UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

NEW YORK STATEWIDE SENIOR ACTION COUNCIL, THE COALITION OF VOLUNTARY MENTAL HEALTH AGENCIES, INC., UNITED SENIOR ACTION OF INDIANA, NATIONAL ALLIANCE FOR THE MENTALLY ILL: MAINE, ACTION ALLIANCE OF SENIOR CITIZENS OF GREATER PHILADELPHIA, MASSACHUSETTS SENIOR ACTION COUNCIL, CONGRESS OF CALIFORNIA SENIORS, and MEDICARE RIGHTS CENTER, Plaintiffs, v. MICHAEL O. LEAVITT, SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, Defendant.	No. **COMPLAINT**

Plaintiffs New York Statewide Senior Action Council, The Coalition of Voluntary Mental Health Agencies, Inc., United Senior Action of Indiana, National Alliance for the Mentally Ill: Maine, Action Alliance of Senior Citizens of Greater Philadelphia, Massachusetts Senior Action Council, Congress of California Seniors, and Medicare Rights Center, by their undersigned attorneys, allege as follows:

NATURE OF THE ACTION

1. Approximately 6,400,000 poor persons receive health benefits under both Medicare (Soc. Sec. Act Title XVIII, 42 U.S.C. § 1395, *et seq.*) and the Medicaid program of the state in which they reside (Soc. Sec. Act Title XIX, 42 U.S.C. § 1396, *et seq.*). All of these people are elderly, disabled or ill; many fall into two or three

of these groups. These persons are among the most disadvantaged and vulnerable in America.

2. At present, all of these persons (referred to as "dual eligibles") receive outpatient prescription drug coverage under Medicaid. Medicare, in contrast, does not currently offer an outpatient prescription drug benefit.

3. Under the Medicare Prescription Drug, Improvement, and Modernization Act ("MMA" or the "Act") (Pub. L. No. 108-173, Soc. Sec. Act §1860D-1, *et seq.*, 42 U.S.C. § 1395W-101, *et seq.*), signed into law in 2003, Medicare will, for the first time, make outpatient prescription drug benefits available to eligible persons, commencing January 1, 2006. The Act obligates the Secretary of the U.S. Department of Health and Human Services ("HHS") to transfer all dual eligibles from their existing Medicaid drug coverage to new Medicare drug coverage.

4. The Secretary of HHS, however, is not taking adequate steps to meet his obligations under the statute. Unless he does so, countless dual eligibles will fall through the cracks of this massive program transition; they will not be effectively transferred to new Medicare prescription drug coverage and may be left without needed prescription drug coverage on and after January 1, 2006. Because many of these persons need prescription medications to function or survive, the consequences of no longer receiving prescription drug coverage will be calamitous.

5. Accordingly, plaintiffs bring this lawsuit to compel the Secretary of HHS to meet his statutory obligations to ensure that these persons now eligible for Medicaid drug coverage are not without effective drug coverage in January 2006.

JURISDICTION AND VENUE

6. This Court has jurisdiction pursuant to 5 U.S.C. § 702 and 28 U.S.C. § 1331, as this action arises under the Administrative Procedure Act and the MMA.

7. Venue in this district is proper pursuant to 28 U.S.C. § 1391(e), as a substantial part of the events or omissions giving rise to the claim occurred within the Southern District of New York and certain plaintiffs and their members reside within the district.

THE PARTIES

8. Plaintiff New York Statewide Senior Action Council ("NYSSAC"), a not-for-profit corporation with offices in New York, New York and Albany, New York, is a statewide senior citizens membership organization. NYSSAC was founded in 1972 and currently has approximately 16,000 members, including approximately 4,000 in New York City. Some of NYSSAC's members are dual eligibles. Among other things, one purpose of NYSSAC is to provide a unified and articulate voice on behalf of older New Yorkers, especially as an advocate for the low-income elderly and low-income persons of all generations. Among NYSSAC's health care priorities are: (a) stopping cuts to Medicaid that reduce coverage, access and quality of care not only for seniors, but the vulnerable disabled, and low-income children and families; and (b) protecting dual eligibles from harmful increased costs and restrictions in access to prescription drugs that result from the MMA. NYSSAC brings this lawsuit on its own behalf and on behalf of its members.

