

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF PENNSYLVANIA

BARBARA L. ERB; SAMUEL STYLES by his)
mother and guardian ad litem, MARY STYLES;)
DOROTHY BOYD; EA A. FAHRINGER;)
VIRGINIA PEARSON; ANN ROSEN;)
SUSAN OBERMEYER; ACTION ALLIANCE OF)
SENIOR CITIZENS OF GREATER)
PHILADELPHIA; CENTER FOR ADVOCACY)
FOR THE RIGHTS AND INTERESTS OF THE)
ELDERLY; on behalf of themselves)
and all others similarly situated)

Plaintiffs,

v.

MARK B. McCLELLAN, Administrator,)
Centers for Medicare and Medicaid Services;)
MICHAEL O. LEAVITT, Secretary)
of Health and Human Services.)

Defendants.

Civil No.

COMPLAINT FOR
DECLARATORY,
INJUNCTIVE, AND
MANDAMUS RELIEF

COMPLAINT - CLASS ACTION

I. PRELIMINARY STATEMENT

1. This is an action for declaratory, injunctive, and mandamus relief against the Secretary of the Department of Health and Human Services or HHS (the Secretary) and the Administrator of the Department's Centers for Medicare and Medicaid Services or CMS (the Administrator), as the officials responsible for implementing the Medicare and, jointly with the states, Medicaid programs which provide health insurance benefits for low-income elderly and disabled individuals. Individuals who are dually eligible for Medicare and Medicaid are often referred to

as “dual eligibles.” In violation of Medicare beneficiaries’ right to elect whether to receive their Medicare benefits through original fee-for-service Medicare or a managed care plan of their choosing, defendants recently established a process that involuntarily terminates thousands of dual eligibles in Pennsylvania from the original fee-for-service Medicare coverage or the Medicare Advantage managed care plan coverage that they affirmatively elected by right and "passively" enrolls them into Medicare Advantage managed care plans that they did not choose. Consequently, effective January 1, 2006, without being afforded the benefit of accurate information, adequate recourse to opt out of passive enrollment, advanced written notice or a formal agency rulemaking by the defendants, many Pennsylvania dual eligibles will be assigned against their wishes to a managed care provider network. These networks may not include their doctors and other providers from whom they had been receiving health care. As a result, many will experience disruption in their health care and difficulty accessing their health care providers. Other class members may be assigned to a Medicare managed care plan that does not cover the drugs they have been prescribed. These actions by the defendants violate the Medicare statute and regulations, the Administrative Procedure Act, and the Due Process Clause of the Fifth Amendment.

II. JURISDICTION

2. Jurisdiction is conferred on this Court by 28 U.S.C. § 1331 and 1361, and by 42 U.S.C. § 1395ff(b) and 405(g).

III. PARTIES

Individual Plaintiffs

3. Plaintiff Barbara L. Erb is a 37 year old woman who resides in York County. She has original Medicare coverage as well as full Medicaid coverage.

4. Plaintiff Samuel Styles is a 21 year old man who resides in Philadelphia. He has original Medicare coverage as well as full Medicaid coverage. He brings this action by his mother and guardian *ad litem*, Mary Styles.

5. Plaintiff Dorothy Boyd is a 81 year old who resides in Allegheny County. She has original Medicare coverage as well as full Medicaid coverage.

6. Plaintiff Ea A. Fahringer is a 56 year old woman who resides in Lehigh County. She has Medicare coverage through Senior Blue, a managed care organization that she chose, as well as full Medicaid coverage.

7. Plaintiff Virginia Pearson is a 76 year old woman who resides in Philadelphia. She has Medicare coverage through Elder Health, a Medicare Advantage plan that she chose, as well as full Medicaid coverage.

8. Plaintiff Ann Rosen is a 52 year old woman who resides in Philadelphia County. She has original Medicare coverage as well as full Medicaid coverage.

9. Plaintiff Susan Obermeyer is a 53 year old woman who resides in Philadelphia County. She has original Medicare coverage as well as full Medicaid coverage.

Organizational Plaintiffs

10. Plaintiff THE CENTER FOR ADVOCACY FOR THE RIGHTS AND INTERESTS OF THE ELDERLY (“CARIE”) is a Pennsylvania not-for-profit corporation whose mission is to serve the frail elderly in Pennsylvania. Founded in 1977, CARIE provides direct assistance,

information, and education to many elderly individuals who have both Medicare and Medicaid coverage. CARIE brings this lawsuit on its own behalf, on behalf of the dual eligibles it serves, and on behalf of similarly situated Medicare beneficiaries in Pennsylvania. CARIE is headquartered at 100 North 17th Street, Suite 600, Philadelphia, PA 19103.

11. Plaintiff ACTION ALLIANCE FOR SENIOR CITIZENS (“AASC”) is a non-profit membership organization comprised of older adults residing in southeastern Pennsylvania, many of whom have both Medicare and Medicaid coverage. Founded in 1973, AASC is a coalition of over 320 senior clubs and organizations that represents over 120,000 elderly people in the greater Philadelphia area. AASC brings this lawsuit on its own behalf, on behalf of its members, and on behalf of similarly situated Medicare beneficiaries in Pennsylvania. AASC headquarters are located at 1201 Chestnut Street, Philadelphia, PA 19107.

Defendants

12. Defendant MARK B. McCLELLAN is the Administrator of the Centers for Medicare and Medicaid Services, an agency within the United States Department of Health and Human Services. He is responsible for the overall operations and direction of the Medicare program and specifically for the CMS policy allowing passive enrollment of dual eligibles into Medicare HMOs. He is sued in his official capacity.

