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The Voice for Health Care Consumers

SPECIAL REPORT

June 2007

Whose Advantage? Billions in Windfall Payments Go to Private Medicare Plans

When lawmakers added private plans to Medicare, they claimed that such plans would save money and provide better care. Proponents of these plans, now called "Medicare Advantage" plans, argued that because they would foster "coordination of care" and inject the "efficiency of the private market" into Medicare, these plans would result in savings for taxpayers and better health care for beneficiaries. The truth is, these private plans have never saved money. In fact, private Medicare Advantage plans now cost billions of dollars more than traditional Medicare—*even though they may do little or no coordination of care*.

In 2003, Congress passed the Medicare Modernization Act (MMA), which pumped substantial new funding into Medicare's private plans and increased the windfall payments that these plans receive. While proving to be very lucrative for insurance companies, who have since increased their enrollment and thus their profits, this change has come at a high cost to taxpayers, and it has weakened the Medicare program as a whole. According to the Medicare Payment Advisory Commission (MedPAC), Medicare Advantage plans are paid an average of 12 percent more than traditional Medicare *to provide the same care*. MedPAC estimates that the resulting overpayments will add up to $54 billion over five years and $149 billion over 10 years.

The task of correcting these overpayments to Medicare Advantage plans has taken on extra urgency this year. One reason is that Congress, which must reauthorize the State Children's Health Insurance Program (SCHIP), is considering extending SCHIP coverage to all eligible but unenrolled children. This expansion of coverage would require about $50 billion in new funding. Although there are several options for coming up with this additional funding, reducing overpayments to Medicare Advantage plans could deliver a substantial share of the funds necessary to expand SCHIP to eligible children. The funds saved by reducing these overpayments could also be used to improve Medicare coverage for low-income seniors by strengthening Medicare Savings Programs and the Part D low-income subsidy.[1]

This report takes a closer look at how Medicare Advantage has evolved over the years and addresses the following issues:

- Medicare Advantage plans are heavily subsidized, to the tune of billions of dollars a year, and these dollars come out of the pockets of Medicare beneficiaries and taxpayers;
- Four out of five beneficiaries remain in traditional Medicare, but Medicare Advantage enrollment has grown substantially since 2003, especially in the least efficient plans; and
- The "better benefits" promised to Medicare Advantage enrollees may not be as good as promised.

Medicare Advantage: The New Alphabet Soup

Medicare Advantage is an umbrella term for a range of privately administered plans that substitute for traditional Medicare. A dizzying array of new types of private Medicare plans has emerged in recent years, including health maintenance organizations (HMOs), preferred provider organizations (PPOs), private fee-for-service (PFFS) plans, and special needs plans (SNPs) (see box on page 3, "Types of Medicare Advantage Plans"). These plans differ from traditional Medicare both in how services are delivered and in how the plans are paid.

A beneficiary in traditional Medicare may see any doctor or other provider who accepts Medicare coverage. Medicare reimburses the provider directly for services rendered to that beneficiary. In contrast, a beneficiary who selects a Medicare Advantage plan must follow guidelines regarding which providers are covered by his or her plan. Medicare pays these plans a flat rate per beneficiary, which varies by county across the country.

Medicare Advantage plans may limit a beneficiary's choice of providers. These plans may also cover benefits that are not offered by traditional Medicare, such as eyeglasses; offer coverage with reduced premiums; and/or charge cost-sharing that differs from traditional Medicare.

Types of Medicare Advantage Plans

- **Local Coordinated Care Plans**: These plans offer coverage on a county-by-county basis through local health maintenance organizations (HMOs) and preferred provider organizations (PPOs), which offer services through defined provider networks. HMOs, which are theoretically able to achieve efficiency through managing care, are the oldest type of private plans in Medicare. PPOs were added in 1997. Some local provider-sponsored organization (PSO) plans are also available under Medicare Advantage.
- **Regional PPOs**: Created by the Medicare Modernization Act (MMA) in 2003, regional PPOs must serve an entire Medicare Advantage region rather than a single county. Regional PPOs were intended to expand plan options in rural areas, and they include a less extensive set of quality reporting requirements than local coordinated care plans. Like local PPOs, regional PPOs charge lower cost-sharing when beneficiaries choose "in-network" providers that have contracts with the plan.
- **Private Fee-for-Service (PFFS) Plans**: Unlike HMO and PPO plans, PFFS plans are not required to coordinate care, establish provider networks, or adhere to quality reporting and utilization management requirements. Beneficiaries enrolled in PFFS plans must inform their providers that they have PFFS coverage prior to receiving services. Providers are free to accept or deny PFFS coverage on a case-by-case and visit-by-visit basis. This means that a provider can accept Mrs. Jones's PFFS coverage and reject Mr. Smith's PFFS coverage, or accept Mrs. Jones's coverage one week and deny her services the next week.
- **Special Needs Plans (SNPs)**: Also established under the MMA, SNPs are coordinated care plans that are designed to meet the needs of chronically ill beneficiaries. Enrollment in these plans is limited to people who are eligible for both Medicare and Medicaid (dual eligibles), people living in institutions, and people with certain chronic and disabling conditions.
- **Medical Savings Accounts (MSAs)**: These plans combine a high-deductible Medicare Advantage plan with a set annual deposit in a medical savings account. Originally authorized as a pilot program in 1997, the MMA allowed these plans to be available nationwide. In 2007, MSA plans were offered in 38 states and the District of Columbia, but enrollment to date has been quite low.

