuring that the rules under which they deliver health insurance to their needier children are fair, consistent and applied in accordance with the governing statute

and regulations. The amici also have a compelling interest in ensuring that these children have access to the services to which they are entitled by law and that states benefit from the funding to which they are entitled. If CMS' letter is implemented, the fate of health insurance for thousands of low-income children in Connecticut and Massachusetts will be at risk.

OVERVIEW OF THE SCHIP PROGRAM AND CMS' AUGUST 17 LETTER

When Congress enacted the SCHIP program in 1997 as Title XXI of the Social Security Act (Act), Pub. L. No. 105-33, 42 U.S.C. §§ 1397aa-1397jj (2000), it authorized federal reimbursement to the states for a percentage of their "child health assistance" expenditures made pursuant to the state's federally-approved SCHIP state plan. 42 U.S.C. § 1397ee. An outgrowth of the Medicaid program, SCHIP was intended to provide health insurance to "targeted low-income children," i.e., children living in low-income families who nonetheless fall above Medicaid eligibility limits. The SCHIP statute specifically allows each state to determine eligibility rules, including those related to income and resources. 42 U.S.C. § 1397bb(b). Mirroring the statutory grant of discretion, the SCHIP regulations provide 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 (2007).

In enacting SCHIP, Congress was concerned that the federal investment in children's health insurance would have the broadest possible impact. For this reason, Congress sought to avoid merely shifting already-insured children from employer-sponsored plans onto federally-subsidized plans. To ensure that the SCHIP program provided federal matching dollars on health coverage only for those without other coverage options, the SCHIP statute and implementing regulations required states to adopt "reasonable procedures" to ensure that public coverage does

not substitute for, or "crowd-out," private, employer-sponsored group insurance plans. 42 C.F.R. § 457.805.

Following the federal Act's passage, Connecticut and Massachusetts, like all other states, enacted their own state SCHIP programs to provide health insurance to their "targeted low-income children." Conn. Gen. Stat. § 17b-292; Mass. Gen. Laws ch. 118E, § 16C. In accordance with the discretion granted to them by the federal statute, and with approval by HHS, Connecticut and Massachusetts chose to extend health insurance coverage to children living in families with incomes up to 300 percent of the FPL. Likewise, as required by statute and regulation, the states adopted effective crowd-out procedures, which have been consistently approved by CMS.

With its August 17, 2007 letter, CMS exceeded its powers by imposing new requirements on the states and substantially changing the rules governing the provision of SCHIP health coverage to "children in families with effective family income levels above 250 percent of the Federal poverty level."[1] Reflecting its concern about "the potential for crowd-out" with higher income beneficiaries, CMS announced new rules for states that cover these children. Issued without the benefit of the requisite notice and comment process, the letter requires that affected states now include specific crowd-out strategies in their state plans, including:

> (1) assuring that at least 95 percent of the children in the state below 200 percent of the FPL who are eligible for SCHIP or Medicaid are enrolled;

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[1] A copy of the letter is attached hereto as Exhibit 1. The applicability of the letter is unclear due to CMS' use of the term "effective family income," when the Act and implementing regulations apply only to "targeted low-income children." Because neither the Act nor the regulations defines "effective," and the definition does not appear in CMS' letter, it is ambiguous as to how broadly and to whom the letter applies. CMS officials have advised some states that "effective" family income means gross income, while other states are operating under the impression that effective income connotes a family's net income.

(2) assuring that the number of children in the target population insured through private, employer-sponsored plans has not decreased by more than two percent over the prior five-year period;

(3) preventing employers from changing their dependent coverage obligations on the part of families; and

(4) requiring a minimum of a one-year period of uninsurance for individuals prior to obtaining insurance through SCHIP.

The letter indicates that CMS "expect[s]" affected states to amend their SCHIP state plans within 12 months. Should states fail to do so, "CMS may pursue corrective action."[2]

With the imposition of these additional requirements, the letter imposes new and substantive obligations on the states, significantly limits their discretion and represents a significant departure from longstanding agency policy. As such, the letter constitutes a legislative rule, which should have been promulgated in accordance with the notice and comment requirements of the Administrative Procedure Act. 5 U.S.C. § 553 (2000).

To determine whether a rule is legislative or interpretive, courts focus on the intended legal effect of the rule, not the stated intent of the agency. See General Motors Corp. v. Ruckelshaus, 742 F.2d 1561, 1565 (D.C. Cir. 1984). Thus, "where necessary, the court will look behind the particular label applied by the agency . . . in order to discern its real intent and effect." Batterson v. Marshall, 648 F.2d 694, 705 n.58 (D.C. Cir. 1980). Legislative rules are those "that impose new duties upon the regulated party [and] have the force and effect of law." SBC v. Fed.