13. Defendant MICHAEL O. LEAVITT is the Secretary of Health and Human Services (HHS) and ultimately is responsible for the overall operations and direction of the Medicare program through the HHS agency known as the Centers for Medicare and Medicaid Services (CMS). He is sued in his official capacity.

IV. CLASS ACTION ALLEGATIONS

14. Plaintiffs bring this action on behalf of themselves and all others similarly situated, pursuant to Rules 23 (a) and (b)(2) of the Federal Rules of Civil Procedure.

15. The class consists of all Medicare beneficiaries in Pennsylvania who also have Medicaid coverage and who have been scheduled to be passively enrolled.

16. The requirements for certification of a class are met, as follows:

a. Joinder is impracticable due to the large number of class members and for other reasons, including but not limited to their geographic diversity, their ages and/or disabilities, inability to read or speak English and their relatively low incomes. There are approximately 110,000 dual eligible individuals in the proposed class.

b. There are questions of law and fact common to the class members concerning the legality of passive enrollment. The passive enrollment plan crafted by defendants will impact all class members similarly by depriving them of their statutorily guaranteed right to choose how to obtain their Medicare coverage. The named plaintiffs' claim that defendants lacked the statutory authority to implement the passive enrollment plan is a common question of law to all class members. The named plaintiffs' allegation that defendants implemented this plan in a fashion that violates both the Administrative Procedure Act and the Due Process Clause of the Fifth Amendment of the United State Constitution is also a question of law that is common to all class members. Common questions of fact include the lack of notice from CMS regarding the loss of their current type of Medicare coverage, the operation of defendants' passive enrollment plan and the lack of notice from CMS as to how they will receive prescription coverage if they opt out of their Medicare Advantage Plan into which they were to be passively enrolled.

c. The claims of the named plaintiffs are typical of the claims of the class members. The named plaintiffs are, like the proposed class, lower-income individuals or organizations that represent lower-income individuals with Medicare and Medicaid who have by state mandate been receiving Medicaid coverage through a Medicaid managed care organization and have by election been receiving Medicare coverage through original, Fee-for-Service Medicare or a Medicare Advantage plan which they affirmatively elected. The named individual plaintiffs are, like all members of the proposed class, individuals who received no notice from defendants prior to the termination of their original, Fee-for-Service Medicare or previous Medicare Advantage plan coverage. The named individual plaintiffs are, like all members of the proposed class, individuals who received no information from defendants about passive enrollment or their rights with respect to the passive enrollment plan.

d. The named plaintiffs will fairly and adequately protect the interests of the class. They have no interest that is or may be potentially antagonistic to the interests of the class. Moreover, plaintiffs are represented by competent counsel, who have represented classes in numerous other cases involving public benefit programs.

V. LEGAL FRAMEWORK

17. Medicare is the nation's publicly-funded health insurance program for elderly and disabled people. It was originally enacted as part of the Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286, 42 U.S.C. § 1395 *et seq.* Beneficiaries of Medicare have the option of receiving their benefits through fee-for-service ("original") Medicare or through a managed care ("Medicare Advantage") plan.

18. “Fee-for-service” refers to a health insurance system whereby medical providers are reimbursed for each service they perform and there are few limits or strictures on the patient regarding what provider they see or how often they see that provider, other than medical necessity.

19. “Managed care” is a health care system where the insurer is paid an agreed upon rate (called a “capitated rate”) for each enrolled beneficiary and bears the ultimate financial risk if costs exceed the total payment received. Such plans manage care by restricting beneficiaries to providers in the plan’s provider network and by requiring beneficiaries to have most medical care and visits to specialists authorized by a primary care provider who acts as a “gatekeeper.”

20. Medicare presently includes two types of health care coverage. Medicare Part A is hospital insurance that covers hospitalization, skilled nursing facility care, home health care, and hospice. Medicare Part B is medical insurance that covers doctors visits, durable medical equipment, physical therapy, mental health services, home health care, and prescription drugs administered in a provider’s office. Both Medicare Part A and Part B include considerable cost-sharing obligations for beneficiaries in the form of premiums, deductibles, and co-payments. As originally established, Parts A and B provide coverage on a fee-for-service basis.

21. Medicare Part C does not provide a benefit package, but instead allows Part A and B benefits to be provided through a Medicare managed care plan. Part C was created in 1997 as an alternative to the original, fee-for-service Medicare program and enrollment in such a plan is optional for beneficiaries.

22. Under the traditional, fee-for-service Medicare program, a beneficiary can access all Part A and Part B services from any doctor, hospital, nursing facility, durable medical equipment

supplier, home health agency, behavioral health care provider and other providers covered by Parts A and B that participate in the Medicare program. Historically, this has been an immensely broad array of providers.

23. Part C plans, also called Medicare Advantage plans, are designed to control the beneficiary's Medicare costs by limiting member access. By definition, managed care plans limit members' access to only those doctors, hospitals, nursing facilities, durable medical equipment suppliers, home health agencies, behavioral health care providers, and other covered providers that have agreed to the plan's contract terms.

24. Medicaid is the joint federal state program that provides health care coverage for low-income individuals and families. The federal statute setting forth the requirements for state provision of Medicaid benefits is found at Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.* The state's Public Welfare Code authorizes Pennsylvania's participation in the Medicaid program and governs administration of the program. 62 P.S. § 441.1 *et seq.* (originally enacted by Act of June 13, 1967, P.L. 31).

25. Many lower-income disabled and elderly Medicare beneficiaries also qualify for Medicaid. These individuals are known as "dual eligibles," because they are eligible for coverage under both programs. There are approximately 250,000 dual eligibles in Pennsylvania.