9. Plaintiff The Coalition of Voluntary Mental Health Agencies, Inc. ("CVMHA"), a not-for-profit corporation, based in New York, New York, is a membership organization representing over 100 non-profit community-based mental health agencies that collectively serve more than 300,000 clients in New York City. CVMHA was founded in 1972. Among CVMHA's members are community mental health centers, private voluntary hospitals, outpatient clinics, and other agencies. These member organizations sustain some of New York's most vulnerable citizens: those with psychiatric and addictive disabilities, the homeless, victims of domestic violence, persons with HIV, struggling families, the fragile elderly, and troubled children. Among these categories of individuals are dual eligibles. Among CVMHA's purposes is to advocate on behalf of community-based mental health providers. CVMHA is very concerned about the effect of the MMA on the over 500,000 dual eligibles in New York. CVMHA brings this lawsuit on its own behalf and on behalf of its agency members and their clients.

10. Plaintiff United Senior Action of Indiana ("USAI"), a not-for-profit corporation based in Indianapolis, Indiana, is a statewide senior citizens members organization. USAI was founded in 1979, and currently has approximately 14,000 dues-paying members. USAI's membership includes dual eligibles. USAI's primary purpose is to advocate for Indiana seniors in critical public policy arenas. USAI has been working for many years to improve the quality of life of Indiana citizens who need long term care and to improve access to affordable prescription drugs. USAI brings this lawsuit on its own behalf and on behalf of its members.

11. Plaintiff National Alliance for the Mentally Ill: Maine ("NAMI: Maine"), a not-for-profit corporation, is a statewide membership organization located in

Augusta, Maine. NAMI: Maine was founded in 1984 and currently has 1,400 members, including some dual eligibles. NAMI: Maine's mission is to improve the lives of people affected by mental illness. Its activities to achieve this mission include public policy advocacy. NAMI: Maine brings this lawsuit on its own behalf and on behalf of its members.

12. Plaintiff Action Alliance of Senior Citizens of Greater Philadelphia ("AASC"), a non-profit organization located in Philadelphia, Pennsylvania, was founded in 1973. AASC is a coalition of over 320 senior clubs and organizations in the Philadelphia area, representing over 120,000 elderly people. Among AASC's members are dual eligibles. Among AASC's priorities is to protect and preserve Social Security, Medicare and Medicaid. AASC brings this lawsuit on its own behalf and on behalf of its members.

13. Plaintiff Massachusetts Senior Action Council ("MSAC"), a non-profit organization located in Boston, Massachusetts was founded in 1981. MSAC currently has approximately 2,500 members. Among MSAC's members are dual eligibles. Most of MSAC's members have low incomes. MSAC is involved in community organizing and legislative advocacy on health care and other issues. MSAC brings this lawsuit on its own behalf and on behalf of its members.

14. Plaintiff Congress of California Seniors ("CCS"), a not-for-profit corporation located in Sacramento, California, was established in 1977. CCS is a statewide education and advocacy organization dedicated to improving the lives of senior citizens and their families. CCS devotes its efforts to legislative and consumer affairs that deal primarily with issues concerning older adults. CCS has approximately 650,000

members, some of whom are dual eligibles. CCS brings this lawsuit on its own behalf and on behalf of its members.

15. Plaintiff Medicare Rights Center ("MRC"), a not-for-profit corporation founded in 1989 and based in New York, New York, is a national organization that provides counseling services to people with Medicare problems and questions. Since then, it has helped more than one million people with Medicare related issues. Many of the people whom MRC serves are dual eligibles, and MRC has expended considerable resources in counseling and educating this vulnerable population about the upcoming transition of their prescription drug coverage from Medicaid to Medicare. MRC will be required to expend considerably greater resources if any of its clients are wrongfully deprived of government funded coverage for prescription drugs. MRC brings this lawsuit on its own behalf and on behalf of its clients.

16. Defendant Michael O. Leavitt is the Secretary of HHS (the "Secretary"). In that capacity, he has ultimate responsibility for the conduct and policies of HHS. The Centers for Medicare and Medicaid Services ("CMS"), which administers the Medicare program and works with the States to administer the Medicaid program, is part of HHS.

FACTS AND BACKGROUND

Medicare and Medicaid

17. In 1965, Congress enacted Title XVIII and Title XIX of the Social Security Act (42 U.S.C. § 1395 *et seq.*), creating Medicare and Medicaid.

18. Medicare, a program funded by the federal government through beneficiary premiums, payroll taxes, and general revenues, provides certain health care

coverage to some 43 million eligible individuals who are either age 65 or over or have long-term disabilities or specified medical conditions. Medicare provides coverage for in-patient hospital stays, doctor and clinic visits, and certain other reasonable and necessary services and items, but does not currently provide coverage for prescription drugs.

