FACT SHEET
PART C RECONSIDERATION APPEALS DATA - 2007

Part C Appeals Process

An appeal is the process by which an individual enrolled in a Medicare Health Plan (an "enrollee") may challenge a plan's organization determination. Appeals begin with a request by an enrollee (or his or her representative) for a reconsideration by the plan. If the plan's reconsideration decision continues to uphold its original denial (in whole or in part), the plan must forward the reconsideration to the Part C independent review entity (also called the Part C qualified independent contractor or "Part C QIC"). An enrollee who is dissatisfied with the independent review entity's decision may appeal to an administrative law judge. If the enrollee continues to be dissatisfied with the decision, additional appeal levels include the Medicare Appeals Council and federal judicial review.

The following data summarizes and highlights some of the key data on Part C reconsiderations from January 1, 2007 – December 31, 2007.

Reconsideration Volume

The Part C QIC received 28,315 reconsideration requests during calendar year 2007. This represents a rate of 3.27 reconsiderations for each 1000 Medicare beneficiaries enrolled.[1] It also represents a 26% increase in the aggregate number of appeals received in 2006. The dollar value of the 2007 appeals is estimated at $89M.

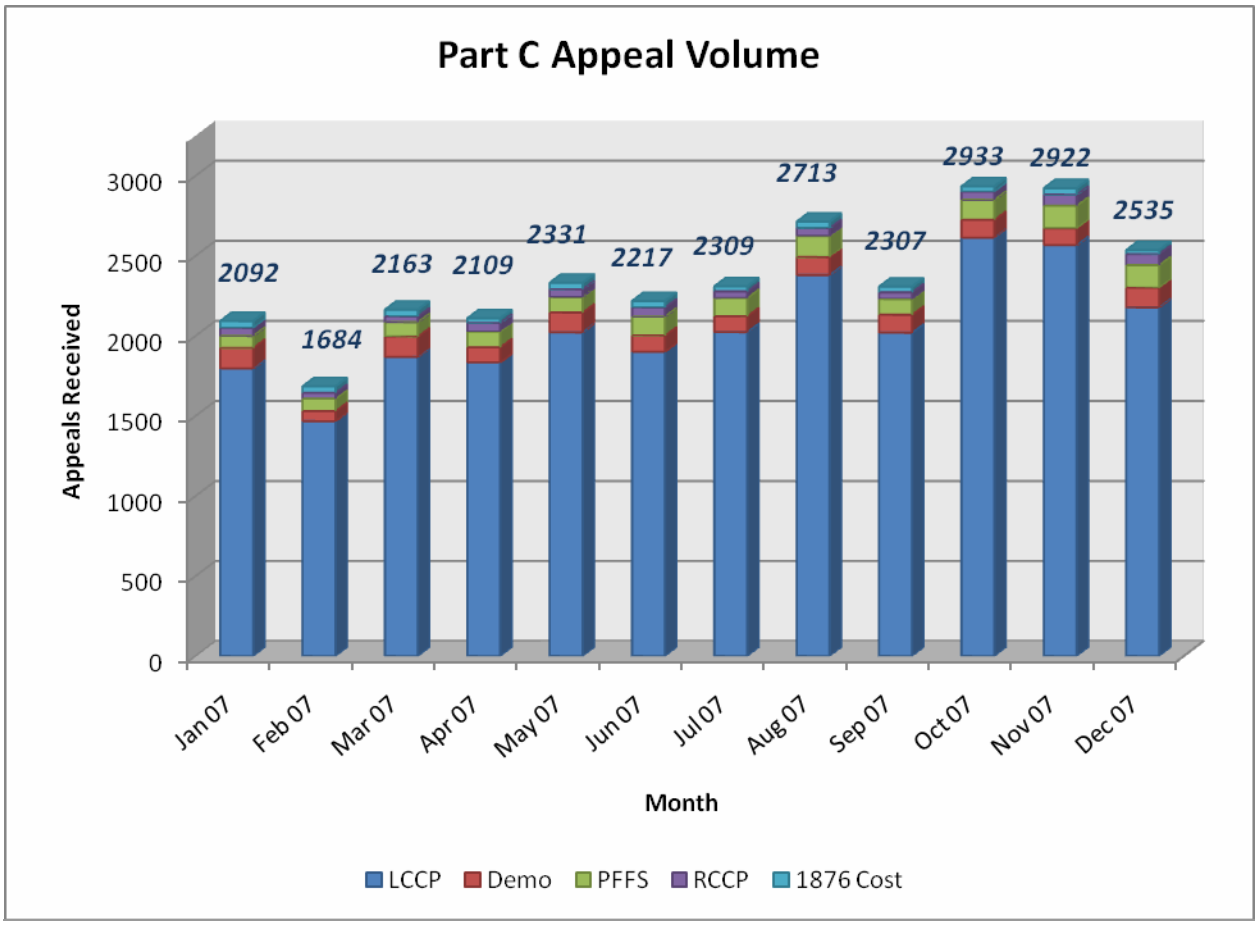
Standard pre-service cases represented 23% of all appeals received and resulted in a rate of 0.75 reconsiderations for each 1000 beneficiaries enrolled.