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[2] The letter imposes additional requirements as well, including expanded monitoring and reporting requirements on the part of the programs and increased cost-sharing on the part of families (possibly up to a level that is five percent of a family's income). Massachusetts, in its premium assistance program, already charges families at income levels between 250 and 300 percent of the FPL more than twice the amount it charges families below 200 percent of the FPL. All these requirements make the provision of coverage to low-income children more difficult, are inconsistent with the purposes of the program and should have been subject to rulemaking. Until now, CMS has consistently approved the amici states' plan provisions on these matters.

Comm. Comm'n, 414 F.3d 486, 497 (3d Cir. 2005) (citations omitted). These types of rules are subject to the Administrative Procedure Act because they create "substantive changes in prior regulations or create new law rights or duties." Id. (citations omitted).

Contrary to CMS' assertion, this letter cannot be classified as interpretive, as it does far more than simply clarify existing "reasonable procedures" with which states currently comply. Rather, the letter's requirements constitute substantive changes that go well beyond the scope of existing statutory and regulatory requirements. Thus, because this letter was issued without notice and comment, it is invalid.[3]

As a practical matter, the effect of the letter is to deprive states of federal funding for their coverage of thousands of low-income children because the letter imposes requirements so onerous that affected states will simply be unable to comply with all of them. To receive federal funding under the new standard, for example, states will be required to enroll 95 percent of their low-income children (a percentage matched only by Medicare, which has automatic enrollment) and will be held accountable for an employer's past coverage decisions. States are not in a position to do either.

[3] For example, in Am. Frozen Foods Inst. v. United States, 855 F.Supp. 388 (Ct. of Int'l. Trade 1994), the statute imposed a duty on importers to conspicuously mark food containers. Id. at 391. Customs imposed new, specific labeling requirements in applying this statute. The court concluded that the detailed and restrictive requirements imposed by Customs did not interpret the statute, but rather imposed additional obligations on food importers and therefore violated the Administrative Procedure Act. Id. at 396.

ARGUMENT

I. THE EFFECT OF CMS' LETTER IS TO DENY FUNDING FOR HEALTH SERVICES FOR THOUSANDS OF NEEDY CONNECTICUT AND MASSACHUSETTS CHILDREN.

If Connecticut and Massachusetts are required to comply with the August 17 letter, the states will, in all likelihood, lose federal funding for health insurance for thousands of low-income children as the failure to comply subjects them to CMS enforcement actions that could potentially deny all federal reimbursement to the state under SCHIP. 42 U.S.C. § 1397ff; 42 C.F.R. § 457.200 et seq. Faced with this loss, Connecticut and Massachusetts may be forced to eliminate the health care assistance benefits that they currently provide to such children. Alternatively, the states may elect to continue providing such assistance, at entirely state expense. In that case, the funds that each state is required to expend to compensate for the loss of federal reimbursement will negatively impact its ability to provide other necessary governmental services and benefits.

A. Connecticut's Federally-Approved SCHIP State Plan

Connecticut's original SCHIP state plan was federally-approved by CMS on April 27, 1998, effective retroactive to January 1, 1998. Connecticut's state plan builds on its federally approved Medicaid state plan by covering children who are ineligible for assistance under Medicaid due to too much family income. Because Connecticut's Medicaid program covers all children with family incomes up to 185 percent of the FPL, that income level serves as the floor for Connecticut's SCHIP program. From the inception of the SCHIP program more than a decade ago, Connecticut's federally-approved SCHIP state plan has provided for the "disregard" of any family income between 235 and 300 percent of the FPL in determining eligibility for

SCHIP. As a result, children in families with gross incomes up to 300 percent of the FPL have been covered under the SCHIP state plan.[4]

As of April 1, 2008, approximately 15,900 children participate in Connecticut's SCHIP program, of whom almost 5,000 have gross family income that exceeds 250 percent of the FPL. If by "effective" income, CMS means net income, about 4,100 Connecticut children are affected by the CMS rule. If turnover within the program is factored in, the number of affected children may be closer to 7,500.

Connecticut expended almost $36 million on its SCHIP program in federal fiscal year 2007 and received approximately $23 million in federal reimbursement. Approximately $6 million of that amount was attributable to children in families with income over 250 percent of the FPL. The loss of such funding seriously undermines the state's continued ability to provide services.

B. Massachusetts' Federally-Approved SCHIP State Plan

Massachusetts implemented its SCHIP program in 1998, following enactment of Chapter 170 of the Acts of 1997, Mass. Gen. Laws ch. 118E, § 16C. The program is administered as a combination Medicaid expansion and separate SCHIP program. Medicaid covers children in families with incomes up to 150 percent of the FPL. Until 2006, the separate SCHIP program covered children living in families with incomes between 150 percent and 200 percent of the FPL, picking up where the Medicaid expansion coverage left off.

