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18 UNITED STATES DISTRICT COURT  
19 NORTHERN DISTRICT OF CALIFORNIA

20 XIUFANG SITU, JOSEPHINE GUIN, BOBBI )  
21 BEER, WILLARD ELLIS, KAZIMIERA )  
22 SOKOLOWSKI, ROSA BEGUN, IRENE )  
23 CRAM, JO ANN BURBES, MILDRED )  
24 SNIDER, LILLIAN EMERY, VINCENT )  
25 PERILLO, ED RANDOLPH, LUDMINA )  
26 SCHWARTZLE, CALIFORNIA ALLIANCE )  
27 FOR RETIRED AMERICANS, ACTION )  
28 ALLIANCE OF SENIOR CITIZENS OF )  
GREATER PHILADELPHIA, ILLINOIS )  
NETWORK OF CENTERS FOR )  
INDEPENDENT LIVING and STONE-HAYES )  
CENTER FOR INDEPENDENT LIVING )  
on behalf of themselves and all others similarly )  
situated, )  
Plaintiffs, )  
v. )  
MICHAEL O. LEAVITT, )  
Secretary of Health and Human Services, )  
Defendant. )

CIVIL ACTION NO.: C06-02841 TEH

**SECOND AMENDED COMPLAINT  
FOR INJUNCTIVE, DECLARATORY,  
AND MANDAMUS RELIEF**

1 **I. INTRODUCTION**

2 1. This action challenges the failure of the defendant, Secretary of Health and  
3 Human Services (the Secretary), to provide Medicare Part D prescription benefits to millions of  
4 impoverished beneficiaries who are entitled to them and who cannot obtain the drugs that they  
5 need.

6 2. The Medicare Part D program went into effect on January 1, 2006 and is  
7 intended to provide access to prescription drug benefits through private insurance plans to all  
8 Medicare beneficiaries. Enrollment in the Part D program is voluntary for all beneficiaries  
9 except for the more than 6,000,000 individuals eligible for both Medicare and Medicaid, known  
10 as dual eligibles. These dual eligible beneficiaries, all of whom are by definition elderly and/or  
11 disabled, must participate in the Medicare Part D program (or have no drug coverage at all)  
12 because they no longer have drug coverage through the Medicaid program. Medicaid  
13 prescription drug coverage ended for these individuals on December 31, 2005. To ensure a  
14 smooth transition for the dual eligibles, Congress mandated that the Secretary establish a process  
15 to automatically enroll all dual eligibles into a Part D prescription drug plan to ensure that they  
16 had access to prescription drug coverage. Congress also established a Low Income Subsidy  
17 program (LIS) to waive the monthly Part D premium and annual deductible and to reduce cost  
18 sharing substantially for dually eligible individuals and others who meet the LIS financial  
19 eligibility criteria. While most low income beneficiaries must apply for the subsidy, dual  
20 eligibles are considered to be subsidy eligible without any action necessary on their part. The  
21 Secretary is obligated to inform the prescription drug plan in which the individuals are enrolled  
22 of their status as subsidy eligible individuals. Finally, Congress entitled all dual eligible  
23 individuals to an ongoing Special Enrollment Period (SEP) to allow them to change Part D plans  
24 at any time.

25 3. The Secretary has failed:

26 a. to implement uniformly and properly the auto-enrollment requirement, causing  
27 dual eligibles not to be enrolled in a Part D plan;



1 Social Security Card. She was reluctant to show the pharmacist her Social Security card, so she  
2 left the pharmacy without getting her medication.

3 8. Ms. Situ's husband contacted Bay Area Legal Aid about another matter and Ms.  
4 Situ's Part D problems were revealed on April 21, 2006. The attorney there called CMS to find  
5 out which plan Ms. Situ was enrolled in and was told Pacificare. She called Pacificare and was  
6 told Ms. Situ was inactive in their system. Ms. Situ has been unable to access the drugs she  
7 needs under Medicare Part D. She is extremely confused about what to do and is worried about  
8 how she will get her medicine.

9 9. Plaintiff JOSEPHINE GUIN is 76 years old and lives with her 71 year old  
10 husband in Tallahassee, Florida. Their household monthly income is \$1,464. Ms. Guin takes  
11 eight prescriptions per month for congestive heart failure. Prior to 2006, Ms. Guin received her  
12 medications through the Florida Medicaid program. Because of her status as a dual eligible in  
13 2005, Ms. Guin is automatically eligible for the full Low Income Subsidy to assist with her  
14 prescription drug costs. Nevertheless, \$14.10 per month is being deducted from her Social  
15 Security check to pay the premium for her WellCare Part D plan. Most recently Ms. Guin tried  
16 to pick up the drug Coreg and was told it would cost \$15.00. She did not get the drug because  
17 she does not have the money to pay for it.

