Congress of the United States
U.S. House of Representatives
COMMITTEE ON WAYS AND MEANS
1102 LONGWORTH HOUSE OFFICE BUILDING
(202) 225-3625
Washington, DC 20515-6348
http://waysandmeans.house.gov

November 2, 2007

Timothy B. Hill
Chief Financial Officer
Centers for Medicare and Medicaid Services
7500 Security Boulevard, Mailstop C3-01-24
Baltimore, MD 21244-1850

Dear Mr. Hill:

Please provide answers to the following Questions for the Record from the 10/16/2007 Joint Health and Oversight Subcommittee Hearing on Oversight and Accountability in the Medicare Advantage Program:

Questions from Chairman Lewis

1. What is the personnel make-up of the CMS Office of the Ombudsman? What is the budget for the Office of the Ombudsman?

2. Has CMS contemplated any changes to the website or other information portals providing the phone number or contact information for the Office of the Ombudsman?

Questions from the Honorable Lloyd Doggett

1. CMS's Inability to Account for Millions Paid to Private Medicare Plans

In May 2007 the GAO reported that CMS paid $100 million to private Medicare Part D plans for retroactive coverage for dual eligibles, despite the fact that CMS did not inform beneficiaries of their right to seek reimbursement for drug costs incurred during these periods. The GAO reported that "CMS does not monitor its payments to PDPs for retroactive coverage or the amounts PDPs have reimbursed dual-eligible beneficiaries."

In response to my question to CMS at the June 21 hearing about whether CMS would be able to track these payments, CMS delivered a written reply on October 17, the day after the hearing, stating "CMS is currently in the process of tracking these retro-active

enrollments and will use this information to determine how many months of retroactive coverage the Agency is providing to new dual-eligible individuals." CMS testified on October 16 that the reconciliation process necessary to track how this money was used is, in fact, complete. Several questions are outstanding:

(b) Does CMS already know how many months of retroactive coverage were provided since it paid $100 million dollars to plans for that retroactive coverage?
(c) How many months of coverage were provided?
(d) How many people were retroactively enrolled?
(e) How many of the new dual eligible beneficiaries who were retroactively enrolled were already in a Part D plan before they were awarded dual eligible status?
(f) How have you verified that the plans in which people were already enrolled reimbursed those beneficiaries for the copayment amounts they paid over the limit of that owed by a dual eligible?
(g) For those who were not already enrolled in a Part D plan during the period of retroactive coverage, how many people submitted claims to their new plan for drugs purchased during the retroactive coverage period?
(h) How much did plans pay out in benefits for all retroactively enrolled dual eligibles for which Part D plans received $100 million?

2. Ensuring Consumers Have Access to a Fair and Timely Appeals Process

(a) Do you require MA, MA-PD, and PDP bids to have a line item under administrative costs demonstrating that they have dedicated enough funding to appropriately handle appeals?
(b) What specific steps does CMS take to ensure plans have an appeals process in place that complies with statutory requirements?
(c) Are plans allowed to simply attest that they have an appeals process without providing further detail to demonstrate this is the case?

3. CMS's Failure to Update Consumer Report Cards on Medicare.gov

The Corrective Action Plans (CAPs) available on CMS's website show that Humana's Regional PPO contract number R5826 has 18 pending CAPs for deficiencies in its appeals processes (Chapter 13: Grievances, Coverage Determinations, and Appeals). Though the CAPs for Humana R5826 were issued July 31, 2007, as of October 24, 2007 on Medicare.gov that same contract number in Texas shows that the plan has three out of three stars – a perfect score – on appeals. When will CMS remove stars for this and other poor-performing plans so that beneficiaries can make decisions based on accurate information?

4. CMS's Failure to Reply to Request for Comments on Prescription Coverage Now Act

Nearly six months have passed since I requested at the May 3, 2007 hearing that CMS inform me of any specific objections it had to the Prescription Coverage Now Act, legislation I have introduced with 170 cosponsors to improve Medicare Part D for low-income beneficiaries. I have still not received comments on that legislation. You said you are working with other agencies to provide technical and policy comments. When will those comments be ready?