Private Inefficiency: Medicare Advantage Costs More

During the 1990s and early 2000s, the problem of overpayments to private Medicare plans was well-documented.[2] Even when plans were paid nominally less than traditional Medicare, as was the case during most of the 1990s, they were still being overpaid because they had enrolled healthier-than-average beneficiaries whose care was less expensive.

With the passage of the MMA in 2003, Congress abandoned any pretense of using private plans to make Medicare more efficient.

With the passage of the MMA in 2003, Congress abandoned any pretense of using private plans to make Medicare more efficient. Instead, it created a new payment formula that ensured that Medicare Advantage plans would receive substantially more per member than the cost of providing care through traditional Medicare. This new formula was adopted without regard to the costs to the Medicare program, other beneficiaries, and taxpayers.

Today, on average, Medicare Advantage plans are paid 12 percent more per person than traditional Medicare.[3] However, payments to plans vary by county and across plan type according to a complex formula set by Congress, with payments typically higher in rural areas. HMOs, for example, are more prevalent in urban areas and are paid an average of 10 percent more per person than traditional Medicare. PFFS plans, which have proliferated especially in rural areas, are paid an average of 19 percent more.[4]

The True Cost of Private Plan Overpayments

The current 12 percent overpayment rate means that billions of dollars above and beyond the cost of traditional Medicare are spent on Medicare Advantage plans every year. According to the Congressional Budget Office (CBO), these overpayments will amount to $54 billion over five years and more than $149 billion over 10 years.[5] This wasteful spending effectively takes money away from seniors, taxpayers, and other national priorities to line the pockets of for-profit insurers.

Medicare Advantage overpayments result in higher costs for beneficiaries. The millions of beneficiaries enrolled in traditional Medicare pay higher Part B premiums—$24 more per person this year—due to these overpayments.[6] State Medicaid programs also pay these additional premium costs when they cover the Part B premiums for dual eligibles (low-income beneficiaries who qualify for both Medicaid and Medicare) through one of the Medicare Savings Programs.

The Medicare program suffers as well because overpayments to private plans drain the program's financial resources and direct funds away from hospital and acute care services. If these subsidies to private plans remain intact, the burden on Medicare will grow with time and will place health care services that millions of seniors rely on at risk.[7]

Medicare Advantage Relies on Government Subsidies to Be Profitable

The Medicare Payment Advisory Commission (MedPAC), a non-partisan organization that advises Congress on Medicare financing issues, has for several years recommended that Medicare Advantage payments be made equal to traditional Medicare payments so that private plans and traditional Medicare compete on a level playing field.[8]

Traditional Medicare is a remarkably efficient program: Administrative costs average around 2 percent of total spending.[9] It has significant economies of scale, limited overhead, and no shareholders who expect it to generate profits.

Private Medicare plans, on the other hand, must generate a profit to remain viable. These plans add layers of expensive administrative and operational costs: They pay fees to agents and brokers who enroll beneficiaries in their plans, and they spend a significant amount of money on marketing and advertising. With all of this extra overhead, Medicare Advantage plans rely on substantial government subsidies to turn a profit.

In recent years, Medicare Advantage has emerged as a lucrative new market for large health insurers. Goldman Sachs estimates that Humana, for example, will earn 66 percent of its net income from Medicare Advantage this year. And Medicare Advantage will generate 11 percent of UnitedHealthcare's net income in 2007.[10] It is not surprising, therefore, that insurers have mobilized to defend the current Medicare Advantage payment formula, which produces a steady stream of profits.[11]

A Growing Problem

The increases in Medicare Advantage payments enacted by the MMA have had a predictable effect—plan participation and enrollment are on the rise. Total enrollment in Medicare Advantage plans grew by more than 40 percent between December 2005 and May 2007.[12] As of May 2007, about one in five (20.1 percent) Medicare beneficiaries was enrolled in a Medicare Advantage plan.[13] This proportion varies by state (Table 1). However, these higher levels of participation and enrollment have come with their own set of problems.

The Least Efficient Plans Have Grown the Fastest

Across the U.S., the percentage of counties with at least one Medicare Advantage plan available has grown from 91 percent in 2005 to 98 percent in 2007. People in every urban county and in 94 percent of rural counties now have access to at least one private plan.[14] While access to private plans has grown, these percentages do not tell the whole story.