26. Medicare is the primary payer and Medicaid is the secondary payer for dual eligibles. This means Medicare is billed first and has the main responsibility for paying for covered services and Medicaid pays only residual amounts after Medicare has paid. In practice, Medicaid pays the Medicare Part A and B premiums, deductibles and copayments for services covered by both programs such as hospitalization, physician care, home health services, medical

equipment, and mental health services, as required by law. This is a significant benefit for dual eligibles who generally cannot afford the cost-sharing obligations normally associated with Medicare coverage. Medicaid also pays for those services which Medicare does not cover, such as dental care, medical transportation, and, until December 31, 2005, prescription drugs. As a result, dual eligibles have a comprehensive package of benefits with little or no out-of-pocket costs.

27. Effective January 1, 2006, a new prescription drug plan, Part D of the Medicare program will be implemented for individuals who are entitled to Medicare coverage based on age (65) or disability. The Medicare Modernization Act (“MMA” or the “Act”), 42 U.S.C.1395w-101, *et seq.*, created a complex new program of prescription drug benefits, under which Medicare beneficiaries could choose to obtain coverage from either a stand alone prescription drug plan (PDP), or through a managed care plan, known as a Medicare Advantage with Prescription Drugs (or “MA-PD”) plan, which combines drug coverage with all other Medicare benefits.

28. Currently, dual eligibles receive comprehensive outpatient prescription drug coverage as part of their Medicaid coverage. Beginning January 1, 2006, dual eligibles, like other Medicare beneficiaries, will be entitled to prescription drug coverage under Medicare Part D. Also, starting January 1, 2006, the MMA discontinues federal funding of Medicaid prescription drug coverage for dual eligibles.

29. The MMA requires the Secretary to “establish a process for enrollment. . . . of eligible individuals in prescription drug plans consistent with” the statute. 42 U.S.C.1395w-101(b)(1)(A). The MMA further directs that the enrollment process shall be consistent with the provisions in 42 U.S.C. § 1395w-21 relating to exercise of choice of whether to receive Medicare

benefits through original fee-for-service Medicare or through a Medicare Advantage plan which the beneficiary has affirmatively elected. 42 U.S.C. § 1395w-101(b)(1)(B)(ii).

30. Under 42 U.S.C. § 1395w-101(b)(1)(C), the enrollment process established by the Secretary shall include “in the case of a part D eligible individual who is a full-benefit dual eligible...who has failed to enroll in a prescription drug plan or an MA-PD plan, for the enrollment in a prescription drug plan.” This section clearly directs the Secretary to auto-enroll dual eligibles into a stand-alone prescription drug plan (also called a “PDP”) should they fail to affirmatively elect a plan on their own by December 31, 2005. The purpose of this auto enrollment is to ensure that dual eligibles have Part D drug coverage starting January 1, 2006 to replace their drug coverage from Medicaid.

31. A PDP is a stand-alone prescription drug insurance policy that only provides coverage of prescription drugs, the Part D benefit. Under the terms of the MMA, enrollment in a stand-alone PDP does not effect access to Part A hospitalization insurance or Part B medical insurance benefits under original Medicare. On the other hand, a MA-PD is a Medicare Advantage managed care plan that provides the Part D prescription drug coverage in addition to its provision of a managed Medicare Part A and Part B benefit.

32. Until December 31, individual plaintiffs and the class they propose to represent receive their Medicaid through Pennsylvania’s Medicaid managed care program. As of the end of the year, Pennsylvania has decided to cease managed care for dual eligibles and instead provide coverage through a fee for service system.

33. Pennsylvania utilizes two different delivery systems under its Medicaid program: managed care and fee-for-service. Medicaid managed care is mandatory for well over half of the

state's Medicaid population who live in 25 primarily urban counties, and voluntary for Medicaid recipients who live in 27 counties where it coexists with fee-for-service. In the remaining 15 counties, Medicaid coverage is provided exclusively through a fee-for-service system.

34. While nominally in Medicaid managed care, the Pennsylvania Medicaid program has not imposed limits on the Medicare freedom of choice rights (under 42 U.S.C. § 1395a) of its Medicaid enrollees. Thus, these dual eligibles have enjoyed complete freedom of choice of Medicare providers and have never been restricted to specific provider networks or required to navigate typical managed care hurdles, such as referral or prior authorization requirements for Medicare covered services. The protections of 42 U.S.C. § 1395a have applied, wherein all Medicare beneficiaries are afforded the right to freely choose the providers from whom they will receive their care:

“Any individual entitled to insurance benefits under this title may obtain health services from any institution, agency, or person qualified to participate under this title if such institution, agency, or person undertakes to provide him such services.”

42 U.S.C. § 1395a. This has effectively given Pennsylvania dual eligibles freedom of choice to see any provider who accepts Medicare, since Medicare is the primary insurance.

35. Under 42 U.S.C. § 1395w-21, Medicare beneficiaries have the right to elect to receive their Medicare coverage through a Medicare Advantage plan. In contrast with original Medicare, Medicare Advantage plan members are restricted to the network of health care providers who have signed contracts and been credentialed as plan participants. Dual eligibles in Pennsylvania's Medicaid managed care have always enjoyed the choice of enrolling in a

Medicare Advantage plan or receiving their Medicare coverage through original, fee-for-service Medicare.

36. While some dual eligibles have chosen a Medicare Advantage plan, most dual eligibles have chosen to retain original Medicare coverage. Defendants' published reports show that only 25% of all Pennsylvania Medicare beneficiaries have chosen to receive care from a Medicare managed care plan. CMS, Medicare Managed Care Contract Report, Medicare Enrollee Distribution by State as of November 1, 2005, available at <http://www.cms.hhs.gov/healthplans/statistics/mmcc>.