5. Incomplete Reply on Marketing Abuses Request

As follow-up to a May 22 hearing on Private Fee-for-Service Marketing Abuses at which Abby Block testified, I submitted the following question to CMS: "1. Please provide us with specific documentation of the process by which CMS identified and acted to curb marketing abuses. Include the number of complaints, all corrective action plans against specific plans and a full detail of other intermediate sanctions levied against plans for marketing abuses. Also provide any interagency memos or reports detailing the extent of abusive marketing practices and possible solutions to the problem."

The documents provided by CMS in response to this question did not include a single e-e-mail or memo to or from Ms. Block, who runs the Center on Beneficiary Choices. This is surprising since Ms. Block testified on May 22 that it is this Center that she heads that that receives and handles complaints, and is responsible for administering both the Medicare Advantage and the Medicare prescription drug program. On October 16, CMS testified that Ms. Block does indeed communicate by e-mail. I therefore request that CMS supplement its Sept. 21 reply to include these communications, which should have already been provided.

Question from the Honorable Earl Pomeroy

At the hearing you alluded to the fact that there are approximately 500 people within CMS overseeing Medicare Advantage marketing practices. Please provide the Committee with verification of these 500 staff members and an accounting of what percent of time each is engaged in monitoring marketing practices and enforcing regulations. For example, are these 500 people working full-time or part-time to monitor Medicare Advantage marketing practices? If they are working part-time, how much of their time is devoted to Medicare Advantage oversight? Does their work on Medicare Advantage oversight detract from their routine work? If so, what is their routine work?

Moreover, at a previous Health Subcommittee hearing on May 22, 2007 on Private Fee-For-Service plans I asked, in a Question for the Record, "How many FTEs were added at CMS regional offices to review advertising and other marketing materials of PFFS plans". CMS responded by saying that "The rapid growth in PFFS plans is not something that was anticipated, which would have been required in order to add FTEs for this specific purpose", the response went on to state "Based on information available, we

cannot state that new FTEs were added to the CMS workforce specifically for the purpose of PFFS plan reviews".

Given CMS's response above and the fact that you now know that the PFFS product is growing at an exponential rate, are there any plans to hire new staff to deal with Medicare Advantage marketing and oversight?

Additional Written Questions from the
W&M Joint Health and Oversight Subcommittee Hearing
On Oversight and Accountability in the
Medicare Advantage Program
October 16, 2007

Questions from Chairman Lewis

1. **What is the personnel make-up of the CMS Office of the Ombudsman? What is the budget for the Office of the Ombudsman?**

Answer: The Office of the Ombudsman employs 34 full time equivalent employees. For fiscal year 2007, the operating budget for the office was as follows:

Travel:	$13,000
Training:	$2500
Awards:	$19,000
Supplies:	$1400
Contracts:	$1,677,600

2. **Has CMS contemplated any changes to the website or other information portals providing the phone number or contact information for the Office of the Ombudsman?**

Answer: The Medicare Beneficiary Ombudsman works within the Medicare program to identify and resolve system-wide issues impacting people with Medicare and to bring about changes that could help prevent future problems. Unlike some other Ombudsmen that people may be familiar with, the Medicare Beneficiary Ombudsman is not intended to be the initial contact for information and complaints. There are several points of contact in the Medicare program for individual questions, complaints, and grievances such as 1-800 MEDICARE and medicare.gov on the web. In addition, there is a function within the 'Frequently Asked Questions' section of medicare.gov that provides the opportunity for beneficiaries to submit their questions or complaints. People with Medicare and those acting on their behalf can also contact entities such as the State Health Insurance Assistance Programs (SHIPs) and CMS Regional Offices for assistance with their individual questions, complaints, and grievances.

Nonetheless, the Office of the Medicare Ombudsman (OMO) does respond to many of the beneficiary inquiries and complaints that are initially received by the CMS Central Office (whether through 1-800 MEDICARE, through a Regional Office, or through other channels). For example, in instances where the 1-800 MEDICARE customer service representatives cannot handle a caller's request for information or complaint, the call can be forwarded to the OMO.

