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**Contacts:**

**Alissa Eden Halperin, Esq.  
The Pennsylvania Health Law Project  
215-625-3897**

**Richard Weishaupt, Esq.  
Community Legal Services  
215-981-3773**

**Poor Pennsylvanians Sue Centers for Medicare and Medicaid Services for Plan to Force Them into HMOs**

Lower-income Pennsylvanians with Medicare and Medicaid filed a class action lawsuit on November 30, 2005 to stop the federal government from forcing them and others like them into Medicare HMOs.

The Centers for Medicare and Medicaid Services (CMS), the federal agency that runs the Medicare program, has approved and overseen implementation of a “passive enrollment” plan which allows private insurance companies to remove these lower-income Pennsylvanians from the Original fee-for-service Medicare coverage they had chosen and to enroll them – without the beneficiaries’ having requested it - in Medicare HMOs run by those insurance companies. The insurance companies involved sent direct mail to over 110,000 Pennsylvanians informing them that they were going to become members of those companies’ Medicare HMOs on January 1, 2006 and that they will receive their Medicare Prescription Drug Benefit through the HMO.

The lawsuit alleges that the Centers for Medicare and Medicaid Services (CMS) did not have the legal authority to reverse the affirmative choice of these lower-income Pennsylvanians to receive their Medicare coverage through the Original Medicare program. Moreover, CMS never sent beneficiaries any notice that their Original Medicare was being changed to a Medicare HMO. The “Medicare and You 2006 Handbook” sent to Pennsylvania Medicare beneficiaries contains no mention of the passive enrollment plan, and no information is available about it on the [www.medicare.gov](http://www.medicare.gov) website. CMS also failed to promulgate any regulations governing this major change to the benefits of thousands of beneficiaries.

Passive enrollment will cause poor Medicare beneficiaries in Pennsylvanians to lose the freedom of choice of health care providers which is guaranteed by the Medicare statute. They will be limited to the network of providers that participate in the Medicare HMO, which may not include some of their physicians and other health care providers. In addition, they will be subject to utilization control measures such as being required to get referrals and having to get prior authorizations for some services.

Although those who are being passively enrolled can disenroll from the plan to which they are assigned, there is concern that many beneficiaries are confused by all of the changes taking place in Medicare and do not understand that they are being enrolled in an HMO or how to disenroll. Many beneficiaries who have tried to disenroll have had difficulty doing so and those who try to do so after January 1, 2006 will experience delays of up to a month before the disenrollment takes effect, during which time they may not be able to access their health care providers.

Plaintiffs hope to prevent the passive enrollment plan from taking place so that no Medicare beneficiary will wake up on January 1, 2006 to find, to their surprise, that they are unable to go to their physicians, psychiatrists or other health care providers. At a minimum, plaintiffs seek detailed notice from CMS to inform beneficiaries clearly about the change to their coverage and a requirement that all of the Medicare HMOs provide these consumers with the same full access to critical health care that they would have had had they not been passively enrolled.