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[4] Connecticut has amended its SCHIP state plan several times in the intervening years, but never with respect to income disregards, i.e., amounts not included in a family's countable income for purposes of determining eligibility. The disregards have remained in place, unchallenged by CMS for more than a decade. Moreover, Connecticut's coverage of children in families up to 300 percent of the FPL has been codified into state law. Conn. Gen. Stat. § 17b-292(a). Thus, Connecticut cannot come into compliance with the August 17 letter merely by administratively amending its SCHIP state plan.

In 2006, with the passage of the Commonwealth's landmark health care reform legislation, Massachusetts' separate SCHIP program expanded coverage to include children with family incomes up to 300 percent of the FPL. This expansion was enacted as a central component of health care reform in an effort to provide health coverage to as many Massachusetts residents as possible. Ch. 58 of the Acts of 2006, § 26, Mass. Gen. Laws ch. 118E, § 16C (3)). Like Connecticut, Massachusetts covers children with family income up to 300 percent of the FPL through the use of approved income disregards.

CMS approved this statutory expansion as part of the Commonwealth's most recent state plan amendment, which became effective July 1, 2006. Since that time, and relying on CMS' approval of the state plan, the Commonwealth has been able to make health coverage available to many more low-income children. As of February 2008, program enrollment has grown by 19,000 children as a result of the expansion. Of those 19,000 children, roughly 6,000 live in families with incomes between 250 and 300 percent of the FPL.

Massachusetts expended $327 million on its SCHIP program in federal fiscal year 2007, and received approximately $212 million in federal reimbursement. $9.3 million of that amount was attributable to children in families with income over 250 percent of the FPL. Accordingly, factoring in turnover, the loss of at least $9.3 million affects the ability of approximately 11,000 Massachusetts children to receive health care coverage in a year. Particularly in Massachusetts, where adequate funding of each component of the state's health reform is critical to its success, the loss of federal funding will have an enormous impact.

II. THE REQUIREMENTS OF THE CMS LETTER ARE INCONSISTENT WITH THE SCHIP STATUTE AND REGULATIONS AND THUS CONSTITUTE UNLAWFUL RULEMAKING.

The provision of federal SCHIP funds to the states for the health coverage they provide to uninsured "targeted low-income children" is dependent upon the state's submission of a state plan that meets the Act's statutory and regulatory requirements. Assuming that the state's plan meets those criteria, it is entitled to receive capped federal reimbursement for a percentage of the expenditures it incurs in providing "child health assistance" benefits to eligible children.[5] Two such criteria, of central importance in this matter, are (1) the state's determination of program eligibility on the basis of family income and (2) the state's development of "reasonable procedures" to prevent crowd-out. Historically, CMS has consistently approved Connecticut's and Massachusetts' treatment of these criteria. However, the August 17 letter makes it clear that such approval will no longer be forthcoming.

A. CMS' Letter Is Inconsistent with Congress' Intent to Grant States Discretion in Making Income Determinations for Their SCHIP Programs.

Given the almost insurmountable barriers imposed by the August 17 letter, the amici states question whether the letter reflects not only the agency's concern about "crowd-out" but perhaps, more fundamentally, a view that states should be restricted in their practice of covering

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[5] States are not reimbursed solely on the basis of their expenditures. To the contrary, the amount that each state receives is capped by its allotted share of block grant funds that are made available each year by Congress. A state's allotment of the total block grant funding is determined by a statutory formula that takes into account a number of factors, including the number of low income uninsured children in the state. 42 U.S.C. § 1397dd. Thus, in addition to the administrative supervision provided by CMS, Congress can indirectly control the state's exercise of discretion under the Act by controlling the amount of the annual appropriation.

children at the higher end of the low-income spectrum.[6] This view is wholly inconsistent with what Congress intended and it imposes unnecessary obstacles to the efforts of states with high costs of living such as Connecticut and Massachusetts to make affordable health insurance available to all children.

When Congress enacted SCHIP, it intentionally gave states wide discretion in determining how income will be counted for eligibility purposes. Each state's child health plan is required to describe "the standards used to determine the eligibility of targeted low-income children for child health assistance under the plan." 42 U.S.C. § 1397bb(b)(1)(A). The term "targeted low-income children" is defined expansively so as potentially to include children from families with incomes over 200 percent of the FPL. Specifically, 42 U.S.C. § 1397jj(b)(1) reads as follows:

> . . . [T]he term "targeted low-income child" means a child –
>
> (A) who has been determined eligible by the State for child health assistance under the State plan;
> (B) (i) who is a low-income child, or
> (ii) is a child –
> (I) whose family income (as determined under the State child health plan) exceeds the Medicaid applicable income level . . . , but does not exceed 50 percentage points above the Medicaid applicable income level . . . (emphasis added).