Questions from the Honorable Lloyd Doggett

1. CMS's inability to Account for Millions Paid to Private Medicare Plans

In May 2007, the GAO reported that CMS paid $100 million to private Medicare Part D plans for retroactive coverage for dual eligibles, despite the fact that CMS did not inform beneficiaries of their right to seek reimbursement for drug costs incurred during these periods. The GAO reported that "CMS does not monitor its payment to PDPs for retroactive coverage or the amounts PDPs have reimbursed dual-eligible beneficiaries."

In response to my question to CMS at the June 21 hearing about whether CMS would be able to track these payments, CMS delivered a written reply on October 17, the day after the hearing, stating "CMS is currently in the process of tracking these retroactive enrollments and will use this information to determine how many months of retroactive coverage the Agency is providing to new dual—eligible individuals." CMS testified on October 16 that the reconciliation process necessary to track how this money was used is, in fact, complete. Several questions are outstanding:

(a) Does CMS already know how many months of retroactive coverage were Provided since it paid $100 million dollars to plans for that retroactive coverage?

Answer: No, but the analysis necessary to answer this question is currently underway. We will provide the information to your staff once the analysis is complete.

(b) How many months of coverage were provided?

Answer: This is not a question to which we currently have an answer but the analysis necessary to answer this question is currently underway. We will provide the information to your staff once the analysis is complete.

(c) How many people were retroactively enrolled?

Answer: This is not a question to which we currently have an answer but the analysis necessary to answer this question is currently underway. We will provide the information to your staff once the analysis is complete.

(d) How many of the new dual eligible beneficiaries who were retroactively enrolled were already in a Part D plan before they were awarded dual eligible status?

Answer: This is not a question to which we currently have an answer but the analysis necessary to answer this question is currently underway. We will provide the information to your staff once the analysis is complete.

(c) How have you verified that the plans in which people were already enrolled reimbursed those beneficiaries for the copayment amounts they paid over the limit of that owed by a dual eligible?

Answer: Medicare Part D plan sponsors have an obligation to reimburse their members (or another payer) for costs incurred retroactively. However, to fully analyze this question would require the use of prescription drug event (PDE) data. PDE data are collected pursuant to section 1860D-15(f)(1) of the Social Security Act. Section 1860D-15(f)(2) restricts the use of these data solely for CMS payment to plans. Consequently, consistent with longstanding interpretation of similar statutes by the Office of Legal Counsel within the Department of Justice, we would be unable to disclose that information.

(f) For those who were not already enrolled in a Part D plan during the period of retroactive coverage, how many people submitted claims to their new plan for drugs purchased during the retroactive coverage period?

Answer: To fully analyze this question would require the use of prescription drug event (PDE) data. PDE data are collected pursuant to section 1860D-15(f)(1) of the Social Security Act. Section 1860D-15(f)(2) restricts the use of these data solely for CMS payment to plans. Consequently, consistent with longstanding interpretation of similar statutes by the Office of Legal Counsel within the Department of Justice, we would be unable to disclose that information.

(g) How much did plans pay out in benefits for all retroactively enrolled dual eligibles for which Part D plans received $100 million?

Answer: To fully analyze this question would require the use of prescription drug event (PDE) data. PDE data are collected pursuant to section 1860D-15(f)(1) of the Social Security Act. Section 1860D-15(f)(2) restricts the use of these data solely for CMS payment to plans. Consequently, consistent with longstanding interpretation of similar statutes by the Office of Legal Counsel within the Department of Justice, we would be unable to disclose that information.

2. **Ensuring Consumers Have Access to a Fair and Timely Appeals Process**

(a) Do you require MA, MA-PD, and PDP bids to have a line item under Administrative costs demonstrating that they have dedicated enough funding to appropriately handle appeals?

(b) What specific steps does CMS take to ensure plans have an appeals process in place that complies with statutory requirements?

(c) Are plans allowed to simply attest that they have an appeals process without providing further detail to demonstrate this is the case?