18 10. Plaintiff BOBBI BEER is a 65 year old dual eligible who lives in San Diego  
19 California, and makes \$973 a month. She has physical and mental disabilities and takes twelve  
20 different prescription drugs each month. She recently found out that her drug plan, Healthnet  
21 Orange, has been charging her trustee incorrect amounts for her medications. Since she is a dual  
22 eligible and should be on the Low Income Subsidy, she should have only paid \$1 or \$3 for her  
23 medications. Her drug plan has been charging her \$35 for her Cymbalta and even higher co-  
24 payments for other medications. She is currently out of four of her medications. She has asked  
25 for reimbursement, but is worried that she won't get reimbursed by the drug plan, and she will  
26 stop taking her medications if she has to keep paying these incorrect co-payments.

27 11. Plaintiff WILLARD ELLIS is a 64 year old man who lives in an assisted living  
28 center in Yucaipa, California. He is a dual eligible on Med-Cal and Medicare who suffers from

1 mental illness and high blood pressure. He walks with a cane and recently had back surgery. He  
2 takes seven prescription medications every month. His brother, Gary Ellis, is an independent  
3 pharmacist network administrator who handles his medical and insurance issues for him.

4 Although Willard Ellis should be fully subsidized as a dual eligible under Medicare Part D he  
5 has repeatedly been billed for prescription drug costs beyond the appropriate nominal co-pays  
6 and recently received a bill from the network pharmacy for \$36.37 with a statement that his  
7 account is past due and that his account will be suspended.

8 12. Plaintiff KAZIMIERA SOKOLOWSKI is an 80 year old dual eligible who lives  
9 in Liberty Borough, Pennsylvania, and suffers from Alzheimer's Disease. In January 2006, Ms.  
10 Sokolowski attempted to fill her prescriptions through her Medicaid plan, having not been  
11 notified that her Medicare Advantage Plan with Security Blue now covered prescription drugs.  
12 She was unable to obtain her prescriptions and was subsequently advised by her caseworker to  
13 join a stand alone Prescription Drug Plan. As a result, she enrolled in a stand alone plan with  
14 Humana, effective February 1, 2006.

15 13. During the month of February Ms. Sokolowski paid more than \$200 in  
16 premiums and co-payments because Humana had not received confirmation of her dual eligible  
17 status from CMS. After discovering that her Security Blue plan offered prescription drug  
18 coverage, Ms. Sokolowski attempted to disenroll from her Humana plan in March of 2006. On  
19 March 24, 2006 she received a letter from CMS requiring her to choose between the two plans.  
20 Upon receiving this letter Ms. Sokolowski followed the instructions in the letter for electing  
21 coverage through Security Blue. Despite these attempts, she was informed in April of 2006 that  
22 she had been involuntarily disenrolled from her Security Blue coverage on February 21, 2006  
23 and from her Humana plan on March 31, 2006.

24 14. Ms. Sokolowski has been extremely confused and frustrated by these errors.  
25 She does not know if she will be able to re-enroll in her Security Blue plan or who is conducting  
26 an investigation to determine her status. She has not been reimbursed for her out-of-pocket  
27 expenses paid in February and does not know whether Security Blue has ever been informed of  
28 her Low Income Subsidy. She currently needs to have four prescriptions filled.

1           15.       Plaintiff ROSA BEGUN is a 75 year old San Francisco resident. She has heart  
2 problems, high blood pressure, arthritis and recently had her right knee replaced. She is very low  
3 income, receives SSI and is on Medi-Cal and Medicare. She takes as many as sixteen  
4 prescriptions a month. She has had numerous enrollment and disenrollment problems with  
5 Medicare Part D. She was auto-enrolled in a Humana plan in November then later into  
6 HealthNet Orange and then also into a Blue Cross plan. She does not know why she was  
7 enrolled in so many different plans, but she keeps getting letters saying that she is enrolled in the  
8 various plans.

9           16.       Ms. Begun received assistance from Ms. Vlada Gulchin, the residential service  
10 coordinator in the senior housing program where she lives, who has repeatedly tried to find out  
11 why she keeps getting enrolled in so many different plans and to get her into the plan that she  
12 wants to be in. The computers for the plans show different information from the letters she  
13 receives. Although Ms. Gulchin called 1-800-MEDICARE numerous times and a filed  
14 complaint on Ms. Begun's behalf, when the problems happened again, Medicare claimed they  
15 had no record of a complaint filed on Ms. Begun's behalf. Ms. Gulchin has spent many hours on  
16 the telephone over many days with the various plans and with 1-800-MEDICARE, and has  
17 recorded various reference numbers from these calls, but Ms. Begun still seems to be in more  
18 than one plan. Although Ms. Begun should be fully subsidized under Part D and pay no  
19 premiums, she received a bill for a \$35 premium.