Congress specifically defined the term "targeted low-income child" (1) to allow the use of an income limit of 50 percentage points higher than the applicable Medicaid income level for children in the state (in lieu of the 200 percent of the FPL standard inherent in the definition of a "low income child") and (2) to authorize explicitly a state's discretion to compute family income

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[6] A review of the Administration's budget for FY 2009 lends credence to this view. As proposed, the Administration would target SCHIP funds to children with family incomes below 200 percent of the FPL and establish a "hard cap" for SCHIP eligibility at 250 percent of the FPL based on a family's gross income, without accounting for income disregards.

in the manner specified by the state in its SCHIP state plan. CMS regulations mirror the statute, defining a "targeted low-income child" as a child with family income either at or below 200 percent of the FPL or 50 points higher then the state's Medicaid income eligibility limit for children. 42 C.F.R. § 457.310. The term "family income" is defined as meaning "income as determined by the State ..." 42 C.F.R. § 457.10.

By these very terms, Congress and CMS recognized the states' authority to provide coverage to children in families with incomes over the cap that CMS now imposes. Through the use of income counting methodologies that disregard specified types and amounts of income, states were granted wide latitude in determining a family's countable income for eligibility purposes.[7] Any suggestion by CMS that the states are administering the program improperly by covering higher income children is baseless. To the contrary, the regulations appropriately gave high cost of living states the flexibility to adapt their SCHIP programs to individual state needs. CMS has repeatedly approved the SCHIP state plans of Connecticut and Massachusetts, as well

[7] Consistent with its approach to other public assistance programs, Congress afforded states discretion to determine how income is to be determined in the SCHIP program. SCHIP builds on the Title XIX Medicaid program by allowing the coverage of children whose family income exceeds the Medicaid income eligibility limit but, as determined by the state, is below specified levels. In the Medicaid context, Congress addressed the income counting dilemma by generally providing that the states must use the "same methodology" as is employed in the most closely related federal-state "cash assistance" program. For children, this is the former Aid to Families with Dependent Children (AFDC) program, codified at Title IV A of the Social Security Act. 42 U.S.C. § 1396a(r)(2)(A). The former AFDC program, now replaced by the Temporary Assistance to Needy Families program, required that certain deductions be taken from gross income for purposes of determining eligibility, and allowed other deductions to be taken at state election. Furthermore, if a state wished to be more liberal than AFDC in its income counting methodologies, the Medicaid Act expressly allows the states to employ "less restrictive methodologies" in their programs. 42 U.S.C. § 1396a(r)(2)(A); 42 C.F.R. § 435.601(d). Thus, the use of income counting methodologies, including income disregards, is expressly allowed in the Medicaid program, on which SCHIP is based.

as many other states that cover children in these higher income brackets.[8] Even now, CMS does not directly call for the outright prohibition on states covering such children. Instead, it seeks to impose requirements that, as a practical matter, will make such coverage impossible.

B. CMS' Letter Is Inconsistent with Congress' Intent to Grant States Discretion in Devising Their Own "Crowd-Out" Provisions, and Its Own Regulations.

Similarly, the SCHIP Act and its implementing regulations direct participating states to devise "crowd-out" provisions but do not dictate the form such provisions must take. By "crowd-out," CMS means the substitution of government subsidized health coverage under SCHIP for coverage that would otherwise be available to the child under employer-sponsored, group health plans. Specifically, the Act requires only that states include in their SCHIP state plans:

> . . . a description of procedures to be used to ensure –
>
> . . .
>
> (c) that the insurance provided under the State child health plan does not substitute for coverage under group health plans . . .

42 U.S.C. § 1397bb(b)(3)(C). In addition, states are to include within their annual reports to CMS an assessment of whether their programs result in "crowd-out." 42 U.S.C. § 1397hh. The implementing regulations similarly require SCHIP state plans to include "a description of reasonable procedures to ensure that health benefits coverage provided under the State plan does

[8] As of December 2007, at least eleven states cover children with family incomes over 250 percent of the FPL. An additional three, California, Rhode Island and Washington, currently set their income eligibility limits at 250 percent of the FPL, but may be impacted by the CMS letter because they use various deductions to calculate "net income." Four other states have curtailed coverage expansions due to the letter. Cindy Mann and Michael Odeh, Ctr. for Children and Families, Moving Backward: Status Report on the Impact of the August 17 SCHIP Directive To Impose New Limits on States' Ability to Cover Uninsured Children (Dec. 2007) available at http://ccf.georgetown.edu/index/moving-backward-status-report-of-aug-17-2007-directive?highlight=moving%20backward.