37. Retaining original Medicare coverage has enabled beneficiaries to visit any doctor, hospital or other health care provider who accepts Medicare, without the limitations imposed by the Pennsylvania Medicaid program. Dual eligibles who enroll in Medicare Advantage plans do not retain freedom of choice of Medicare providers. They are restricted to the Medicare Advantage plans' managed care network and its care management requirements.

38. The Pennsylvania Department of Public Welfare recently decided to provide Medicaid coverage for dual eligibles using a fee for service system, rather than continuing enrollment in Medicaid managed care as of December 31, 2005. Beginning January 1, 2006, dual eligibles who have been enrolled in Medicaid managed care will return to Medicaid fee-for-service coverage.

39. Dual eligibles in Medicaid fee-for-service and original Medicare likewise have complete freedom of choice of Medicare provider, do not need a referral to see a specialist, nor are they limited to a restricted panel of health care providers.

40. On August 3, 2004, defendants issued a notice of proposed rulemaking to implement the newly enacted MMA. 69 Fed. Reg. 46,631-977.

41. On January 28, 2005, defendants issued final regulations on the MMA, 70 Fed. Reg. 4,193-4,741, establishing, *inter alia*, a process for auto-enrollment of dual eligibles into stand-alone prescription drug plans (PDPs), as required under 42 U.S.C. § 1395w-101(b)(1)(C).

42. In the final regulations, 70 Fed. Reg. at 4607, defendants explicitly rejected a suggestion to auto-enroll dual eligibles into Medicare Advantage plans, instead of stand alone PDPs:

“The default authority in 1851(c)(3)(A)(ii) of the Act would not, however, permit an individual to be considered by default to have elected an MA-PD plan if he or she was already a Medicare beneficiary and had elected not to receive Medicare benefits through an MA Organization. Therefore, we decline to enroll by default existing full-benefit dual eligible individuals into an MA-PD if they are currently in original Medicare and only receive Medicaid benefits through that organization. We will continue to evaluate alternatives to facilitate enrollment in Part D for this population.”

43. Despite the language in the MMA at 42 U.S.C. § 1395w-21 (guaranteeing beneficiary election for managed care), 42 U.S.C. § 1395w-101(b)(1)(C)(permitting auto-enrollment by Secretary only into a stand-alone prescription drug plan), 42 U.S.C. § 1395a (establishing beneficiary freedom of choice), as well as the explicit rejection of the suggestion to enroll beneficiaries in MA-PDs, 70 Fed. Reg. at 4607, CMS has devised and is implementing a process to involuntarily transfer Pennsylvania dual eligibles who presently participate in a Medicaid managed care program into MA-PDs, effective January 1, 2006. This plan is being called “passive enrollment,” since Medicare beneficiaries are being enrolled in a managed care plan without their having given any indication that they desire such enrollment.

44. If passively enrolled in a Medicare Advantage plan, dual eligibles who were previously in original Medicare will lose their freedom of choice of Medicare providers and will be restricted to using only those providers that are under contract with the plans to which they are assigned. They will also be required to use the referral process and other requirements inherent in a managed care plan. The Medicare Advantage plans into which dual eligibles are being passively enrolled also have limited service areas and varying degrees of limitations on provider access.

45. CMS has not promulgated any rule or regulation authorizing passive enrollment or articulating the process for and beneficiary rights under passive enrollment, despite the substantive nature of its policy decision affecting the nature of coverage for dual eligibles.

46. The only documents authorizing Medicare Advantage plans to passively enroll over 110,000 Pennsylvania dual eligibles are a series of letters to Medicare Advantage plans that CMS refers to as “Call Letters.” The CMS “Call Letter” of April 15, 2005 states:

“Under certain conditions, and with CMS approval, Medicare Advantage organizations with a current Medicaid managed care contract and a dual eligible MA Special Needs Plan (SNP) in the same service area may passively enroll members of their Medicaid plan with original (fee-for-service) Medicare into the SNP for an effective date of January 1, 2006.”

Call Letter at Page 9 (see attached Exhibit 1). The letter goes on to state that “This is a one-time only process and applies only to January 1, 2006 enrollments.” *Id.* at 10.

47. As a result of the Call Letter, over 110,000 dual eligibles in Pennsylvania are being passively enrolled in one of six Medicare Advantage-Prescription Drug managed care plans. The decision as to which plan they are assigned to depends on their former Medicaid managed care plan – dually eligible individual are passively enrolled in a Medicare managed care plan that is

operated by the same company that previously operated their Medicaid managed care plan. This assignment is being made despite the fact that the individual will never be enrolled in both plans simultaneously since the individual will leave that Medicaid managed care plan effective December 31, 2005 and return to Medicaid fee-for-service, just as they are enrolled in the Medicare managed care plan January 1, 2006. Thus these dual eligibles will no longer be “current” members of the Medicaid plan owned by the parent company and the Medicare Advantage organization will no longer have a “current” Medicaid managed care contract to serve the dual eligible population.

48. The rationale that passive enrollment furthers efficiency and benefits consumers by allowing them to receive Medicare and Medicaid services through the same insurer does not apply in Pennsylvania.

49. Defendants are terminating the original Medicare or previous Medicare Advantage plan coverage of over 110,000 dual eligible persons who had elected that coverage in accordance with their rights under 42 U.S.C. § 1395w-21, without any written notice from CMS of that termination.

50. Defendants are enrolling over 110,000 low-income Medicare beneficiaries into Medicare Advantage plans without any written notice from CMS of that enrollment.