Standard retrospective cases represented 68% of all appeals received and resulted in a rate of 2.21 reconsiderations for each 1000 beneficiaries enrolled.

Expedited cases represented 9% of all appeals received and resulted in a rate of 0.31 expedited cases for each 1000 beneficiaries enrolled.

[1] Annual volume, divided by mid-year enrollment (times 1000) is used to calculate the annual rate of appeals per 1,000 enrollees.

Number of appeals received by the Part C QIC by month



Part C Appeal Volume by Contract Type

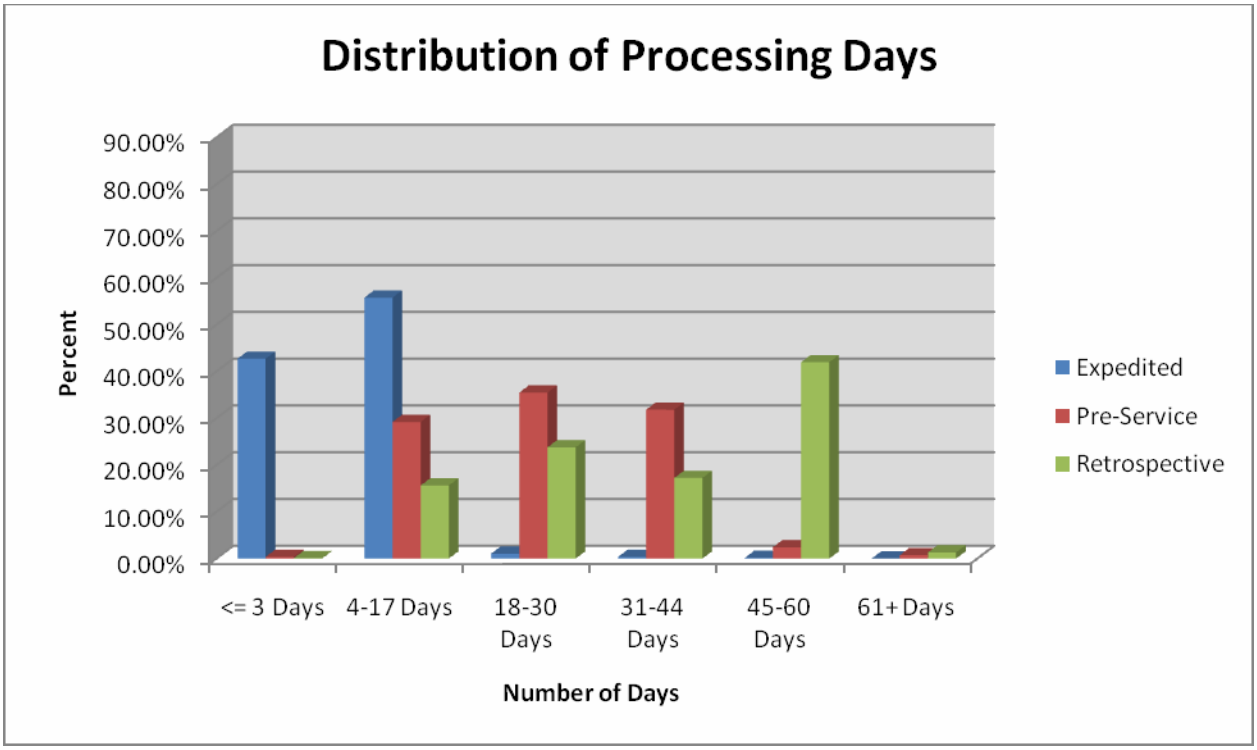
Month	LCCP	Demo	PFFS	RCCP	1876 Cost	Total
Jan 07	1,796	129	75	50	42	2,092
Feb 07	1,467	63	78	36	40	1,684
Mar 07	1,868	128	90	36	41	2,163
Apr 07	1,834	95	98	54	28	2,109
May 07	2,022	124	96	49	40	2,331
Jun 07	1,901	101	119	57	39	2,217
Jul 07	2,024	99	114	41	31	2,309
Aug 07	2,380	112	132	50	39	2,713
Sep 07	2,020	112	98	42	35	2,307
Oct 07	2,613	112	125	51	32	2,933
Nov 07	2,567	105	141	69	40	2,922
Dec 07	2,178	123	141	69	24	2,535
Total	**24,670**	**1,303**	**1,307**	**604**	**431**	**28,315**