20           17.       Plaintiff IRENE CRAM is 76 years old and lives in National City, California.  
21 She has numerous medical conditions including osteoporosis, spinal degeneration, glaucoma,  
22 and eye cataracts. She also has a hiatal hernia and suffers from vertigo and takes eight  
23 prescriptions. She is a dual eligible on Medi-Cal and Medicare. On April 10, 2006, her  
24 prescription drug plan, United Medicare, sent her a bill for \$18.36. The bill stated that if she  
25 didn't pay the charges she would be disenrolled from her plan effective May 31, 2006. As a dual  
26 eligible individual, Ms. Cram ought to receive the Low Income Subsidy and pay no premiums.  
27 Her monthly premiums of \$4.59 have gone unpaid since her auto enrollment into Medicare Part  
28

1 D coverage in January 2006. United Healthcare has no record of her LIS status and has  
2 threatened to disenroll her.

3 18. Plaintiff JO ANN BURBES is 71 years old. She lives in St. Louis, Missouri and  
4 she is dually eligible for Medicare and Medicaid. She has a heart condition, spinal stenosis,  
5 arthritis, edema and problems with her nerves for all of which she takes Potassium chloride,  
6 Lipitor, Zoloft, Flexeril, Piroxicam, and Maxzide.

7 19. Prior to Part D implementation, Ms. Burbes relied on Missouri Medicaid to get  
8 her medications. In January, when she needed to fill her prescriptions she was told that she was  
9 not enrolled in a plan. She was told this by her pharmacist, and by representatives when she  
10 called 1-800-MEDICARE. She never received a yellow auto-enrollment letter. Through self-  
11 advocacy and with help from legal services, she obtained prescriptions and enrolled in a plan.  
12 She went for a time without her prescriptions in January and early February, and she always  
13 experienced delays in January and February when the pharmacist refused to fill her prescriptions  
14 without her Part D ID card. One time, a pharmacist filled only a fifteen-day supply. After she  
15 enrolled in a plan (Wellcare Signature), she began receiving information from a different plan  
16 (Blue Medicare Rx) indicating that she had been auto-enrolled in that plan by CMS. There was  
17 additional confusion in both processes, because the plans use other business entities to conduct  
18 enrollment activities (Anthem, Unicare, etc.).

19 20. Between February 3, 2006 and February 14, 2006, Ms. Burbes received letters  
20 from three different plans (Medicare Rx Rewards, Medicare Blue Rx and Wellcare Signature),  
21 each telling her she was enrolled in that plan. In March and April, she received additional letters  
22 from each of the plans, including a letter each from Medicare Blue Rx and Wellcare indicating  
23 they had paid for prescriptions in the month of February.

24 21. Ms. Burbes ended up being enrolled in two plans, and began receiving premium  
25 invoices from a third plan, Unicare. Beginning in March, 2006 she has been able to obtain her  
26 medications without delay through her coverage under Blue Medicare Rx, though she continues  
27 to get invoices for premiums and confusing statements about her coverage limit.

28

1           22.       Plaintiff MILDRED SNIDER is a dual eligible individual living in Monette  
2 Manor Nursing Center, a nursing facility in Monette, Arkansas. She is 79 years old and suffers  
3 from dementia, COPD and atrial fibrillation, and takes ten prescription drugs for these  
4 conditions. She was auto-enrolled into Medicare Part D provided by WellCare Health Plan, Inc.  
5 Since her auto enrollment in the Part D plan in January 2006, her pharmacy, Monette Discount  
6 Drug, has been told to charge a co-payment for her prescriptions. As a nursing home resident,  
7 she should have no co-payments under Medicare Part D. The staff at Monette Manor have made  
8 numerous phone calls on her behalf to WellCare, Social Security, Medicare, and the local  
9 Medicaid office. Each of these entities told Monette Manor staff to call someone else, and that  
10 they could not do anything for Ms. Snider. These attempts to verify Ms. Snider's subsidized  
11 status have yielded no results whatsoever. Her pharmacy still has no record of her subsidized  
12 status.

13           23.       Plaintiff LILLIAN EMERY is 80 years old and is a dual eligible individual  
14 living in Monette Manor Nursing Center, a nursing facility in Monette, Arkansas. She recently  
15 underwent surgery for a subdural hemorrhage and also has high blood pressure. Her dual  
16 eligible and nursing home status is supposed to exempt her from all co-payments at her regular  
17 pharmacy, Monette Discount Drug. For the last four months, she has been asked to make a co-  
18 payment because her prescription drug plan, AARP, has no record of her status as a dual eligible.  
19 The staff at Monette Manor have attempted to help Ms. Emery by contacting AARP as well as  
20 the local Social Security, Medicare and Medicaid offices. Despite their efforts they have not  
21 been able to correct the problem for Ms. Emery.