51. Defendants have violated the requirement under 42 U.S.C. § 1395w-101(c) to “conduct activities that are designed to broadly disseminate information to Part D eligible individuals...regarding the coverage provided under this part,” in that the “Medicare and You” 2006 Handbook issued by defendants to Pennsylvania Medicare beneficiaries and designed to explain the Medicare program to those beneficiaries makes no mention of the passive enrollment

plan. Nor have defendants undertaken any other effort to broadly disseminate information to class members or other Part D eligible individuals about passive enrollment.

52. The Department of Health and Human Services has elected to be covered by the notice and publication requirements of the Administrative Procedure Act, 36 Fed.Reg. 2532 (1971), and is also required to publish regulations in a matter consistent with section 1871 of the Social Security Act, 42 U.S.C. § 1395(hh).

53. Defendants' decision to permit the passive enrollment of 110,000 dual eligibles in Pennsylvania is a final decision. Exhaustion of administrative remedies to prevent passive enrollment would be futile.

VI. STATEMENT OF FACTS

54. The only information dual eligibles have received regarding their involuntary passive enrollment have been letters sent directly by Medicare Advantage plans to which they have been assigned. These Medicare Advantage letters are incomplete, inaccurate, and misleading.

55. The letters from the Medicare Advantage Plans falsely informed class members that they had to act by October 31, 2005 in order to avoid being passively enrolled effective January 1, 2006.

56. Initial enrollment for Part D begins on November 15, 2005 and ends May 15, 2006. 42 C.F.R. § 423.38 (a)(1).

57. Contrary to the letter from the Medicare Advantage plans, dual eligibles, like all other Medicare beneficiaries may legally enroll in a Prescription Drug Plan between November 15, 2005 and December 31, 2005 to begin coverage on January 1, 2006.

58. The official “Medicare and You” handbook published by CMS and required to be sent to every Medicare beneficiary states that initial enrollment period for prescription drug benefits under Medicare Part D runs from November 15, 2005 to May 15, 2006.

59. The “Medicare and You” handbook states that dual eligibles who fail to elect a plan between November 15, 2005 and December 31, 2005 will be auto-enrolled in a stand-alone Prescription Drug Plan for coverage effective January 1, 2006.

60. The “Medicare and You” handbook includes no information about passive enrollment of dual eligibles into Medicare Advantage Plans, nor about the October 31, 2005 deadline or what a person would have to do after October 31, 2005 to obtain their choice of Part D coverage.

61. Defendants have not required that the Medicare Advantage plans send written information to class members scheduled to be passively enrolled in their plans that explains what steps those class members may take after October 31, 2005 to disenroll from the Medicare Advantage plan into which they have been passively enrolled.

62. Defendants have not required that the Medicare Advantage plans send written information to those scheduled for passive enrollment that explains what steps those individuals may take after October 31, 2005 to obtain Part D coverage through a Prescription Drug Plan in time to have coverage effective January 1, 2006 that does not require them to be in a managed care plan.

63. Dual eligibles have more extensive health care needs than the general Medicare or Medicaid populations, including higher rates of Alzheimer’s disease, diabetes, pulmonary

disease and stroke than other people covered by Medicare. Approximately 38% of dual eligibles have mental or cognitive impairments.

64. Sixty-one percent of dual eligibles do not have high school diplomas and a significant percentage of dual eligibles either do not speak English or have limited English proficiency.

Plaintiff Barbara L. Erb

65. In October 2005, Plaintiff Erb received a letter from Amerihealth Mercy Health Plan informing her that she would be passively enrolled into Amerihealth65, a Medicare Advantage Plan.

66. Plaintiff Erb lives in York County. Her residence, however, is right on the border of Cumberland County, Pennsylvania. All of her health care providers are located in Cumberland and Dauphin Counties.

67. Although Amerihealth Mercy Health Plan (her Medicaid health plan) currently serves 15 counties, including Cumberland County and Dauphin County, Amerihealth65 will only serve 5 counties, including York but excluding Cumberland and Dauphin Counties. None of her present providers presently participate in Amerihealth 65. All of her providers have informed her that they will not join Amerihealth65 or any other Medicare Advantage plan that for Cumberland and Dauphin Counties.

68. On October 25, 2005, Plaintiff Erb called Amerihealth65 and asked to opt-out. Plaintiff Erb asked for written confirmation that her opt-out request was processed and that she would not be passively enrolled effective January 1, 2006. She has not received written confirmation that her opt-out request was processed.

69. Plaintiff Erb has never been provided with information from Medicare about passive enrollment or how to avoid being passively enrolled. Plaintiff Erb has not been provided with information from Medicare about how to obtain other coverage should she decline passive enrollment.

70. If passively enrolled, Plaintiff Erb would be unable to see her physician, psychiatrist, and otolaryngologist. Additionally, if passively enrolled, according to defendants' web site at the www.medicare.gov, she would only be able to obtain coverage for one of her three prescription drugs.

71. Plaintiff Erb is scheduled for significant surgery on or about December 13, 2005. She is distraught about how she will access her providers while recovering.

Plaintiff Samuel Styles

72. Samuel Styles has Down Syndrome as well as several other serious medical conditions that have been found to be disabling under the terms of the Social Security Act and is therefore entitled to Social Security payments and Medicare on his parent's earnings record. He lives with his mother, Mary Styles, who cares for him and makes all his medical decisions.

73. Samuel Styles did not receive a passive enrollment letter or other written communication from Keystone 65 Complete.

74. On November 7, 2005, plaintiff's mother, Mary Styles, heard a public presentation on Part D. She was informed about the passive enrollment of dual eligibles in Medicare Advantage plans. That same day, Mrs. Styles called Keystone 65 Complete to find out if her son was scheduled for passive enrollment. Mrs. Styles spoke to a member services

representative for Keystone 65 Complete and was told that her son was scheduled to be passively enrolled into Keystone 65 Complete, a Medicare Advantage plan.