not substitute for coverage provided under group health plans . . ." 42 C.F.R. § 457.805. Accordingly, the SCHIP Act and its implementing regulations afford the states wide discretion to determine their own "reasonable" crowd-out procedures. CMS' attempt to prescribe specific, mandatory crowd-out procedures in the letter is inconsistent with this grant of discretion.[9]

III. CMS' NEW CROWD-OUT REQUIREMENTS ARE UNLAWFUL AND WILL UNDERMINE THE STATES' CONTINUED ABIILITY TO PROVIDE HEALTH BENEFITS TO THEIR NEEDY CHILDREN.

According to its August 17, 2007 letter, CMS "will expect" each state with "an effective [income eligibility] level of 250 percent of the FPL" to adopt the specific crowd-out procedures identified in the letter. Should states fail to amend their SCHIP state plans accordingly, CMS may pursue corrective action."[10] The CMS letter makes it essentially impossible for states to cover children with family incomes higher than 250 percent of the FPL.

For Connecticut and Massachusetts, this denial translates into thousands of affected children. For the programs themselves, the requirements of the letter create an unnecessary administrative burden where the states already have CMS-approved procedures in place to address this issue and there is no real evidence of crowd-out. To the contrary, evidence suggests

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[9] The only circumstance in which CMS imposes specific, mandatory crowd-out procedures is in the administration of state premium assistance programs. See 42 C.F.R. § 457.810. CMS cannot, by mere letter, add a series of new, mandatory requirements applicable to coverage for a specific class of children (those in families with "effective" income over 250 percent of the FPL). If CMS wishes to impose mandatory requirements beyond those already adopted by regulation, it must amend the existing regulations through proper notice and comment rulemaking.

[10] The CMS letter states that "[w]e would not expect any effect on current enrollees from this review strategy . . . ," apparently authorizing the "grandfathering" of current enrollees. It must be noted, however, that the turnover rate for children assisted under the program is high, with Connecticut and Massachusetts experiencing a rate of at least 50 percent. Any "grandfathering" of current children will not prevent thousands of new children applying for assistance from being harmed, or prevent the states from experiencing the loss of federal revenue that they are entitled to receive.

that, if anything, expanding eligibility has a positive impact on increased participation rates among previously eligible, lower income children.[11] Moreover, despite being added under the rubric of crowd-out, several of the requirements have little to do with crowd-out, or the "reasonable procedures" intended to prevent it.

A. The Requirement That States Provide Assurance That They Have Enrolled At Least 95 Percent of the Medicaid or SCHIP-Eligible Children in the State Below 200 Percent of the Federal Poverty Is Unlawful.

According to the August 17 letter, a state will only be permitted to cover children at the higher income levels if it provides an assurance that it has enrolled at least 95 percent of the children in the state below 200 percent of the FPL who are eligible for either SCHIP or Medicaid. Despite CMS' claim that this assurance somehow serves to prevent crowd-out among higher income children, the requirement only addresses how effective the state has been in enrolling lower income children in the program. In other words, it relates to the outcome achieved, not to the reasonableness of the procedures employed. CMS' characterization of this requirement as a clarification of the existing "reasonable procedures" requirement is inaccurate.

CMS' letter asks the impossible. The *only* health insurance program that comes close to reaching 95 percent enrollment is the Medicare program, which has automatic enrollment. Thus, no matter how diligent a state's efforts, the 95 percent enrollment is tantamount to a prohibition

[11] Mann and Odeh, supra at 4. See also Teresa A. Coughlin and Mindy Cohen, The Urban Institute, for the Kaiser Commission on Medicaid and the Uninsured, A Race to the Top: Illinois's All Kids Initiative (Aug. 2007), available at http://www.kaiserfamilyfoundation.org/uninsured/7677.cfm.

on covering children with family incomes over 250 percent of the FPL.[12]

One of the most effective means of increasing program enrollment is to engage in extensive outreach. To this end, participating states are, by law, required to engage in outreach and coordination with other health insurance programs. 42 U.S.C. § 1397bb(c). Connecticut and Massachusetts employ aggressive outreach efforts, all of which have been approved by CMS in their state plans. For example, both Connecticut and Massachusetts operate extensive "out station locations," use a simplified application process, and assist applicants with necessary paperwork. To date, CMS has never questioned the adequacy of the amici states' outreach efforts.[13]

Moreover, the 95% enrollment requirement is problematic because a number of eligible low-income children will not be covered by an assistance program no matter how vigorous a state's outreach efforts. Families fall in and out of poverty (and, therefore, in and out of eligibility requirements) as a result of a host of factors, including the death of the employed parent, divorce and job loss. Yet, they do not necessarily apply for health care assistance for their children as soon as they lose a job or experience a death or divorce, but wait out of hope

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[12] "No means-tested program where people have to apply and be reviewed for eligibility has reached this high standard of participation." Mann and Odeh, supra note 8, at 2. The low-income subsidy for the Medicare Part D benefit achieves a participation rate of only approximately 43 percent. Nationally, participation rates for SCHIP and Medicaid approximate 63 and 79 percent, respectively. Id.