22           24.       Plaintiff VINCENT PERILLO is a dual eligible living in San Diego, California.  
23 He is 58 years old and suffers from low grade chronic depression. Mr. Perillo currently takes  
24 seven prescription drugs. Prior to the January 2006 start of Medicare Part D, Mr. Perillo was  
25 pre-enrolled in a prescription drug plan with BlueCross. After January 1, 2006 he attempted to  
26 get his normal prescriptions and found that some of his medications were not on the formulary  
27 provided by his plan. Mr. Perillo then called 1-800-MEDICARE, who suggested a plan with  
28 either Humana or AARP. He chose the Humana plan and contacted Humana by phone on March

1 31, 2006 to enroll. At that time he was told that his enrollment would have an effective date of  
2 April 1, 2006.

3 25. In order to make sure that his enrollment had been completed, Mr. Perillo called  
4 Humana on April 1, 2006 to verify his coverage. Humana informed him that they had no record  
5 of his account number or policy identification number. He continued calling Humana and 1-800-  
6 MEDICARE for the next week without receiving any confirmation of his status from either  
7 source. Two weeks later he received a booklet including his enrollment confirmation, but not his  
8 identification card. The booklet did not have his policy number and had other confusing errors,  
9 such as listing Mr. Perillo as a female. He only managed to receive an identification card after  
10 dozens of phone calls to Humana and 1-800-MEDICARE. However, he has now received  
11 payment coupons and a letter stating that he must make monthly premiums payments for his  
12 prescription drug coverage despite the fact that he should not have to pay any premiums at all as  
13 a subsidized individual. Mr. Perillo contacted Humana, who had no record of his dual eligible  
14 status.

15 26. As a disabled individual suffering from chronic depression, this ordeal has been  
16 particularly detrimental to Mr. Perillo. His efforts to return to work have been repeatedly  
17 thwarted by the loss of time, energy and peace of mind to the frustrating task of switching out of  
18 his default Part D plan. He has not received notice of disenrollment from his Blue Cross plan  
19 and, as a result, does not know who is paying for his prescriptions. He fears that he will lose  
20 access to his normal routine of medications if California's emergency relief plan ends.

21 27. Plaintiff ED RANDOLPH is a 47 year old married man living in Barnesville,  
22 Ohio. He is dually eligible for Medicare and Medicaid and receives a Social Security disability  
23 check of \$536 per month which is his sole source of income.

24 28. Mr. Randolph has medications for heart disease, asthma, diabetes-related  
25 conditions, conditions related to stomach bypass surgery and depression. These medications  
26 include nitro patches, nitroglycerin, Albuterol, Lamisil, Lidex, nystatin cream, nexiam and  
27 Zoloft. Since January 2006, due to complications with Part D, Mr. Randolph has not purchased  
28 many of his medications.

1           29.       Mr. Randolph was originally auto-enrolled in First Health Premier, a plan  
2 offered in Ohio. He called Humana seeking only information and later discovered he was,  
3 without his consent, enrolled into Humana Complete, a plan with a premium above the  
4 subsidized premium amount for his region. Premiums of \$49.40/month began to be deducted  
5 from his Social Security disability check. In April, Humana refunded him the difference  
6 between the subsidized premium and the higher Complete premium for the months of January  
7 and February, apparently acknowledging that the deductions were incorrect. However, the  
8 amount continues to be deducted from his disability check, and he has not received another  
9 refund check from Humana.

10           30.       As of mid-May, Medicare showed that he disenrolled from Humana on  
11 February 28th, and showed him as enrolled in First Health Premier as of March 1st. In mid-May,  
12 First Health Premier showed him as not being currently enrolled, but he has subsequently  
13 received a card from them. In mid-May, Humana showed him as being enrolled in Humana  
14 Standard as of March 1st. In mid-May, the local Social Security office showed him enrolled in  
15 Humana Complete.

16           31.       As of June 1, 2006, Medicare, First Health Premier, and Mr. Randolph's  
17 pharmacy show him as enrolled in First Health Premier. Mr. Randolph successfully filled his  
18 prescriptions at his pharmacy and was charged the correct low-income subsidy co-payments.  
19 Mr. Randolph continues, however, to have premiums for Humana Complete deducted from his  
20 disability check, and on June 6, 2006 received a new welcome letter from Humana, dated May  
21 23, 2006, saying his coverage is effective June 1, 2006.

22           32.       In addition to going without some medications, during this time, Mr. Randolph  
23 and his wife have had to cut back on several services in order to make ends meet. They have, for  
24 the first time, turned to the Salvation Army for assistance. This winter they received Emergency  
25 Heat assistance. To save on food costs, Mr. Randolph usually plants a garden, but this year was  
26 forced to plant less than usual. In addition, they have ended their Internet service, cut back to the  
27 most basic phone service, and can no longer afford their satellite T.V. service, one of their few  
28

1 expenses on entertainment. The money they had in savings, which was intended to pay their  
2 house taxes, has since been used to cover other costs.