75. Mrs. Styles requested over the telephone to opt her son out of passive enrollment so that he could continue to get his coverage under original Medicare.

76. Keystone 65 Complete member services staff informed Mrs. Styles that it was too late to opt-out because she had missed the deadline, but that her son's name would be put on a waiting list of people wanting to opt-out and that someone would be in touch with him by mail when Keystone 65 Complete got down to his name on the waiting list.

77. On November 29, 2005, Samuel Styles received a letter from Keystone 65 Complete confirming that Mrs. Styles' opt-out request would be honored.

78. Plaintiff Styles has never received a Medicare and You 2006 Handbook or any written or other information from defendants about passive enrollment or about how to obtain prescription drug coverage.

79. Plaintiff Styles has not received an auto-enrollment notice from defendants notifying him of his assignment to a stand-alone prescription drug plan.

Plaintiff Dorothy Boyd

80. Dorothy Boyd receives Medicare based on her age. Like many elderly women, she has several serious health care needs and sees her physicians regularly. She has original Medicare coverage as well as Medicaid coverage through MedPlus.

81. In October 2005, Mrs. Boyd received a passive enrollment letter from Unison Medicare Advantage plan.

82. Believing it to be just another solicitation letter from a plan she did not know and did not want, she ignored it.

83. On November 1, 2005, Mrs. Boyd went to a public presentation on Medicare prescription drug coverage and was informed about passive enrollment. She then carefully read the Unison passive enrollment letter and, to her surprise, learned that her health care coverage will be completely disrupted on January 1, 2006, since a number of her physicians did not appear to be covered. The letter advised her that she could opt out by October 31, 2005. The letter made no mention of what steps she could take if she missed the deadline or what could do to explore alternative coverage.

84. Mrs. Boyd called Unison to opt-out. She was told it was too late and that she would have to complete a disenrollment form, which they would send her, in order to get out of the plan. Mrs. Boyd never received a disenrollment form from Unison.

85. If passively enrolled into Unison, Mrs. Boyd will be limited to a restricted network of providers, will be required to designate one primary care doctor and obtain written referrals from that doctor prior to seeing necessary specialists, and will not be able to obtain all the prescription medications that she presently requires.

Plaintiff Ea A. Fahringer

86. Ms. Fahringer is blind and receives Medicare coverage based on her medical conditions, including her blindness, as well as a serious kidney problem. She received a passive

enrollment letter that she could not read. When read to her, she learned that the letter stated her that she would be passively enrolled into the Gateway Assured Medicare Advantage plan.

87. Ms. Fahringer is already enrolled in Senior Blue, a Medicare Advantage plan that she selected in 2003.

88. Ms. Fahringer also received a letter that she would be enrolled into Senior Blue's Medicare Advantage.

89. Both letters instructed Ms. Fahringer to take no action and stated that her enrollment would be automatic.

90. On October 26, 2005, Ms. Fahringer called Gateway Assured to inquire about passive enrollment, available coverage, and the opt out process. She left a message but never received a return call.

91. Five of the critical healthcare providers Ms. Fahringer must see regularly do not participate in Gateway Assured. Additionally, Gateway Assured has refused to provide any written information to Plaintiff Fahringer about whether the 22 prescription and OTC medications she must take are covered. Absent access to known health care providers who are familiar with her highly complicated and complex health care situation and life sustaining medications, Ms. Fahringer will suffer irreparable harm.

92. Ms. Fahringer received no written information from CMS or Gateway Assured as to what steps she would have to take to opt-out or otherwise disenroll after the October 31, 2005 deadline.

Plaintiff Virginia Pearson

93. Virginia Pearson suffers from multiple health problems and takes many different prescription drugs to treat these conditions.

94. Ms. Pearson learned that she was being passively enrolled into Keystone 65 Complete during a telephone conversation with a Keystone 65 Complete agent.

95. The Keystone agent told her that she was on a list of people who were enrolled in the Keystone Mercy Medicaid plan and therefore that she was going to be enrolled in Keystone 65 Complete. Upon informing the agent that she was already enrolled in Elder Health, a Medicare managed care plan of her choosing, Ms. Pearson was informed that her Elder Health enrollment would not be a problem and that Keystone 65 Complete would override her Elder Health plan.

96. The agent claimed that Keystone 65 Complete was the best plan for Ms. Pearson, that it was a partner plan to her Keystone Mercy plan and that it would pick up where Keystone Mercy left off.

97. When Ms. Pearson told the agent that she did not understand this explanation and that she did not want to enroll in Keystone 65 Complete, the agent told her that he would send a sales representative out to her home to explain the changes in benefits to her. The sales representative never came to her home.

98. After her conversation with the Keystone 65 Complete agent, Ms. Pearson became further confused when she was contacted by a representative of her current plan, Elder Health, who sent her more sales information in the mail.

99. Ms. Pearson never obtained an understandable explanation of what changes she was being subjected to, what new requirements will be placed upon her vis-à-vis network providers or referrals and she remains thoroughly confused and unsure of which plan will provide coverage

and whether all her physicians and medications will be covered. Such interference with her choice of plans, and the uncertainty of her medical future is causing her irreparable injury.

Plaintiff Ann Rosen

100. Plaintiff Ann Rosen suffers from multiple health problems and must take more than 15 prescription drugs on a daily basis.

101. Ms. Rosen received a letter from Keystone 65 Complete in October 2005. She did not understand the content of the letter. She called the telephone number listed in the notice but was unable to get an explanation of the changes to her benefits.