19. Medicaid, a program funded jointly by the states and the federal government, pays for medical assistance for certain individuals with limited incomes and resources. Although Medicaid coverage varies from state to state (subject to federal guidelines), it generally covers the same types of health care services as Medicare, as well as outpatient prescription drugs, long term care, and certain other items and services.

Dual Eligibles

20. There are approximately 6,400,000 dual eligibles in the United States—*i.e.*, individuals who qualify for and receive certain benefits under both Medicaid and Medicare. Most dual eligibles have earnings below the federal poverty line, and all are elderly, disabled, and/or ill. Dual eligibles account for approximately one in seven Medicaid enrollees.

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

22. As a result, dual eligibles, as a group, are highly dependent upon prescription medications. Dual eligibles are expected to fill 20 million prescriptions in January 2006 alone. Over half of dual eligibles are in fair or poor health. Given the extensive health care needs of dual eligibles, the total health care costs of dual eligibles is, on average, double that of other Medicare beneficiaries.

23. Dual eligibles, as a group, also have other characteristics beyond their health care needs that render them particularly vulnerable. For example, dual eligibles are more likely to live in rural areas than other Medicare beneficiaries; 61% of dual eligibles do not have high school diplomas; more than 60% of dual eligibles live below the poverty level; 71% of dual eligibles have an annual income of below $10,000; and more than 40% of dual eligibles are part of a racial or ethnic minority. A significant percentage of dual eligibles either do not speak English at all or have limited English proficiency.

24. Currently, dual eligibles receive outpatient prescription drug coverage as part of their Medicaid coverage. By law, when a state chooses to provide drug coverage as part of its Medicaid program (and all states do), it must provide coverage for a comprehensive list of drugs.

The Medicare Prescription Drug,
Improvement, and Modernization Act

25. On December 8, 2003, the MMA was enacted. The MMA establishes a new Medicare prescription drug benefit under a new "Part D" of Medicare, effective January 1, 2006. The MMA provides that the drug benefit will be provided through private prescription drug plans, and it sets forth guidelines for the establishment and operation of these plans.

26. Under the MMA, all Medicare beneficiaries, regardless of income, will be entitled to prescription drug coverage through a Medicare-approved plan. (Soc. Sec. Act § 1860D-1, 42 U.S.C. §1395w-101). A variety of Part D plans will be available to individuals, depending on their geographic location. The plans are permitted to differ in numerous ways, including, but not limited to, patient cost-sharing requirements, the particular prescription drugs covered (or formulary), and the pharmacies in their networks.

27. The MMA entitles all dual eligibles to prescription drug coverage under Part D. Under § 101(a)(1) of the MMA, each "eligible individual" (the definition of which includes all dual eligibles) is "*entitled* to obtain qualified prescription drug coverage." (Soc. Sec. Act § 1860D-1, 42 U.S.C. § 1395w-101). (emphasis added).

28. In order to ensure that all eligible individuals are enrolled in and obtain prescription drug coverage under a Part D plan, section 101(b)(1)(A) of the MMA charges the Secretary with "establish[ing] a process for the enrollment . . . of eligible individuals in prescription drug plans consistent with" the statute. (Soc. Sec. Act § 1860D-1, 42 U.S.C. § 1395w-101). In particular, under §101(b)(1)(C), the process established must provide that those dual eligibles who "fail[] to enroll in a prescription drug plan" on their own will be automatically enrolled in a Part D plan selected at random from those Part D plans in the relevant geographic area that meet certain criteria ("auto-enrollment"). (Soc. Sec. Act § 1860D-1, 42 U.S.C. § 1395w-101).

29. The regulations adopted by CMS pursuant to the MMA purport to implement this right to coverage. Under 42 C.F.R. § 423.34, a regulation promulgated by the Secretary pursuant to the MMA, for example, CMS "*must ensure* the enrollment" into

Part D plans of dual eligibles who fail to enroll in such a plan on their own, and "CMS *must* automatically *enroll* full-benefit dual eligibles who fail to enroll in a Part D plan" into a qualifying Part D plan. (Emphasis added.)

30. The MMA thus requires the Secretary to assign all 6,400,000 dual eligibles (other than those who affirmatively decline coverage) to a Medicare Part D plan. (Soc. Sec. Act § 1860D-1, 42 U.S.C. § 1395w-101).