Types of Appeals and Rates of Overturn of Plan Denials

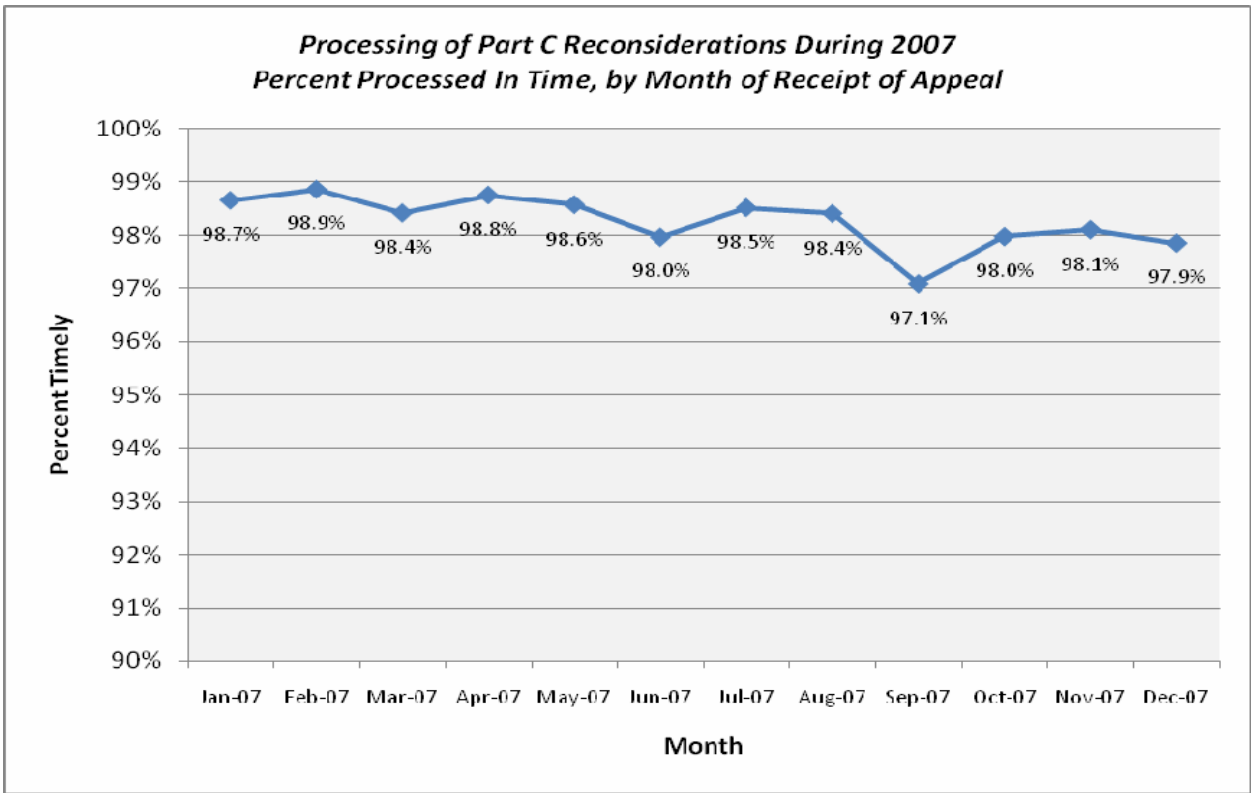
Appeal Type	Cases	Pct of Cases	N Overturned	Pct Overturned [2]	Pct Of All Overturns
DME	2,584	9.1%	212	10.5%	6.0%
Diagnostic Imaging	2,951	10.4%	406	24.4%	11.5%
Drugs	887	3.1%	119	18.8%	3.3%
Emergency	994	3.5%	161	27.6%	4.5%
Home Health	387	1.3%	77	33.6%	2.1%
Hospital Inpatient	2,775	9.8%	397	26.0%	11.2%
Laboratory	1,083	3.8%	87	18.7%	2.4%
Non-MD Practitioner	2,614	9.2%	324	14.6%	9.2%
Other	192	6%	17	11.9%	4%
Out of Area	2,294	8.1%	238	19.1%	6.7%
Physician Services	6,946	24.5%	719	17.4%	20.4%
Prosthetics/Supplies	1,096	3.8%	82	9.1%	2.3%
Skilled Nursing Facility	1,894	6.6%	568	34.6%	16.1%
Transportation	1,618	5.7%	113	12.3%	3.2%
TOTALS:	28,315	100%	3,520	19.2%	100%

[2] Withdrawn and dismissed appeals are removed from the calculation of % Overturned.

Timeliness of Reconsideration Cases, Calendar Year 2007



Variable time standards apply to the completion of appeals of different appeal priorities. Expedited appeals are to be completed in 3 days, unless an extension is warranted to complete information required of the decision. An extension can be for up to 14 additional days. Standard pre-service appeals are to be completed in 30 days; again, and extension of up to 14 days may be taken if warranted. Standard retrospective (claim) denials are to be completed within 60 days.



The Part C QIC is required to process at least 95% of all reconsiderations within the applicable time standard.