102. Ms. Rosen subsequently sought help from other places, including her local Social Security office and Defendant CMS's toll-free telephone number. None of the representatives that she spoke with were able to explain the passive enrollment letter that she received to her satisfaction.

103. Ms. Rosen eventually called Keystone 65 Complete again after November 1, 2005 and spoke with an agent who attempted to explain the changes in her benefits to her. The agent told Ms. Rosen that she had been placed into Keystone 65 Complete and that it was the best plan for her. Ms. Rosen asked the telephone representative what would happen if she wanted to join a different Medicare plan. He responded by telling her that she did not have a choice because she had missed the opt-out deadline of October 28, 2005.

104. The agent also told Ms. Rosen that she was going to be restricted to Keystone 65 Complete's network and referral requirements.

105. Ms. Rosen was confused and frustrated by this telephone conversation, but believed that she did not have a choice as to how she was going to receive Medicare coverage.

106. Ms. Rosen's only income is her Social Security disability benefits of approximately \$640 per month. Given the large number of prescriptions that she takes and her other monthly expenses, Ms. Rosen is not able to pay for her prescription drug needs. Ms. Rosen remains worried that she is going to experience a disruption in her drug coverage and that her health will be severely affected. Many of her medications do not appear on defendants' website, www.medicare.gov, as being covered by the managed care plan to which she is assigned. She would prefer to have original Medicare coverage and a Prescription Drug Plan that covers all her medications. Such interference with her choice of coverage, the possibility of many of her drugs being uncovered and the uncertainty of her medical future is causing her irreparable injury.

Plaintiff Susan Obermeyer

107. Plaintiff Susan Obermeyer never received a notice from Keystone 65 Complete that she was due to be passively enrolled.

108. Plaintiff Obermeyer was told about passive enrollment from her psychotherapist, who, along with her psychiatrist, will not be joining the Keystone 65 Complete network. On October 27, 2005, Plaintiff Obermeyer called Keystone 65 Complete to inquire whether she was scheduled to be passively enrolled. She was informed that she was due to be passively enrolled.

109. She asked to opt-out and was told she would be opted out. However, she did not receive confirmation that her opt-out would be processed until November 29, 2005.

110. Plaintiff Obermeyer has not received a Medicare and You Handbook or any written or other information from defendants about passive enrollment or about how to obtain prescription drug coverage.

111. Plaintiff Obermeyer has not received an auto-enrollment notice from defendants notifying her of her assignment to a stand-alone prescription drug plan.

112. Absent information about available coverage and absent inclusion in the auto-enrollment into a stand-alone prescription drug plan process required by law for all dual eligibles, defendants have placed Plaintiff Obermeyer in jeopardy of being without prescription drug coverage on January 1, 2006. Without prescription drug coverage, Plaintiff Obermeyer will be irreparable harmed.

Plaintiff CARIE

113. Plaintiff, the Center for Advocacy for the Rights and Interests of the Elderly, communicates with dually eligible consumers through regular mail and e-mail communications, and through frequent presentations at senior centers and clubs, and through individual, one-on-one consultations on its toll-free CARIE LINE. Over 4,500 Pennsylvania consumers are served each year by the CARIE LINE and over 18,000 individuals and organizations receive information, updates, or written materials from CARIE each year.

114. As a result of defendant's failure to explain and provide timely and adequate written notice to Medicare beneficiaries of the passive enrollment process, consumers served by CARIE have been and will be deprived of information that they need in order to understand their rights and, where appropriate, to exercise those rights. They will thus be harmed because they will make decisions without knowledge of their right to choose the Medicare option that will provide them with the best coverage. Many will be subjected to a managed care plan that they do not wish to be in, with a provider network that does not include their doctors and health care providers, and which does not cover all their prescriptions drugs. As a consequence, they will be deprived of needed medical care for which Medicare should provide coverage and thus will be irreparably injured.

115. As a further result of defendant's failure to provide timely and adequate explanations and advance written notice of passive enrollment, CARIE will have to devote scarce time, effort, staff, and other resources to its consumers and others in order to explain their rights when they are terminated from original Medicare and enrolled into Medicare Advantage plans. The resources devoted to these efforts could be used for other projects to implement CARIE's mandate. CARIE is thus irreparably harmed by defendants' actions.

Plaintiff Action Alliance

116. Plaintiff Action Alliance of Senior Citizens communicates with its members through a monthly newsletter, frequent presentations at senior centers and clubs, a monthly membership council meeting for club delegates and general members, and through individual, one-on-one assistance to those who contact the organization. The AASC newsletter is sent to more than 2,400 individuals and organizations.

117. As a result of defendant's failure to explain and provide timely and adequate advance written notice to Medicare beneficiaries of the passive enrollment process, members of AASC have been and will be deprived of information that they need in order to understand their rights and, where appropriate, to exercise those rights to choose the form of Medicare coverage that best suits their needs. They will thus be harmed because they will make decisions without knowledge of their right to challenge terminations and, as a consequence, will be deprived of needed medical care for which Medicare should provide coverage. Many will be subjected to a managed care plan that they do not wish to be in, with a provider network that does not include their doctors and health care providers, and which does not cover all their prescriptions drugs. As a consequence, they will be deprived of needed medical care for which Medicare should provide coverage and thus will be irreparably injured.

118. As a further result of defendant's failure to explain and provide timely and adequate advance written notice to Medicare beneficiaries of their passive enrollment plan, AASC will

have to devote scarce time, effort, staff, and other resources to inform its members and others in order to explain their rights to undo the passive enrollment that has been imposed upon them. The resources devoted to these efforts could be used for other projects to implement AASC's mandate. By failing to explain and provide timely and adequate advance written notice, defendants have expanded the number of people needing AASC's assistance and the scope of the assistance needed, has interfered with and impeded AASC's mandate, and has reduced the overall effectiveness of its programs and efforts. Defendants have thus caused AASC irreparable injury.