3 33. Plaintiff LUDMINA SCHWARTZLE is a dual eligible living in San Diego,  
4 California. She is 55 years old and has several serious medical conditions such as End Stage  
5 Renal Disease (ESRD), diabetes, fibromyalgia, and heart problems. She takes 10 prescription  
6 medicines for these conditions. In January, 2006 she was auto-enrolled into a Part D plan with  
7 Humana that did not cover all of her prescriptions. In February, 2006 she called 1-800-  
8 MEDICARE to enroll in a Part D plan with AARP, which covered all of her medications. Yet,  
9 after doing so she did not receive a welcome packet or identification card from AARP. She did  
10 receive a letter from AARP stating that her new coverage would be effective March 1, 2006.  
11 During the month of March she paid as much as \$28 per prescription for three of the ten drugs  
12 she needs at her pharmacy because AARP had no record of her dual eligible status.

13 34. AARP has since received recognition of Ms. Schwartzle's dual eligible status. In  
14 April, 2006 she was reimbursed the equivalent of her expenses above the LIS co-payment level  
15 to receive her three medications. She has yet to receive her welcome packet or identification card  
16 from AARP and is told their system is backed up with nearly 7,000 other transition beneficiaries  
17 awaiting receipt of their benefit card. She requested her member identification number. She is  
18 now receiving her medications each month with AARP and paying the LIS co-payment, but is  
19 still enrolled in two plans.

20 35. When Ms. Schwartzle called Medicare in April, 2006 they told her that she was  
21 still enrolled in Humana. Instead of correcting her problem, they told her to call AARP.

22 36. As of June 1, 2006, Ms. Schwartzle is still enrolled in Humana, months after she  
23 disenrolled. She has been in contact with 1-800-MEDICARE representatives who continue to  
24 tell her to contact AARP. AARP is unable to offer her assistance regarding her dual enrollee  
25 status.

26 37. Plaintiff CALIFORNIA ALLIANCE FOR RETIRED AMERICANS (CARA) is  
27 a statewide nonprofit organization made up of 130 organizations with a combined membership  
28 of more than 750,000 individual Californians. CARA is headquartered in Oakland, California, in

1 Alameda County, and is a broad-based coalition which includes senior centers, tenant  
2 associations, retired public employee organizations, trade union retirees and a variety of other  
3 consumer agencies and associations. Many of its individual members are themselves dual  
4 eligibles struggling with Medicare Part D enrollment problems.

5 38. CARA is dedicated to educating and informing the public and its members about  
6 issues that affect the well-being of California's older adults. CARA has expended an enormous  
7 amount of its resources educating its members, the public and policy makers about Medicare Part  
8 D and the many problems associated with it. The enrollment problems and subsidy errors  
9 associated with Part D and low income people have taken a large amount of time for CARA its  
10 staff, board and members which would otherwise be spent on other matters.

11 39. Plaintiff ACTION ALLIANCE OF SENIOR CITIZENS OF GREATER  
12 PHILADELPHIA is a coalition of over 229 senior clubs and organizations in the Philadelphia,  
13 Pennsylvania area, representing over 110,000 elderly people, including many low income  
14 Medicare beneficiaries also eligible for Medicaid. Its members come from senior centers, union  
15 retiree clubs, church clubs, tenant councils and community groups. Its mission is to fight for a  
16 better life for all seniors.

17 40. Since the passage of the Medicare Act of 2003, Action Alliance has been  
18 educating its members and other seniors about Medicare Part D, and since implementation of the  
19 program in January 2006, its staff and volunteers have been diverted from other activities due to  
20 the need to help members and other seniors navigate Part D plan issues and problems.

21 41. Plaintiff ILLINOIS NETWORK OF CENTERS FOR INDEPENDENT LIVING  
22 (INCIL) is a statewide organization made up of twenty-three Centers for Independent Living  
23 (CILs) in Illinois. INCIL exists to empower individuals with disabilities to take charge of their  
24 lives and make their own choices in order to be as self-sufficient as possible. CILs also lead  
25 efforts to break down barriers and prejudices within communities, with the goal of obtaining  
26 equal access to society for disabled persons.

1           42.       INCIL coordinates the activities and efforts of all of the Illinois CILs, providing  
2 a stronger, more unified voice to promote the needs and priorities of the CILs and the people  
3 they serve. Many of the people served by INCIL and the other Illinois CILs are dual eligibles.

4           43.       The Medicare Modernization Act of 2003 has had a profound impact on the  
5 work of member CILs, who have made extensive efforts to ensure their residents continue to  
6 receive prescription drug benefits under the Medicare Part D program. All of the CILs have  
7 received many calls from dual eligible clients with enrollment and subsidy problems and they  
8 assist them when they are able.