[13] Despite CMS' stated concern about the adequacy of the states' efforts to enroll lower income children in Medicaid and SCHIP, it recently issued regulations that will significantly curtail state outreach efforts in an area that has been the most successful, i.e., arrangements with local public schools to enroll lower income children in Medicaid. The rule became final on December 28, 2007; a moratorium on its implementation is scheduled to expire on June 30, 2008. See Judith Solomon and Donna Cohen Ross, Ctr. on Budget and Policy Priorities, Administration Moves to Eviscerate Efforts to Enroll Uninsured Low-Income Children in Health Coverage Through the Schools (Oct. 1, 2007), available at http://www.cbpp.org/9-17-07health.htm.

that their circumstances will improve. Parents who are illiterate or who do not speak English may be less likely to apply for assistance, no matter how diligent the state's outreach efforts.

Finally, no solid data on enrollment levels exist. CMS has not specified in its letter the data source it will use or how it will gauge whether states have met the 95 percent benchmark. State agencies know about the children who apply for and receive assistance from their programs but they do not have first-hand knowledge of the number, eligibility or circumstances of children under 200 percent of the FPL who have *not* applied for assistance. The only current source of related data is that compiled by the Current Population Survey (CPS). That data, however, only measures children *covered by*, not *eligible for*, SCHIP or Medicaid. CMS has also failed to identify the point in time at which enrollment is to be measured, i.e., a fixed point in time during the year, during any particular month of the year, or some other measure.[14] In the absence of authoritative guidance from CMS, it is impossible for the amici states to even attempt compliance with this requirement.[15]

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[14] Moreover, because the CPS data addresses the total number of children under 200 percent of the FPL but does not address the eligibility of those children for public assistance programs, it is of limited utility for purposes of providing the required assurance. The data's reliability is also questionable. See Congressional Budget Office, The State Children's Health Insurance Program (May 2007) 9, available at http://www.cbo.gov/ftpdocs/80xx/doc8092/05-10-SCHIP.pdf; (Coverage in public programs such as Medicaid is underreported . . ."); Genevieve M. Kenney, The Urban Institute, Medicaid and SCHIP Participation Rates: Implications for New CMS Directive (Sept. 2007), available at http://www.urban.org/Uploaded F/411543_Medicaid_Schip.pdf (". . . there are serious methodological challenges associated with obtaining valid state-level participation rate estimates given the currently available data.")

[15] While CMS staff has made occasional oral representations to Connecticut and Massachusetts that their programs might satisfy the 95 percent enrollment requirement, neither state has received any official communication from CMS on this point. CMS has not provided either state with a written acknowledgement that the state has satisfied the requirement. Thus, the states are placed in the untenable position of hoping that CMS' informal word prevails while still being held to the requirements of the letter. (Based on the methodology that CMS has employed as recently as August 2007, 41 of the 50 states, including Connecticut and Massachusetts, have achieved the required 95 percent participation rate, with many exceeding a rate of 100 percent.

Had CMS complied with the rulemaking requirements, the amici states would have had the opportunity to express these concerns.

B. States Have Little Control Over Whether the Number of Children in the Target Population Insured Through Private Employers Has Decreased by More Than Two Percent Over the Previous Five-Year Period.

The requirement that states be able to establish that the number of children in the target populations insured through private employers has not decreased by more than two percent over a five-year period imposes an unfair and overwhelming burden on the amici states. First, this assurance cannot be said to constitute a "clarification" of the reasonable crowd-out procedures that state agencies are required to adopt, as it does not mandate that states either take any particular action or utilize any particular procedure to deter crowd-out.[16]

Second, CMS is asking state agencies to assume responsibility for the coverage decisions of private employers made in a previous five-year period. Employer coverage has declined sharply for all groups of Americans, including children. It is unreasonable to expect state agencies to somehow alter this trend.[17]

However, the methodology, while favorable to the amici states, has been soundly criticized. Kenney, supra at 2-4.) The fact that New York, which was on the list of compliant states, had its state plan denied in part because of its failure to meet the enrollment requirement, underscores the validity of the amici states' concerns.

