FACT SHEET
PART D RECONSIDERATION APPEALS DATA - 2006

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 an enrollee (or his or her representative) for a redetermination by the plan. If the enrollee is dissatisfied with the plan's redetermination, the beneficiary may request a reconsideration by the Part D independent review entity (also called the Part D qualified independent contractor or "Part D 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 reconsiderations during the first year of the Medicare prescription drug benefit program, January 1, 2006 – December 31, 2006.

Reconsideration Volume

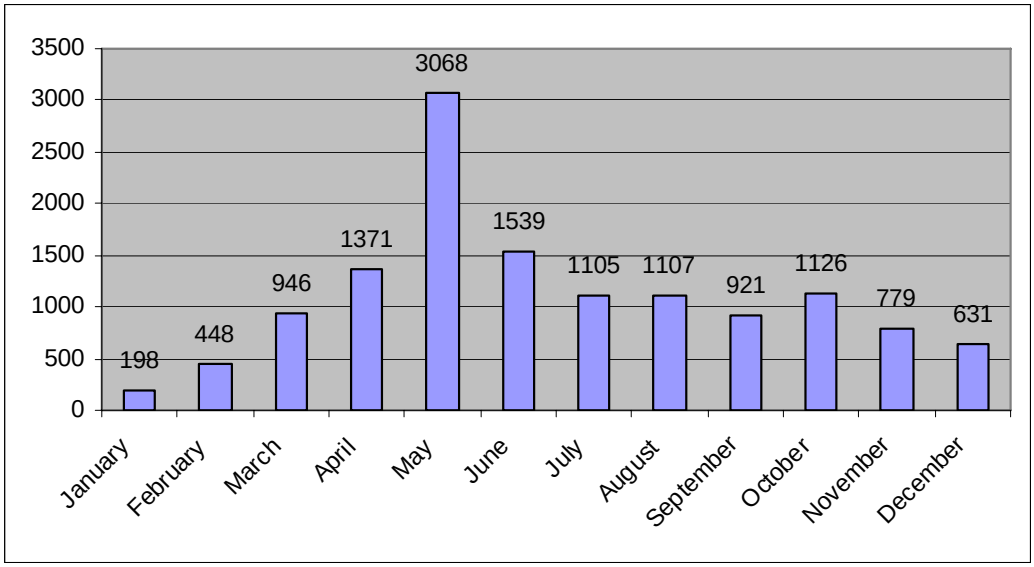
The Part D QIC received 13,239 reconsideration requests during calendar year 2006. This represents a rate of 0.63 reconsiderations for each 1000 Medicare beneficiaries enrolled.[1]

Standard cases represented 86% of all appeals received and resulted in a rate of 0.54 standard cases for each 1000 beneficiaries enrolled.

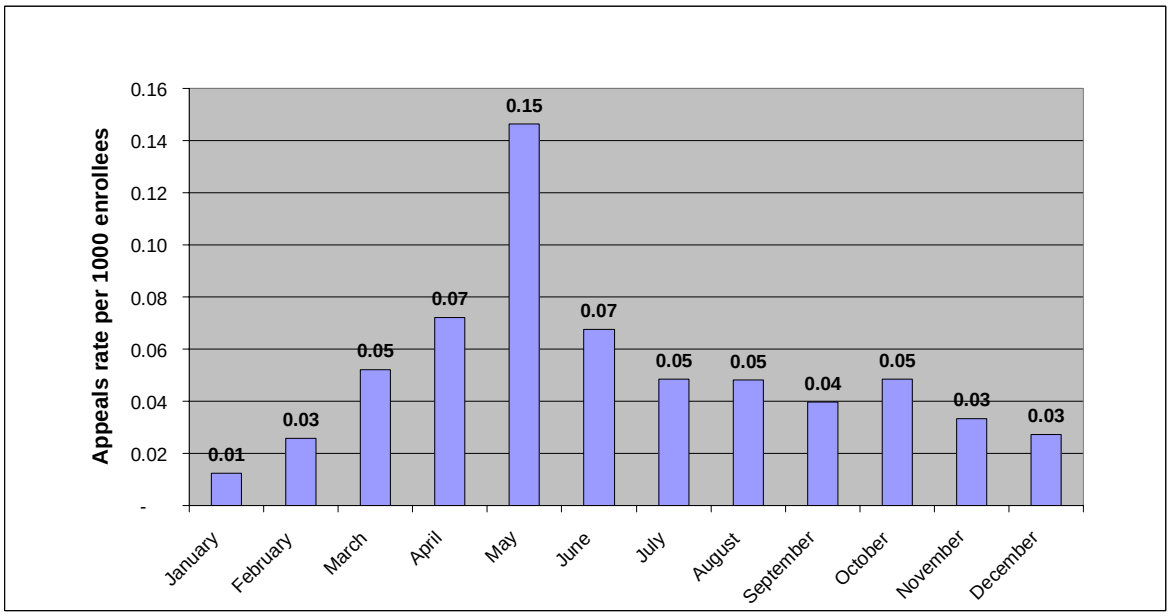
Expedited cases represented 14% of all appeals received and resulted in a rate of 0.09 expedited cases for each 1000 beneficiaries enrolled.

[1] Aggregate numbers were calculated using the average enrollment over the 12-month period from January through December of 2006.

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



Rate of appeals received by the Part D QIC by month:[2]



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

Types of Appeals

Of the 13,088 appeals decided through December 31, 2006:

36% involved a drug utilization management tool dispute and represents 0.22 drug utilization appeals for each 1000 beneficiaries enrolled.

36% involved an off-formulary exception request and represents 0.22 off-formulary exceptions appeals for each 1000 beneficiaries enrolled.

24% involved a non-Part D drug (a drug that is statutorily excluded) request and represents 0.15 non-Part D drug requests for each 1000 beneficiaries enrolled.

<3% involved a cost-sharing dispute and represents .015 cost-sharing dispute appeals for each 1000 beneficiaries enrolled.

<2% involved a tiering exception request and represents .009 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 53% of cases.

Reversal Rates by Appeal Type[3]

Drug utilization management tool dispute	55%
Out-of-network pharmacy coverage	46%
Off-formulary exception request	39%
Tiering exception request	30%
Cost-sharing dispute	28%
Non-Part D drug	20%

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

Timeliness of Reconsideration Cases