VII. INADEQUACY OF REMEDY AT LAW AND PROPRIETY OF ISSUANCE OF A WRIT OF MANDAMUS

119. Plaintiffs are presently suffering irreparable injury that will continue in the future by reason of the defendants' actions. Plaintiffs and the class they seek to represent are elderly and persons with permanent disabilities who will be irreparably harmed by a sudden and unexpected termination of their original Medicare or other Medicare coverage of their own choosing. Involuntary enrollment into a managed care system of limited provider networks, mandatory referrals, a restricted list of covered drugs and prior authorization of services will cause harm and disrupt needed health care services. Plaintiffs have no adequate remedy at law in that their right to choose the form of health care coverage that is best for them has been interfered with and no monetary award could make them whole for the loss of this inchoate right. Only the declaratory, injunctive, and mandamus relief which this court can provide will fully redress the wrongs done to plaintiffs.

120. Plaintiffs have a clear right to the relief sought. There is no other adequate remedy available to correct an otherwise unreviewable defect not related to claims for benefits. The

defendants have a plainly defined and nondiscretionary duty to provide the relief which plaintiffs seek.

VIII. FIRST CAUSE OF ACTION:

VIOLATION OF THE MEDICARE MODERNIZATION ACT

121. Defendants' passive enrollment plan violates 42 U.S.C. § 1395w-21(a) and (c), which allows defendants to enroll beneficiaries in a Medicare Advantage plan only where the beneficiary has affirmatively chosen to enroll in such a plan instead of original Medicare. 42 U.S.C. § 1395w-21(c) also provides that an individual's election to receive coverage through original Medicare or a particular Medicare Advantage plan may only be changed by choice of the individual.

122. Defendants have also violated 42 U.S.C. § 1395-w101(c), which requires them to "conduct activities that are designed to broadly disseminate information to part D eligible individuals ... regarding the coverage provided under this part" by failing to include any information about the passive enrollment process in the "Medicare and You" 2006 Handbook or otherwise disseminating information to class members about passive enrollment.

IX. SECOND CAUSE OF ACTION:

VIOLATION OF THE MEDICARE ACT GUARANTEE OF FREEDOM OF CHOICE.

123. By forcing plaintiffs and the class to receive their health care coverage through a Medicare Advantage plan that they have not chosen, defendants have violated the freedom of choice provision of Section 1802 of the Act, 42 U.S.C. § 1395a.

X. THIRD CAUSE OF ACTION:

VIOLATION OF THE ADMINISTRATIVE PROCEDURE ACT

124. In crafting “passive enrollment” and implementing a significant change in policy affecting the substantive rights of some 110,000 Medicare beneficiaries, defendants have violated 5 U.S.C. § 553 of the Administrative Procedure Act (APA) and Section 1871 of the Social Security Act, 42 U.S.C. § 1395hh, requiring the program to function under regulations duly promulgated.

XI. FOURTH CAUSE OF ACTION:

VIOLATION OF THE ADMINISTRATIVE PROCEDURE ACT

125. Passive enrollment is an agency action that is arbitrary and capricious and contrary to law in violation of 5 U.S.C. § 706(2)(a) of the Administrative Procedure Act (APA).

XII. FIFTH CAUSE OF ACTION:

VIOLATION OF THE DUE PROCESS CLAUSE

126. The termination of the form of Medicare coverage elected by over 110,000 dual eligibles without timely and adequate written notice from CMS, or an opportunity to be heard, violates the Due Process Clause of the Fifth Amendment of the Constitution.

XIII. PRAYER FOR RELIEF

WHEREFORE, plaintiffs respectfully ask this Court to:

1. Assume jurisdiction over this action.

2. Certify that this case is maintainable as a class action under Rules 23(a) and (b)(2) of the Federal Rules of Civil Procedure, and appoint plaintiffs' counsel as class counsel pursuant to Rule 23(g).

3. Issue a preliminary injunction requiring defendants to:

a. Postpone any planned passive enrollment in Pennsylvania pending the outcome of this suit;

b. In the alternative, require managed care plans to develop and widely publicize enforceable benefits procedures that allow passively enrolled members to access health care as if they had not been passively enrolled so that they may continue to do such things as see their doctors and other health care providers regardless of the managed care plans' network composition or referral requirements and require that plans cover all medically necessary drugs for which members have a prescription.

c. Order that defendants provide, in writing and in accessible formats, written notice of the planned passive enrollment, including such information as is necessary to enable all class members, or their representatives, to choose their form of Medicare coverage, including Part D coverage through an appropriate Prescription Drug Plan.

4. Issue a declaratory judgment declaring that:

a. Defendants have violated the Medicare Modernization Act of 2003.

b. Defendants have violated the freedom of choice requirements of the Medicare statute.

b. Defendants have violated the Administrative Procedure Act at 5 U.S.C. § 553.

c. Defendants have violated the Administrative Procedure Act at 5 U.S.C. § 706(2)(a).

d. Defendants have violated the Due Process Clause of the Fifth Amendment of the United States Constitution.

5. Issue a permanent injunction prohibiting defendants from:

a. Passively enrolling Medicare beneficiaries into Medicare Advantage plans they did not select;

6. Award costs of the suit herein, as authorized by 28 U.S.C. § 1920.

7. Award reasonable attorneys' fees and expenses pursuant to the Equal Access to Justice Act, 28 U.S.C. § 2412.

8. Grant such other and further relief as may be just and proper.

Respectfully submitted,
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DATED: November , 2005