[16] The August 17 letter does not define the term "target population," leaving it unclear as to whether the term refers to children with "effective" family income over 250 percent of the FPL who are eligible under the state's SCHIP program, children under 200 percent of the FPL as suggested by CMS, or some other "target" group of eligible children.

[17] Between 2000 and 2006, rates of employer-sponsored coverage fell four percentage points for non-elderly adult workers and almost nine percentage points for all children under 18, irrespective of income. See Paul Frontsin, Employee Benefit Research Institute, Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2007 Current Population Survey (Oct. 2007), available at http://www.ebri.org/publications/ib/index.cfm?fa=main&doc_type=1.

C. States Face Difficult Hurdles in Preventing Employers from Changing Dependent Coverage Policies in a Manner That Would Favor a Shift to Public Coverage.

The August 17 letter's requirement that states "prevent[] employers from changing dependent coverage policies that would favor a shift to public coverage" poses an insurmountable burden for state Medicaid and state health agencies. As a practical matter, requirements preventing employers from changing their benefit plans by dropping health care coverage for dependents can only be adopted by statute, rather than by agency action. Moreover, the Employment Retirement Income Security Act, 29 U.S.C. § 1144(a), may create obstacles to the passage of state laws that attempt to prescribe benefits that must be provided by employer-sponsored benefit plans. See FMC Corp. v. Holliday, 498 U.S. 52 (1990); Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 733 (1985); Alessi v. Raybesto-Manhattan, Inc., 451 U.S. 504 (1981).

D. The Letter's Required One-Year Waiting Period of Uninsurance Is Unlawful to the Extent That It Recognizes No Exceptions and, Even with Exceptions, Would Require Rulemaking.

The one-year waiting period imposed by the CMS letter cannot be justified as an "interpretation" of the statutory requirement that SCHIP not substitute for coverage under group health plans because the waiting period applies without regard to whether coverage under a group health plan is available. Instead, the only effect of the requirement is to deny health care coverage to thousands of children who, in fact, have no access to employer-sponsored health insurance and to deny federal reimbursement to the states for the assistance that they provide these children pursuant to their SCHIP programs. Debilitating life-threatening illnesses do not wait for the mandatory, one-year waiting period prescribed by CMS. Moreover, in a complete departure from its regulations, CMS' letter recognizes no exceptions to the waiting period requirement. Both Connecticut and Massachusetts already impose waiting periods of less than

one year, with the requisite exceptions, as part of their reasonable crowd-out procedures.[18] No need has been demonstrated for the imposition of a longer period of time.

CONCLUSION

For all of the foregoing reasons, the State of Connecticut and the Commonwealth of Massachusetts urge the Court to deny the United States' motion to dismiss and to grant New Jersey's cross-motion for partial summary judgment. Decisions of fundamental importance, impacting on the ability of the states to provide federally-subsidized child health care assistance to targeted low-income children, need to be made through deliberative processes that include notice and comment.

[18] Most other states will be similarly affected by the new one-year waiting period requirement, as few states impose such a lengthy waiting period. See Donna Cohen Ross and Aleya Horn, Center on Budget and Policy Priorities and Caryn Marks, Kaiser Commission on Medicaid and the Uninsured, Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles (Jan. 2008), available at http://kff.org/medicaid/upload/7740.pdf.

RICHARD BLUMENTHAL
ATTORNEY GENERAL
STATE OF CONNECTICUT

BY: Hugh Barber /ecp

Hugh Barber
Assistant Attorney General
Federal Bar No. ct05731
55 Elm Street
P.O. Box 120
Hartford, CT 06141-0120
Tel: (860) 808-5210
Fax: (860) 808-5385

MARTHA COAKLEY
ATTORNEY GENERAL
COMMONWEALTH OF MASSACHUSETTS

BY: Emily R. Paradise

Emily R. Paradise BBO # 566637
Quentin A. Palfrey BBO # 655547
Assistant Attorneys General
Health Care Division
One Ashburton Place
Boston, MA 02108
Tel: (617) 727-2200
Fax: (617) 573-5386

EXHIBIT 1

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations

August 17, 2007 SHO #07-001

Dear State Health Official:

This letter clarifies how the Centers for Medicare & Medicaid Services (CMS) applies existing statutory and regulatory requirements in reviewing State requests to extend eligibility under the State Children's Health Insurance Program (SCHIP) to children in families with effective family income levels above 250 percent of the Federal poverty level (FPL). These requirements ensure that extension of eligibility to children at these higher effective income levels do not interfere with the effective and efficient provision of child health assistance coordinated with other sources of health benefits coverage to the core SCHIP population of uninsured targeted low income children.

