FACT SHEET
PART D RECONSIDERATION APPEALS DATA

Part D Appeals Process

An appeal is the process by which an individual enrolled in a Medicare prescription drug plan (an "enrollee") may challenge a plan's coverage determination. Appeals begin with a request by a beneficiary (or their representative) for a redetermination by the plan. If the reconsideration response by the plan is not satisfactory for the beneficiary, the beneficiary may request a reconsideration by the Part D independent review entity (also called the Part D qualified independent contractor or "QIC"). Beneficiaries may subsequently appeal the independent review decision to an administrative law judge, the Medicare Appeals Council, and federal judicial review.

The following data summarizes and highlights some of the key data on reconsiderations since the inception of the Medicare prescription drug benefit program on January 1, 2006.

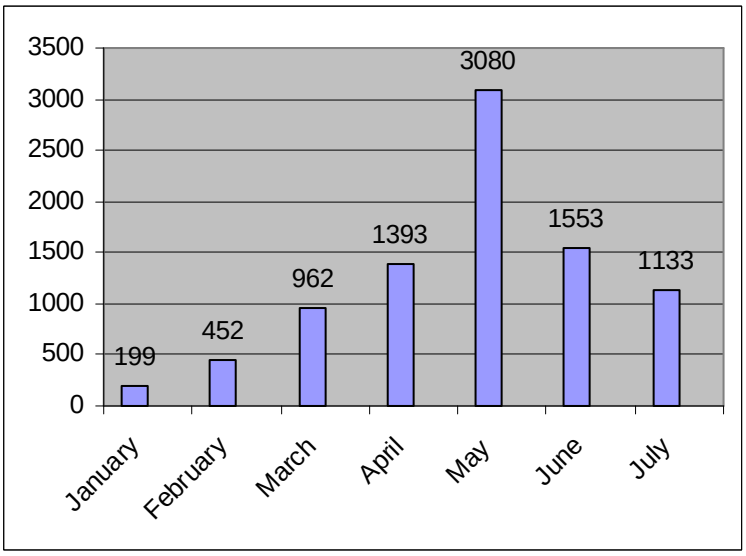
Reconsideration Volume

8,772 reconsideration requests were received from January 1, 2006 through July 31, 2006. [1] This represents a rate of 0.44 reconsiderations for each 1000 Medicare beneficiaries enrolled.[2]

Standard cases represented 90% of all appeals received and resulted in a rate of 0.40 standard cases for each 1000 beneficiaries enrolled.

Expedited cases represented 10% of all appeals received and resulted in a rate of 0.04 expedited cases for each 1000 beneficiaries enrolled.

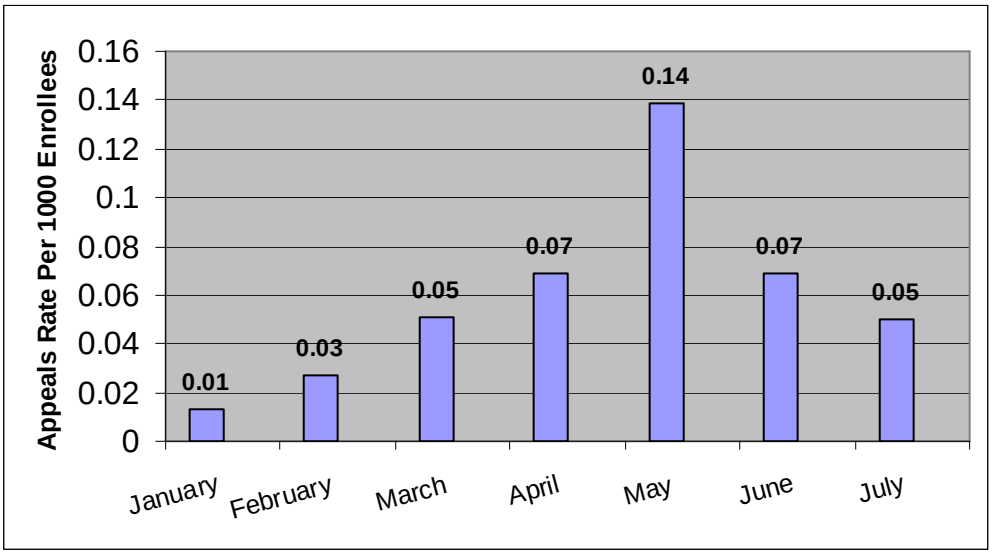
Number of appeals received by the Part D QIC by month:



[1] The Part C QIC received 12,281 appeals during this period. Note that all adverse Medicare Advantage plan decisions are automatically forwarded to the Part C QIC, unlike in the Part D program where the beneficiary must request the appeal.