9           44.       INCIL has been particularly affected by the enrollment and subsidy issues  
10 mentioned in this case because it has handled a huge volume of calls from dual eligible people.  
11 INCIL's number was listed on notices from the Medicaid agency as a place for assistance with  
12 Part D problems. As a result, since November 2005, INCIL has received approximately 4,000  
13 calls for assistance with Part D, most of which are from dual eligibles. Although INCIL has  
14 received a small grant to work on Part D, the volume of calls and problems has taken more of  
15 INCIL's resources than expected and has displaced staff time from other essential and important  
16 activities.

17           45.       Plaintiff STONE-HAYES CENTER FOR INDEPENDENT LIVING (Stone-  
18 Hayes) is located in Galesburg, Illinois and is a resource and advocacy organization for persons  
19 with disabilities. Their staff of eight serves over 125 individuals each year from Knox, Warren  
20 and Henderson Counties. In addition to providing information and advocacy, Stone-Hayes  
21 works to train individuals with disabilities to manage their own lives and effect political change.  
22 Many of the individuals they serve are Medicare beneficiaries with dual eligible status.

23           46.       Stone-Hayes Center has had approximately 129 inquiries regarding Medicare  
24 Part D from January through April. Of these, about 73% were from dual eligibles with  
25 enrollment or low income subsidy issues. Stone-Hayes estimates its advocates spend at least 30  
26 minutes per inquiry, with some cases requiring much more time. Since the Stone-Hayes does not  
27 receive funding or other compensation for Medicare Part D training, counseling or advocacy,  
28

1 undertaking it results in diverting resources from other essential activities including pursuing its  
2 mission of empowering people with disabilities to take charge of their lives.

3 47. Defendant MICHAEL O. LEAVITT is the Secretary of the Department of  
4 Health and Human Services. In that capacity, he has responsibility for the conduct and policies  
5 of the Department of Health and Human Services, including responsibility for the Centers for  
6 Medicare and Medicaid Services (CMS), which administers the Medicare program. He is sued  
7 in his official capacity.

#### 8 **IV. CLASS ACTION ALLEGATIONS**

9 48. Plaintiffs XIUFANG SITU, JOSEPHINE GUIN, BOBBI BEER, WILLARD  
10 ELLIS, KAZIMIERA SOKOLOWSKI, ROSA BEGUN, IRENE CRAM, JO ANN BURBES,  
11 MILDRED SNIDER, LILLIAN EMERY, VINCENT PERILLO, ED RANDOLPH, LUDMINA  
12 SCHWARTZLE, CALIFORNIA ALLIANCE FOR RETIRED AMERICANS, ACTION  
13 ALLIANCE OF SENIOR CITIZENS OF GREATER PHILADELPHIA, ILLINOIS NETWORK  
14 OF CENTERS FOR INDEPENDENT LIVING and STONE-HAYES CENTER FOR  
15 INDEPENDENT LIVING bring this action on behalf of themselves, and, in the case of the  
16 organizations, they bring these claims on behalf of themselves and also on behalf of their  
17 members and the people they serve, and pursuant to Rules 23(a) and (b)(2) of the Federal Rules  
18 of Civil Procedure, as representatives of a class of all others similarly situated, which is defined  
19 as follows:

20 49. All full benefit dually eligible Medicare beneficiaries who are unable to receive  
21 the full benefits of Medicare Part D prescription drug coverage and/or the Low Income Subsidy  
22 program due to the actions or failure to act of the Secretary of Health and Human Services.

23 50. Joinder is impracticable due to the large number of class members and for other  
24 reasons, including but not limited to their geographic diversity, their ages and/or disabilities, and  
25 their low incomes. The composition of the class changes on a daily basis due to beneficiaries  
26 becoming newly dually eligible, as they become eligible for Medicare or Medicaid or both.

27 51. There are questions of law and fact common to all members of the class.

28



1 long term disabilities) with limited incomes and resources. Although Medicaid coverage varies  
2 from state to state (subject to federal guidelines), it generally covers the same types of health  
3 care services as Medicare with two important additions: Medicaid provides comprehensive  
4 coverage for non-skilled long-term care services and, until January 1, 2006, only Medicaid  
5 provided prescription drug coverage.

6 59. At present more than 6 million low-income people qualify for coverage under  
7 both Medicaid and Medicare and are known, in Part D, as full benefit dual eligibles. They are, as  
8 a group, poorer and sicker than other Medicare beneficiaries. Most full benefit dual eligibles  
9 have incomes below the federal poverty line, and all are elderly and/or disabled.

10 60. Dual eligibles have more extensive health care needs than the general Medicare  
11 or Medicaid populations. Approximately 38% of dual eligibles have mental or cognitive  
12 impairments, and almost 25% live in nursing homes or other long-term care facilities. Dual  
13 eligibles have higher rates of Alzheimer's disease, diabetes, pulmonary disease, and stroke than  
14 other people covered by Medicare. The prevalence of chronic conditions is higher among dual  
15 eligibles than among the general Medicare population. One-third of dual eligibles have  
16 significant limitations in activities of daily living.