Answer:

(a) No. CMS does not require MA, MA-PD, and PDP bids have a line item demonstrating they have adequate dedicated funding to appropriately handle appeals. See below for description of CMS requirements for plan appeal processes.

(b) Monitoring compliance with appeals requirements is a key feature of our MA and Part D plan audit guides, and we have implemented many compliance action plans based on appeals-related audit findings. In addition, we monitor plan appeals data (including both first level appeals at the plan and the independent second level reconsiderations done by MAXIMUS as another appeals performance measure. Based on the MAXIMUS data, we have initiated a series of performance improvement programs at plans that have unusually high rates of cases overturned at the MAXIMUS level.

In addition, our audit guide provides for audits of appeals processes. We take samples from Medicare Advantage Organizations (MAOs) to determine if they are processing appeals correctly. We do not require attestations because we actually test this area through the Targeted Appeals Monitoring Strategy (TAMS). The TAMS score has been calculated annually since 2003 for all MAO contractors using measuring adherence to statutory timeliness requirements, congruence with the independent review entity's evaluation, and member satisfaction survey information regarding access to information and processes to make appeals. Review of the TAMS score is a review element in the MA audit in addition to review of actual appeals cases.

(c) There are a number of ways in which CMS documents that plans have appeals procedures in place. As noted above, both MA and Part D audits include appeals components that document not only that appeals are being carried out but also whether or not plans are complying with key appeals-related requirements, such as the regulatory timeframes and notice requirements. We also track Part D appeals through our complaint tracking monitoring system, which includes a specific category on this topic.

3. **CMS's Failure to Update Consumer Report Cards on Medicare.gov**

The Corrective Action Plans (CAPs) available on CMS's website show that Humana's Regional PPO contract number R5826 has 18 pending CAPs for deficiencies in its appeals processes (Chapter 13: Grievances, Coverage Determinations, and Appeals). Though the CAPs for Humana R5826 were issued July 31, 2007, as of October 24, 2007 on Medicare.gov, that same contract number in Texas shows that the plan has three out of three stars – a perfect score – on appeals. When will CMS remove stars for this and other

poor-performing plans so that beneficiaries can make decisions based on accurate information?

Answer: The information that is provided for consumers to help them choose a Medicare Advantage (MA) plan. MA-PD, or Prescription Drug Plan (PDP) was updated as of November 15, 2007 for the Annual Election Period. The information on the Medicare Part C compare tool (Medicare Options Compare) and the Part D compare tool (Medicare Prescription Drug Plan Finder) was expanded to include additional quality and performance measures, to create composites to summarize the performance and quality information and make the information more accessible to users of the site. Additionally, all of the composites and individual measures have 5 star ratings where 1 is poor performance and 5 is excellent performance.

On www.cms.hhs.gov for R5826 there are 18 corrective action plans listed for Humana. Out of the 18, 17 relate to Part D. On www.medicare.gov (the consumer site), there are two Part D performance measures that relate to appeals. One measure captures delays in appeals decisions. Humana received one star for this measure. The other measure focuses on reviewing appeals decisions. Humana had insufficient data to report this measure. The current information on the consumer site is consistent with the information that is available on www.cms.hhs.gov regarding appeals.

4. **CMS's Failure to Reply to Request for Comments on Prescription Coverage Now Act**

Nearly six months have passed since I requested at the May 3, 2007 hearing that CMS inform me of any specific objections it had to the Prescription Coverage Now Act, legislation I have introduced with 170 cosponsors to improve Medicare Part D for low-income beneficiaries. I have still not received comments on that legislation. You said you are working with other agencies to provide technical and policy comments. When will those comments be ready?

Answer: CMS has worked actively on this issue since first requested, and we continue to work with other agencies to develop technical and policy comments on the legislation. Once those comments have been fully vetted and cleared, we will be in a position to provide them to your staff.