The Secretary's Failure to
<u>Comply with His Statutory Duties</u>

31. The Secretary has yet to establish a process, pursuant to his statutory duty, that will ensure that all dual eligibles are enrolled in Part D plans by January 1, 2006. On the contrary, it is virtually certain that on January 1, 2006, some of the 6,400,000 dual eligibles will not be receiving prescription drug coverage under a Part D plan. There is no way to know with certainty how many dual eligibles will fall through the cracks this way. However, even if the Secretary's enrollment process captures 97% of all dual eligibles, more than 180,000 dual eligibles will not be enrolled. They will face grave hardships as they abruptly lose access to affordable prescription medicines that their doctors have prescribed for them.

32. The enrollment process the Secretary has implemented to date is inadequate in at least the following respects:

(a) It fails to address computer system and data errors — resulting in part from the interplay between federal systems and the various systems used by fifty-one Medicaid programs — that are highly likely to result in dual eligibles not being auto-enrolled, being auto-enrolled inappropriately, or not being timely auto-enrolled;

(b) It fails to provide adequately for meaningful notice to be given to all dual eligibles of: (i) their right to elect a Part D plan by December 31, 2005; (ii) their automatic enrollment in a randomly-selected Part D plan if they do not exercise that right; and (iii) the possible loss of Medicaid prescription drug coverage if their enrollment is not effective;

(c) It fails to take adequate account of the particular characteristics of the dual eligible population — including the numerous medical, cognitive, educational, financial, and other difficulties they face — and the impact that those characteristics will have on their ability to adapt to an overnight change in their prescription drug benefit plan; and

(d) It fails to provide an adequate safety net for dual eligibles who are not effectively enrolled in a Part D plan as of January 1, 2006.

33. Computer system failures are inevitable. The auto-enrollment cannot succeed unless CMS: (a) accurately identifies every dual eligible based on a process of "data matching" between State data files and files maintained by the Social Security Administration ("SSA"); (b) obtains accurate up-to-date mailing addresses for all dual eligibles or, when appropriate, their designated representatives; (c) "deem[s]" all identified dual eligibles as enrolled to receive Low Income Subsidies[1]; (d) identifies those dual eligibles who will be "passively enrolled" in a Part D plan associated with a Medicare Advantage health plan and monitors the success of that "passive enrollment" for

[1] Low Income Subsidies provide extra cost-sharing assistance to low income individuals enrolled in Part D plans.

all dual eligibles[2]; (e) matches millions of dual eligibles not "passively enrolled" in a Medicare Advantage Part D plan with one of the eligible Part D plans; (f) ensures that all auto-enrollments are accurately and effectively communicated to the plans and to the beneficiaries or their designated representatives; and (g) ensures that this process is continually updated so that on January 1, 2006, all individuals who are dual eligibles as of December 31, 2005 are enrolled in Part D plans and will not lose prescription drug coverage.

34. Attempts to perform these tasks to date have not been successful. For example, the "data match" between state dual eligible files and SSA's files has resulted in thousands of "unmatched" files. Under CMS's process, such "unmatched" dual eligibles identified by states cannot be "deemed" eligible for Low Income Subsidies and thus cannot be automatically assigned to Part D plans.

35. Moreover, because of lags in the collection of data by CMS, individuals who become dual eligibles in November or December of 2005 may not be automatically enrolled into a Part D plan by January 1, 2006. This problem alone is likely to result in thousands of dual eligibles not being enrolled in a Part D plan by that date.

36. The Secretary has also failed to establish a process to give effective notice regarding the Part D process to dual eligibles. For example, starting in May 2005, CMS was to mail notices to all dual eligibles informing them of the upcoming transition of their prescription drug coverage by mailing notice to each individual. Instead of receiving this notice, however, some dual eligibles received only empty envelopes from

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[2] Medicare Advantage health plans are private health care plans which contract with Medicare to provide all Medicare benefits to those who enroll in such plans.

CMS; others received nothing; and countless others are wholly unaware of whether they received any notice. At the time of the May 2005 mailing, CMS officials were unable to identify how many or which dual eligibles received the empty envelopes, and they declined to resend the notices. Therefore, these individuals have not been sent crucial information about the transition of their prescription drug coverage from Medicaid to Medicare.