17 61. As a result, dual eligibles as a group are highly dependent upon prescription  
18 medications. They take 10 more prescriptions per month than the average Medicare beneficiary.  
19 Given the extensive health care needs of dual eligibles, the health care costs of dual eligibles is,  
20 on a per capita basis, double that of other Medicare beneficiaries.

21 62. Until January 1, 2006 dual eligibles received comprehensive outpatient  
22 prescription drug coverage as part of their Medicaid coverage. Most Medicaid beneficiaries  
23 obtain drug coverage at no cost to them. This varies by state and program. Although nominal  
24 co-payments are permitted, they must be waived for people who cannot afford to pay them. 42  
25 U.S.C. § 1396o(e).

26 The Medicare Modernization Act (MMA) and the Low Income Subsidy

27 63. On December 8, 2003, the MMA was enacted. The MMA establishes the  
28 Medicare prescription drug benefit under the new Part D, effective January 1, 2006.

1 Significantly, the MMA prohibits dual eligibles from receiving their prescription drugs through  
2 the Medicaid program, as they had prior to January 1, 2006.

3         64.         The Medicare Part D benefit is delivered through private prescription drug plans  
4 that provide medically necessary medications to Medicare beneficiaries and are reimbursed by  
5 the federal government pursuant to contract. 42 U.S.C. §§1395w-111-112. In numerous ways  
6 the program operates much like private insurance plans available to the general public, with  
7 premiums, deductibles and other cost-sharing applicable to most beneficiaries. Most  
8 beneficiaries must affirmatively enroll in a plan to get Part D benefits. Medicare beneficiaries  
9 have a choice of plans offering different benefit packages. There are certain out of pocket costs  
10 associated with the benefit, usually including a \$250 annual deductible, monthly premiums, and  
11 variable co-insurance payments for each prescription. In addition the program has significant  
12 coverage gaps that require beneficiaries to pay the full price of some prescriptions. Within  
13 certain parameters plans are allowed to have formularies (lists of covered drugs) that limit the  
14 number and type of drugs that are available. 42 U.S.C. §§ 1395w –102, § 1395w –104 ; 42  
15 C.F.R. § 423.100 *et seq.*. Generally speaking, plans are permitted to differ in numerous ways,  
16 including, but not limited to, cost-sharing requirements, formularies and the pharmacies in their  
17 networks.

18         65.         The MMA statutory scheme contains specific protections for those Medicare  
19 beneficiaries who are also eligible for Medicaid reflecting the Congressional goal of protecting  
20 dual eligibles by mandating that they have access to prescription drugs in a seamless manner.  
21 These MMA protections, in turn, reflect some approximation of the pre-existing situation of dual  
22 eligibles who, under Medicaid, had access to open formularies (with some use restrictions), with  
23 cost-sharing of never more than \$5 per prescription that was required to be waived if the  
24 individual could not pay it.

25         66.         First, the Secretary’s enrollment process must allow for the enrollment into a  
26 fully subsidized plan of all dual eligibles who have failed “to enroll in a prescription drug plan or  
27 an MA-PD plan.” 42 U.S.C. § 1395w-101(b)(1)(C).

1           67.       Congress also directed that dual eligibles should be treated as full subsidy  
2 eligible individuals, excusing them from all Part D cost-sharing except for co-payments of  
3 between \$0 and \$5 (adjusted annually). 42 U.S.C. § 1395w-114(a)(3)(B)(v)(I). Whereas other  
4 subsidy eligible individuals must apply for the subsidy, dual eligibles are entitled to it without  
5 taking any affirmative action.

6           68.       To ensure that dual eligibles (and other low income beneficiaries) actually  
7 received the benefit of their subsidy, the MMA charges the Secretary with providing “a process  
8 whereby, in the case of a part D eligible individual who is determined to be a subsidy eligible  
9 individual and who is enrolled in a prescription drug plan . . . (A) the Secretary provides for a  
10 notification of the PDP [prescription drug plan] sponsor . . . offering the plan involved that the  
11 individual is eligible for a subsidy and the amount of the subsidy under subsection (a) of this  
12 section.” 42 U.S.C. § 1395w-114(c)(1).

13           69.       Finally, unlike other Medicare beneficiaries, dual eligible beneficiaries are  
14 entitled to switch plans at any time. 42 U.S.C. § 1395w-101(b)(3)(D). This special provision  
15 allowing freedom of plan choice was enacted to meet the needs of the Medicaid beneficiaries, as  
16 Congress recognized that dually eligible beneficiaries cannot afford to pay regular out of pocket  
17 costs for uncovered drugs and must be in a plan that covers all or substantially all of their  
18 prescription drug needs. Since the auto-assignment by the Secretary into the Part D plans is  
19 purposefully random, the assignment does not take into account whether the plan covers the  
20 prescription drugs that are routinely utilized by the beneficiary. As a result many dual eligibles  
21 are auto-assigned into plans that do not provide for their medically necessary medications, and it  
22 is critical for them to be able to effectively exercise their right to switch plans.