5. **Incomplete Reply on Marketing Abuses Request**

As follow-up to a May 22 hearing on Private Fee-for-Service Marketing Abuses at which Abby Block testified, I submitted the following questions to CMS: "1. Please provide us with specific documentation of the process by which CMS identified and acted to curb marketing abuses. Include the number of complaints, all corrective action plans against specific plans and a full detail of other intermediate sanctions levied against plans for marketing abuses. Also provide any interagency memos or reports detailing the extent of abuse marketing practices and possible solutions to the problem."

The documents provided by CMS in response to this question did not include a single email or memo to or from Ms. Block, who runs the Center on Beneficiary Choices. This is surprising since Ms. Block testified on May 22 that it is this Center that she heads that receives and handles complaints, and is responsible for administering both the Medicare Advantage and the Medicare prescription drug program. On October 16, CMS testified that Ms. Block does indeed communicate by e-mail. I therefore request that CMS supplement its Sept. 21 reply to include these communications, which should have already been provided.

Answer: Information responsive to this request would be provided to the Chairman and Ranking Member under separate cover, and should not be reproduced as part of the public record, or otherwise published or made public. These documents may contain information protected or prohibited from public disclosure under the Freedom of Information Act (Title 5, United States Code [U.S.C.] section 552), the Trade Secrets Act (Title 18, U.S.C. section 1905), the Privacy Act (Title 5, U.S.C. section 552a), and/or Department regulations.

Question from the Honorable Earl Pomeroy

At the hearing you alluded to the fact that there are approximately 500 people within CMS overseeing Medicare Advantage marketing practices. Please provide the Committee with verification of these 500 staff members and an accounting of what percent of time each is engaged in monitoring marketing practices and enforcing regulations. For example, are these 500 people working full-time or part-time to monitor Medicare Advantage marketing practices?

Answer: Following the enactment of Medicare Prescription Drug Benefit (Part D) with the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), CMS initiated an aggressive strategy to implement the program and provide benefit information to our beneficiaries. A key part of our implementation strategy included the development of an integrated effort to ensure the accuracy and integrity of plan payments, to oversee plan compliance with regulations and other requirements (including marketing guidelines), and to protect beneficiaries. This comprehensive program oversight effort included bid reviews, ongoing compliance monitoring of plans, post-contract bid audits and post-contract financial audits.

The implementation of this comprehensive oversight strategy required the involvement of multiple CMS components and over 500 staff members. The Part C and Part D Actuarial Group administer the bid review process and audits. The ongoing administration and monitoring of the Medicare Advantage and Medicare Prescription Drug Plans compliance with Federal requirements is performed by central office staff in the Center for Beneficiary Choices and regional office staff across the country. The financial audits of one-third of the plans are coordinated by the Office of Financial Management.

CMS maintains a strong commitment to protecting our beneficiaries and taxpayer dollars and ensuring the sound financial management of the Medicare and Medicaid programs. We have taken significant actions to implement our programs and to strengthen our oversight efforts.

We will continue to monitor and assess our efforts to oversee the Medicare Advantage and Medicare Prescription Drug Plans and will work to deploy our CMS resources in the most effieient manner.

Moreover, at a previous Health Subcommittee hearing on May 22, 2007 on Private Fee-For-Service plans I asked, in a Question for the Record, "How many FTEs were added at CMS regional offices to review advertising and other marketing materials of PFFS plans". CMS responded by saying that "The rapid growth in PFFS plans is not something that was anticipated, which would have been required in order to add FTEs for this specific purpose", the response went on to state "Based on information available, we cannot state that new FTEs were added to the CMS workforce specifically for the purpose of PFFS plan reviews".

Given CMS's response above and the fact that you now know that the PFFS product is growing at an exponential rate, are there any plans to hire new staff to deal with Medicare Advantage marketing and oversight?

Answer: CMS hiring is bound by the budget process. CMS manages the Medicare Advantage (MA) program, including marketing and oversight activities, under its program management budget (PM) and FTE allocation. For FY 2008, the CMS PM budget was funded at $3.152 billion by the Congress, or $122.3 million less than the FY 2008 President's Budget request. The Congress did not provide the $183 million requested in FY 2008 for a discretionary Health Care Fraud and Abuse Control, a portion of which was specifically targeted for MA. MA plan oversight is a high priority.