Section 2101(a) of the Social Security Act describes the purpose of the SCHIP statute "to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage." Section 2102(b)(3)(C) of the Act, and implementing regulations at 42 CFR Part 457, Subpart H, require that State child health plans include procedures to ensure that SCHIP coverage does not substitute for coverage under group health plans (known as "crowd-out" procedures). In addition, section 2102(c) of the Act requires that State child health plans include procedures for outreach and coordination with other public and private health insurance programs.

Existing regulations at 42 C.F.R. 457.805 provide that States must have "reasonable procedures" to prevent substitution of public SCHIP coverage for private coverage. In issuing these regulations, CMS indicated that, for States that expand eligibility above an effective level of 250 percent of the FPL, these reasonable crowd-out procedures would include identifying specific strategies to prevent substitution. Over time, States have adopted one or more of the following five crowd-out strategies:

- Imposing waiting periods between dropping private coverage and enrollment;
- Imposing cost sharing in approximation to the cost of private coverage;
- Monitoring health insurance status at time of application;
- Verifying family insurance status through insurance databases; and/or
- Preventing employers from changing dependent coverage policies that would favor a shift to public coverage.

As CMS has developed more experience and information from the operation of SCHIP programs, it has become clear that the potential for crowd-out is greater for higher income beneficiaries. Therefore, we are clarifying that the reasonable procedures adopted by States to prevent crowd-out pursuant to 42 C.F.R. 457.805 should include the above five general crowd-out strategies with certain important components. As a result, we will expect that, for States that expand eligibility above an effective level of 250 percent of the FPL, the specific crowd-out

strategies identified in the State child health plan to include all five of the above crowd-out strategies, which incorporate the following components as part of those strategies:

- The cost sharing requirement under the State plan compared to the cost sharing required by competing private plans must 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;
- The State must establish a minimum of a one year period of uninsurance for individuals prior to receiving coverage; and
- Monitoring and verification must include information regarding coverage provided by a noncustodial parent.

In addition, to ensure that expansion to higher income populations does not interfere with the effective and efficient provision of child health assistance coordinated with other sources of health benefits coverage, and to prevent substitution of SCHIP coverage for coverage under group health plans, we will ask for such a State to make the following assurances:

- Assurance that the State has enrolled at least 95 percent of the children in the State below 200 percent of the FPL who are eligible for either SCHIP or Medicaid (including a description of the steps the State takes to enroll these eligible children);
- Assurance 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; and
- Assurance that the State is current with all reporting requirements in SCHIP and Medicaid and reports on a monthly basis data relating to the crowd-out requirements.

We will continue to review all State monitoring plans, including those States whose upper eligibility levels are below an effective level of 250 percent of the FPL, to determine whether the monitoring plans are being followed and whether the crowd-out procedures specified in the SCHIP state plans are reasonable and effective in preventing crowd-out.

CMS will apply this review strategy to SCHIP state plans and section 1115 demonstration waivers that include SCHIP populations, and will work with States that currently provide services to children with effective family incomes over 250 percent of the FPL. We expect affected States to amend their SCHIP state plan (or 1115 demonstration) in accordance with this review strategy within 12 months, or CMS may pursue corrective action. We would not expect any effect on current enrollees from this review strategy, and anticipate that the entire program will be strengthened by the focus on effective and efficient operation of the program for the core uninsured targeted low-income population. We appreciate your efforts and share your goal of providing health care to low-income, uninsured children through title XXI.

If you have questions regarding this guidance, please contact Ms. Jean Sheil, Director, Family and Children's Health Programs, who may be reached at (410) 786-5647.

Sincerely,

/s/
Dennis G. Smith
Director

cc:

CMS Regional Administrators

CMS Associate Regional Administrators,
Division of Medicaid and Children's Health

Martha Roherty
Director, Health Policy Unit
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association

Debra Miller
Director for Health Policy
Council of State Governments

Christie Raniszewski Herrera
Director, Health and Human Services Task Force
American Legislative Exchange Council

Jacalyn Bryan Carden
Director of Policy and Programs
Association of State and Territorial Health Officials

CERTIFICATE OF SERVICE

I hereby certify that a copy of the foregoing Amici Curiae Brief of the States of Connecticut and Massachusetts, and the exhibits thereto, was served upon the following individuals this 9th day of April, 2008, by U.S. mail, first class postage prepaid:

Megan Lewis
Brian O. Lipman
Office of the New Jersey Attorney General
Division of Law
124 Halsey Street
5th Floor
PO Box 45029
Newark, NJ

Jean Lin
U.S. Department of Justice
Civil Division
Federal Programs Branch
20 Massachusetts Avenue NW
Washington, DC 20530

Linda Lee Keyser
U.S. Department of Health and Human Services
Office of the General Counsel
CMS Division
330 Independence Avenue SW
Room 5327D
Washington, DC 20201

Emily R. Paradise
Assistant Attorney General