23           70.       The regulations adopted by CMS pursuant to the MMA implement the auto-  
24 enrollment process and this right to a subsidy, 42 C.F.R. §§ 423.34, 423.771-.800, and reiterate  
25 that the Secretary must notify the plan of both plan enrollment and eligibility for the subsidy. 42  
26 C.F.R. § 423.800. Regulations also implement dual eligibles’ right to switch plans at any time.  
27 42 C.F.R. § 423.38(c).

1 **VI. STATEMENT OF FACTS**

2 71. Each of the individual plaintiffs is having trouble accessing their prescriptions  
3 under Medicare Part D because of problems with enrollment, disenrollment or the Low Income  
4 Subsidy due to the failures of the Defendant. Each of them needs or needed the assistance of an  
5 experienced advocate to get their medically necessary medicine without paying out sums that  
6 they cannot afford and that are illegal under the law.

7 72. For each named individual there are many more dual eligibles with similar  
8 problems who do not know how to get assistance. Each of the organizations named have  
9 assisted and are assisting many dual eligibles with enrollment, disenrollment and subsidy  
10 problems to the detriment of the people they serve as well as the organizations themselves.

11 73. Due to the plaintiffs' and class members' lack of financial resources they cannot  
12 pay for their prescription drugs. For many, the lack of prescription drugs is a life and death  
13 matter or can cause other severe health consequences.

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

16 74. Plaintiffs are presently suffering irreparable injury that will continue in the  
17 future by reason of the defendant's action and inaction complained of herein. Plaintiffs have no  
18 adequate remedy at law. Only the declaratory, injunctive, and mandamus relief that this Court  
19 can provide will fully redress the wrongs done to plaintiffs.

20 75. Plaintiffs have a clear right to the relief sought. There is no other adequate  
21 remedy available to correct an otherwise unreviewable defect not related to the claims for  
22 benefits. The defendant Secretary has a plainly defined and nondiscretionary duty to provide the  
23 relief that plaintiffs seek.

24 **VIII. FIRST CAUSE OF ACTION**

25 76. Defendant's failure to provide Medicare Part D benefits to dual eligible  
26 beneficiaries violates 42 U.S.C. § 1395 w-101(b)(1)(C) and 42 U.S.C. § 1395w-114 and its  
27 implementing regulations.

1 **IX. SECOND CAUSE OF ACTION**

2 77. Defendant’s failure to enroll dual eligible beneficiaries properly in a Part D drug  
3 plan and to notify prescription drug plans that plaintiffs and class members are subsidy eligible  
4 individuals violates rights guaranteed by the Due Process Clause of Fifth Amendment to the  
5 Constitution.

6 **X. PRAYER FOR RELIEF**

7 WHEREFORE, plaintiffs respectfully request this Court to:

- 8 1. Assume jurisdiction of this matter;
- 9 2. Certify this action as a class action pursuant to Rule 23(a) and (b)(2) and  
10 appoint plaintiffs’ counsel as class counsel pursuant to Rule 23(g);
- 11 3. Declare that the Secretary has violated 42 U.S.C. §§ 1395w-101, 104, 111, 112,  
12 and 114 *et seq.* and plaintiffs’ rights under the Due Process Clause;
- 13 4. Issue a permanent injunction directing the Secretary:
  - 14 a. to promptly auto-enroll all dual eligible beneficiaries who have not chosen  
15 a plan into a Part D plan and inform plans of the assignment;
  - 16 b. to disenroll beneficiaries on a prompt and efficient basis from plans and  
17 enroll them into the appropriate plan of their choice when they have enrolled themselves or  
18 switched plans, and notify the appropriate plan of their enrollment according to the law;
  - 19 c. to inform the appropriate prescription drug plans in a prompt and timely  
20 manner that plaintiffs and the class members are subsidy eligible individuals;
  - 21 d. to refrain from reducing any monthly Social Security benefit check to pay  
22 for Part D premiums for which the plaintiffs and class members are not responsible as subsidy  
23 eligible individuals, or allow Part D plans to bill plaintiffs for any of these amounts;
  - 24 e. to take any and all other steps to ensure that plaintiffs and the class  
25 members receive the full benefits of the Part D program and the LIS program to which they are  
26 entitled. This includes modifying the current “Point of Service” contract or other system of the  
27 Secretary’s choosing to ensure that plaintiffs receive their needed medications at a plan  
28 pharmacy at the subsidized amount;