Congress of the United States
U.S. House of Representatives
COMMITTEE ON WAYS AND MEANS
1102 LONGWORTH HOUSE OFFICE BUILDING
(202) 225-3625
Washington, DC 20515-6348
http://waysandmeans.house.gov

November 2, 2007

Harry Hotchkiss
Senior Products Actuarial Director
Humana, Inc.
500 W. Main Street
Louisville, KY 40202

Dear Mr. Hotchkiss:

Please provide answers to the following Questions For the Record from the 10/16/2007 Joint Health and Oversight Subcommittees Hearing on Oversight and Accountability in the Medicare Advantage Program:

Questions from Chairman Stark

1. Please provide information on how much of Humana's $500 million profit in 2006 was contributed by payments from Medicare Advantage plans.

2. A report by a CIBC World Markets analyst, which was provided to you at the hearing, indicates that Humana's medical loss ratio in private fee-for-service MA plans is 150 basis points better than it is in Humana's HMO plans. Could you please respond to this report?

   - Would this indicate that all of the additional reimbursement that Humana is receiving for its private fee-for-service plans is spent on additional benefits?

3. At the hearing you indicated that Humana has the ability internally to track which extra benefits are used by Medicare Advantage beneficiaries; is this correct?

   - Could you please provide the Committee with the dollar value of the extra benefits that were actually used by Medicare Advantage beneficiaries enrolled in each of your plans for each of the last 2 plan years?

Hotchkiss Questions for the Record
Questions from Chairman Stark

1. **Please provide information on how much of Humana's $500 million profit in 2006 was contributed by payments from Medicare Advantage plans.**

   For calendar year 2006, Humana's consolidated revenues totaled 21.1 billion (excluding investment income). Of that amount, earnings before net investment income and taxes totaled $533 million. Of that amount, earnings related to Medicare totaled $339 million reflecting a Medicare operating margin of 2.9%.

2. **A report by a CIBC World Markets analyst, which was provided to you at the hearing, indicates that Humana's medical loss ratio in private-fee-for-service MA plans is 150 basis points better than it is in Humana's HMO plans. Could you please respond to this report?**

   a. **Would this indicate that all of the additional reimbursement that Humana is receiving for its private fee-for-service plans is spent on additional benefits?**

      First, we note that the CIBC analyst in a follow-up report published on October 9, 2007, reminded investors that: "There is almost no public data available on SG&A *[selling, general & administrative]* ratios by product, however, so this piece of our profitability analysis admittedly relies on nothing more than conversations with industry sources and our best estimates." In fact, the calendar year 2006 medical expense ratio for Humana's Private Fee-for-Service products was only 50 basis points less than the average for our Medicare Advantage products in total. We note that this ratio is affected by the fact that the Medicare Advantage open enrollment period in 2006 extended through June 30, 2006 resulting in less than a year's claims experience on all members.

      Additional reimbursement is targeted for additional benefits, reduced premiums and reduced cost-sharing for beneficiaries. Further, administrative costs include such items as clinical management programs, utilization management, wellness and prevention programs, care coordination programs, customer care programs, provider outreach & education, where applicable—provider contracting, compliance activities, tools to guide member health decisions, etc.

3. **At the hearing you indicated that Humana has the ability internally to track which extra benefits are used by Medicare Advantage beneficiaries; is this correct?**

a. **Could you please provide the Committee with the dollar value of the extra benefits that were actually used by Medicare Advantage beneficiaries in each of your plans for each of the last 2 plan years?**

We have examined ways in which we might be able to provide this information. Extra benefits are provided in a number of ways: reduced cost-sharing, reduced premiums and additional services. Due to these various forms of benefits, we cannot provide the information in the format described above.