37. Further underscoring the unreliability of the Secretary's notice process, a handbook about the Part D program mailed to all Medicare beneficiaries in September 2005 contained at least one significant error about the program directly relating to the rights of dual eligibles. The handbook (entitled "Medicare and You") purported to contain, among other items of information, a list of new Medicare prescription drug plans in which dual eligibles could choose to enroll without having to pay any monthly premium out of their own pockets. The lists contained in the handbook were erroneous, however: while the handbook indicated that dual eligibles could choose to enroll in any prescription drug plan available in their geographic region without having to pay an out-of-pocket monthly premium, in fact, dual eligibles may only enroll in a subset of such plans without incurring monthly out-of-pocket charges.

38. The particular characteristics of dual eligibles make the notice program adopted by the Secretary particularly inappropriate. As noted above, large numbers of dual eligibles have mental or cognitive impairments, and many do not speak or read English or do so with limited proficiency. Many dual eligibles are likely to ignore written notices, to fail to understand the complexities of choosing and enrolling in a Part D program, or be unable effectively to understand or address the restrictions of a plan they

enroll or are enrolled in (such as limitations on the plan's formulary or on the pharmacies in the network).

39. Finally, the process adopted by the Secretary appears to contain no adequate and operative fail-safe mechanism in the event that — as inevitably will occur— individuals are not auto-enrolled, do not receive notice of auto-enrollment, are enrolled in a plan that does not cover drugs they are prescribed, or does not include the pharmacy from which they are used to purchasing drugs.

40. While CMS has stated that it is working on establishing a mechanism, including computer systems, to alleviate these risks, no such mechanisms are yet in place, and CMS has not revealed any details about how these mechanisms would work.

41. Senior CMS officials have admitted that it is inevitable that on January 1, 2006, some percentage of dual eligibles will not be effectively covered by a Part D plan. For example:

(a) Alex Trujillo, a CMS regional administrator, was quoted in the July 29, 2005 Salt Lake Tribune as saying, referring to the January 1, 2006 transition, "If there is a theme to this, it's 'Mission: Impossible.' . . . . Insurance companies and pharmacies have said, 'There is no way you can do this in such a short time frame.' But, we don't have another option";

(b) Julie Goon, a senior advisor to the Secretary, stated on October 6, 2005 at a public forum that there is still "a lot of work to do to make sure [dual eligibles] understand the plan that they are in and how getting drugs is going to work for

them [after January 1, 2006]." She further stated that it "is probably everybody's biggest worry . . . that there will be a systems glitch on day one of this program"; and

(c) Jeff Hall, a regional spokesman for CMS, was quoted in the October 18, 2005 Herald News, North Jersey Media Group, as saying "[CMS is] doing the best we can with what Congress gave us. Our responsibility here is we're looking out for the best interest of our beneficiaries. But, if people are affected—and I'm sure there will be some people that will be affected—it's our responsibility to correct the mistake. They're not going to fall through the cracks *forever*" (emphasis added).

Consequences of a Failure to Enroll Dual Eligibles in Part D Plans

42. Failure to effectively enroll a dual eligible in a Part D plan could result in the interruption of prescription drug benefits to that individual as of January 1, 2006, in direct contravention of the MMA's provision that all dual eligibles are "entitled to obtain qualified prescription drug coverage" and, if they do not elect a Part D plan, to be automatically enrolled in one. (Soc. Sec. Act § 1860D-1, 42 U.S.C. § 1395w-101). Effective enrollment includes, among other things, successfully communicating to a dual eligible the name, benefits, restrictions, and requirements of the Part D plan in which she has been enrolled. If that information is not successfully communicated, the individual may be unable to make use of her prescription drug coverage.

43. Due to the poverty of dual eligibles, interruption of prescription drug coverage, even temporarily, could cause dual eligibles to be unable to afford or obtain their necessary medications.

44. The inability to obtain prescription drugs, even temporarily, could be life-threatening or even fatal to many dual eligibles.

CLAIMS FOR RELIEF

Claim One:
(Medicare Prescription Drug, Improvement, and Modernization Act,
Pub. L. No. 108-173, Soc. Sec. Act § 1860D-1, *et seq.*,
42 U.S.C. § 1395w-101, *et seq.*)

Defendant's Failure to Adequately Ensure Prescription
Drug Coverage to Those Statutorily Entitled to Such Coverage

45. Plaintiffs repeat and reallege paragraphs 1-44 of the complaint as though fully set forth herein.

46. Under the MMA, every dual eligible is entitled to prescription drug coverage under a Part D plan as of January 1, 2006, and the Secretary has a statutory duty to establish a process automatically to ensure such coverage for dual eligibles.