[2] Aggregate numbers were calculated using the average enrollment over the 7-month period from January through July of 2006.

Rate of appeals received by the Part D QIC by month:[3]



Types of Appeals

Of the 8,336 appeals decided through July 31, 2006:

36% involved a drug utilization management tool dispute and represents 0.15 drug utilization appeals for each 1000 beneficiaries enrolled.

34% involved an off-formulary exception request and represents 0.14 off-formulary exceptions appeals for each 1000 beneficiaries enrolled.

26% involved a non-Part D drug (a drug that is statutorily excluded) request and represents 0.11 non-Part D drug requests for each 1000 beneficiaries enrolled.

2% involved a cost-sharing dispute and represents 0.01 cost-sharing dispute appeals for each 1000 beneficiaries enrolled.

<2% involved a tiering exception request and represents 0.01 tiering exceptions appeals for each 1000 beneficiaries enrolled.

<1% involved out-of-network pharmacy coverage.

Overall Reversal Rate

Excluding cases that were dismissed, withdrawn, or remanded (the Part D QIC did not have jurisdiction to make a substantive decision on the case) and cases involving non-Part D drugs, the Part D QIC reversed plan decisions in 42% of cases.[4]

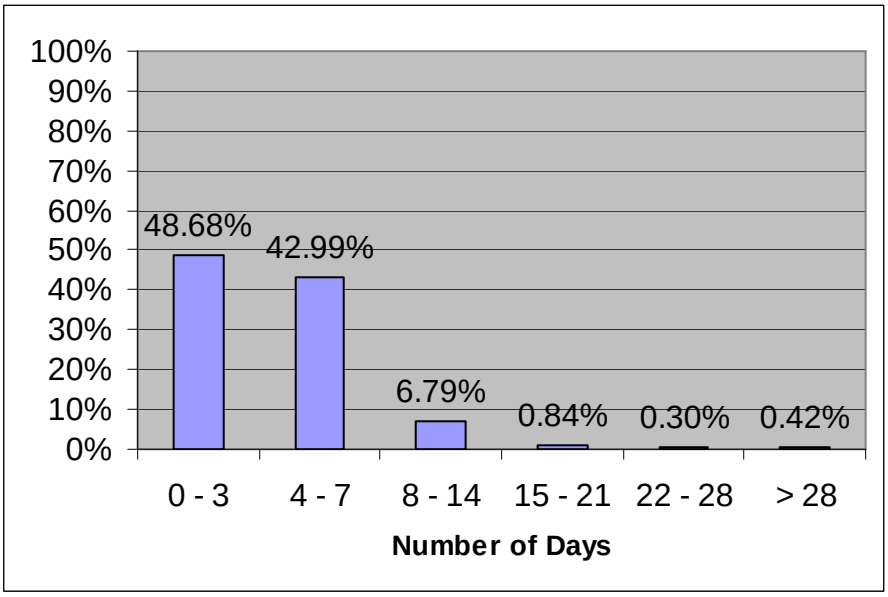
[3] Monthly appeals rate was calculated using the enrollment at the end of each month.

Reversal Rates by Appeal Type[5]

Drug utilization management tool dispute	51%
Off-formulary exception request	31%
Non-Part D drug	15%
Tiering exception request	33%
Cost-sharing dispute	33%
Out-of-network pharmacy coverage	60%

Overall Timeliness of Reconsideration Cases

Distribution of decided appeals by process days for all reconsideration cases:



[4] In comparison, the reversal rate for Part A cases was 24% and for Part B cases was 39% for the same period. The reversal rate for Part C cases during this period was 13%. Note that the reversal rate for Part C is impacted by the fact all adverse Medicare Advantage plan decisions are automatically forwarded to the Part C QIC.

[5] Calculation of the reversal rate by appeal type excludes cases that were dismissed, withdrawn or remanded.