Congress of the United States

U.S. House of Representatives

COMMITTEE ON WAYS AND MEANS

1102 LONGWORTH HOUSE OFFICE BUILDING
(202) 225-3625

Washington, DC 20515-6348

http://waysandmeans.house.gov

November 2, 2007

Cindy Polich
Senior Vice President
Secure Horizons
UnitedHealth Group
P.O. Box 1459
Minneapolis, MN 55440-1459

Dear Ms. Polich:

Please provide answers to the following Questions For the Record from the 10/16/2007 Joint Health and Oversight Subcommittees Hearing on Oversight and Accountability in the Medicare Advantage Program:

Questions from Chairman Stark

1. At the hearing you indicated that UnitedHealth has the ability internally to track which extra benefits are used by Medicare Advantage beneficiaries; is this correct?
   - Could you please provide the Committee with the dollar value of the extra benefits that were actually used by Medicare Advantage beneficiaries enrolled in each of your plans for each of the last 2 plan years?
2. How many total beneficiaries are in UnitedHealth plans?
   - In the UnitedHealth AARP Prescription Drug Plan?
   - In the UnitedHealth AARP Medicare supplement plan?

SecureHorizons®
by UnitedHealthcare

Cindy Polich
Senior Vice President
3120 Lake Center Drive
Santa Ana, CA 92704
Tel 714-825-5308 Fax 714-825-5016
cindy.polich@phs.com

November 1, 2007

The Honorable Pete Stark
Chairman
U.S. House of Representatives
Committee on Ways and Means
Subcommittee on Health
Washington, D.C. 20515

Dear Chairman Stark:

At a joint Health and Oversight Subcommittees hearing on October 16, you stated that "AARP tells us that they are not going to sell that [Medicare Advantage plans underwritten by UnitedHealth Group] for more than 100 percent of fee-for-service". I would like to take this opportunity to correct the record, and to clear up any confusion that may have resulted from this statement.

The statement implies that AARP is offering Medicare Advantage plans. This is not accurate. UnitedHealth Group (UHG) and AARP have entered into a trademark license agreement which allows UHG to use the AARP name on its Medicare Advantage plans. The plans are provided through SecureHorizons, one of UHG's businesses, and are underwritten by various of its licensed entities. In addition, the trademark license agreement between AARP and UHG does not define or influence the Medicare payment that our plans receive. The plans using the AARP name will receive the same level of funding as any other Medicare Advantage plan.

I hope this information is useful. Please let me know if you have any questions.

Sincerely,

Cindy Polich
Senior Vice President
Secure Horizons

CP/cms

SecureHorizons®
by UnitedHealthcare

December 19, 2007

The Honorable Pete Stark
Chairman
U.S. House of Representatives
Committee on Ways and Means
Subcommittee on Health
Washington, D.C. 20515

Dear Chairman Stark:

I am pleased to have this opportunity to respond to your questions from the record from the October 16 hearing.

UnitedHealth Group provides products and services to more than 70 million Americans through our various operating divisions. We insure 16 million people through our UnitedHealthcare division, providing health care for employers and individuals. Uniprise, which is our division that provides health care services for Fortune 500 businesses and other large employers and health plans, serves 12 million people.

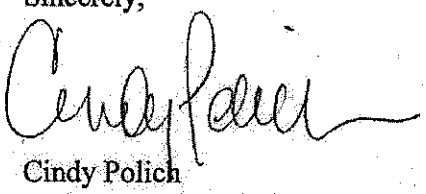
On the Medicare side 4.1 million Medicare beneficiaries receive their Medicare prescription drug benefits through a UnitedHealth Group stand-alone Part D plan that carries the AARP name. In addition, we have more than 2.6 million Medicare beneficiaries enrolled in AARP Medicare Supplement Plans.

Provided below are data on the extra benefits we provide our Medicare Advantage enrollees as included in our annual bid filings:

- 2006 - $79.14 per member per month
- 2007 - $68.46 per member per month
- 2008 - $85.98 per member per month

These benefits are provided for no additional supplemental A/B premium, and the majority of the value of these benefits is related to reducing FFS cost sharing for A/B services. Consistent with CMS bidding requirements, these values also include an allocation for administrative costs.

Sincerely,



Cindy Polich
Senior Vice President
Secure Horizons