47. The Secretary has failed to establish an adequate and workable process that will ensure that each dual eligible who does not affirmatively decline coverage has the prescription drug coverage to which she is entitled on January 1, 2006.

48. As of January 1, 2006, certain of plaintiffs' members may thus be denied their statutory right to prescription drug coverage under a Part D plan.

49. Plaintiffs, and their members who are dual eligibles, face irreparable injury if the Secretary does not comply with his obligations under the Act.

Claim Two:
(Administrative Procedure Act,
5 U.S.C. § 706(1))

Defendant's Unlawful Failure to Establish an Adequate Process
for the Enrollment of all Dual Eligibles into Part D Plans

50. Plaintiffs repeat and reallege paragraphs 1-49 of the complaint as though fully set forth herein.

51. Under the MMA, the Secretary has a statutory duty to establish a process that will ensure the enrollment of all dual eligibles into Part D plans effective January 1, 2006, other than those who affirmatively decline coverage.

52. The Secretary has unreasonably delayed establishing such a statutorily required process and has unlawfully failed to take this required agency action.

53. Failure of the Secretary to establish a process that will ensure the enrollment of all dual eligibles into Part D plans (other than those who decline coverage) will necessarily result in certain dual eligibles being denied their statutory right to automatic enrollment in a Part D plan. These dual eligibles may thus be denied the prescription drug coverage to which they are statutorily entitled as of January 1, 2006.

54. Plaintiffs' members who are dual eligibles have been denied their right under the MMA to a process which will ensure the enrollment into Part D plans of all dual eligibles who do not decline coverage.

Claim Three:
(Administrative Procedure Act,
5 U.S.C. § 706(2))

Defendant's Actions Are Arbitrary and
<u>Capricious in Violation of the Administrative Procedure Act</u>

55. Plaintiffs repeat and reallege paragraphs 1-54 of the complaint as though fully set forth herein.

56. The regulations promulgated by the Secretary for the establishment of a process by which all dual eligibles will be enrolled in a Part D plan effective January 1, 2006 are arbitrary and capricious in that:

(a) the regulations fail to adequately address particular critical aspects of the transition, such as the particular characteristics of dual eligibles, which make

ensuring the effective enrollment of all dual eligibles, and the communication of necessary enrollment information to each dual eligible, particularly challenging; and

(b) the regulations fail adequately to address the fact that CMS's existing resources, data files, and systems are not capable of ensuring that each of the expected 6,400,000 dual eligibles (other than those who decline coverage) will be enrolled in a Part D plan as of January 1, 2006, and will be aware of such enrollment.

57. Thus, the process established by these regulations is inadequate to ensure that no dual eligible loses prescription drug coverage, even temporarily, on January 1, 2006.

PRAYER FOR RELIEF

WHEREFORE, plaintiffs request that this Court:

(a) Direct the Secretary to establish and implement an adequate procedure to ensure the enrollment of all dual eligibles into Part D plans effective January 1, 2006;

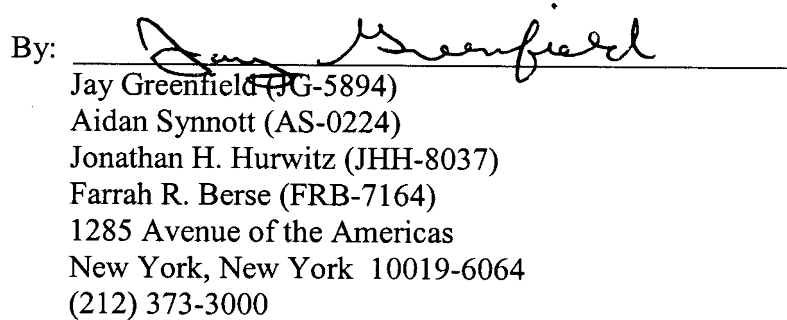
(b) Direct the Secretary to establish and implement an adequate procedure to ensure the communication to all dual eligibles of their enrollment into Part D plans effective January 1, 2006, and of their rights under such plans;

(c) Compel the Secretary to establish and implement an adequate procedure to ensure that each dual eligible who is not effectively enrolled in a Part D plan on January 1, 2006 will continue to receive at least the drug benefits she is now receiving until she is effectively enrolled in a Part D plan; and

(d) Grant plaintiffs all other relief that the Court considers just and proper.

Dated: New York, New York
November 14, 2005

PAUL, WEISS, RIFKIND, WHARTON & GARRISON LLP



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