Table 1

Enrollment in Medicare Advantage Plans and Traditional Medicare, by State

State	Total Enrollment in Medicare, December 2005	Enrollment in Medicare Advantage Plans, January 2007	Enrollment in Traditional Medicare	Percent of Enrollees in Medicare Advantage Plans
Alabama	781,601	106,966	674,635	13.7%
Alaska	45,701	275	45,426	0.6%
Arizona	818,639	284,419	534,220	34.7%
Arkansas	489,388	34,822	454,566	7.1%
California	4,386,037	1,444,229	2,941,808	32.9%
Colorado	542,294	162,662	379,632	30.0%
Connecticut	540,699	46,323	494,376	8.6%
Delaware	132,269	2,581	129,688	2.0%
District of Columbia	77,597	6,998	70,599	9.0%
Florida	3,129,832	783,923	2,345,909	25.0%
Georgia	1,076,986	107,267	969,719	10.0%
Hawaii	189,271	67,011	122,260	35.4%
Idaho	198,714	36,395	162,319	18.3%
Illinois	1,749,064	148,878	1,600,186	8.5%
Indiana	934,910	79,220	855,690	8.5%
Iowa	502,547	52,600	449,947	10.5%
Kansas	412,026	28,667	383,359	7.0%
Kentucky	704,727	73,121	631,606	10.4%
Louisiana	642,618	100,277	542,341	15.6%
Maine	243,190	4,113	239,077	1.7%
Maryland	718,389	53,486	664,903	7.4%
Massachusetts	1,007,212	168,389	838,823	16.7%
Michigan	1,537,840	203,489	1,334,351	13.2%
Minnesota	721,521	202,364	519,157	28.0%
Mississippi	471,940	43,508	428,432	9.2%
Missouri	942,794	145,185	797,609	15.4%
Montana	153,286	15,931	137,355	10.4%
Nebraska	267,836	23,519	244,317	8.8%
Nevada	308,802	92,133	216,669	29.8%
New Hampshire	194,363	2,873	191,490	1.5%
New Jersey	1,270,110	113,073	1,157,037	8.9%
New Mexico	277,591	59,108	218,483	21.3%
New York	2,879,429	654,329	2,225,100	22.7%
North Carolina	1,318,782	163,292	1,155,490	12.4%
North Dakota	106,313	5,899	100,414	5.5%
Ohio	1,811,669	301,416	1,510,253	16.6%
Oklahoma	559,862	62,215	497,647	11.1%
Oregon	557,661	212,861	344,800	38.2%
Pennsylvania	2,189,492	712,282	1,477,210	32.5%
Rhode Island	177,579	60,635	116,944	34.1%
South Carolina	673,878	52,710	621,168	7.8%
South Dakota	128,623	6,277	122,346	4.9%
Tennessee	955,071	165,636	789,435	17.3%
Texas	2,641,789	364,028	2,277,761	13.8%
Utah	245,106	50,836	194,270	20.7%
Vermont	100,351	839	99,512	0.8%
Virginia	1,023,393	86,001	937,392	8.4%
Washington	851,609	157,567	694,042	18.5%
West Virginia	367,440	35,504	331,936	9.7%
Wisconsin	854,772	153,441	701,331	18.0%
Wyoming	73,560	3,246	70,314	4.4%
United States	**42,986,173**	**7,942,819**	**35,043,354**	**18.5%**

Source: December 2005 Medicare enrollment data are from Brian Biles and Emily Adrion, George Washington University, January 2006 Medicare Advantage enrollment data are from Kaiser State Health Facts Online. Enrollment in traditional Medicare was derived by subtracting Medicare Advantage enrollment from total Medicare enrollment.

Note: Enrollment data do not include Puerto Rico or the Virgin Islands.

Coordinated care plans (HMOs and PPOs) offer at least the theoretical advantage of generating savings and better outcomes through managing care. But the most significant growth since 2005, especially in rural areas, has been in private fee-for-service (PFFS) plans, which typicallly do not provide coordinated care.

Ninety-one percent of urban counties have a local HMO or PPO. By contrast, only 42 percent of rural counties have local HMOs and PPOs.[15] (Regional PPOs are available in most urban and rural areas, but they have attracted few members.) The most prevalent type of plan in rural areas is PFFS plans, which are now offered in 94 percent of rural areas. These PFFS plans are the least efficient: They have no obligation to coordinate care and, as noted in the box on page 3, they are exempt from quality reporting requirements.

Total enrollment in Medicare Advantage rose from 6.1 million in December 2005 to 8.6 million in May 2007, an increase of more than 40 percent.[16] Although enrollment grew in all plan types, PFFS plans have been the fastest-growing plan type by a substantial margin. Enrollment in PFFS plans increased more than six-fold between December 2005 and May 2007, rising from just over 200,000 enrollees to more than 1.5 million enrollees (Table 2).[17]

Table 2

Enrollment in Medicare Advantage & Other Medicare Private Plans, December 2005 to May 2007

Plan Type	Enrollment, December 2005	Enrollment, May 2007	Enrollment Growth, December 2005 to May 2007
Local Coordinated Care Plans (HMO, PPO, PSO)	5,157,627	6,176,316	19.8%
Regional PPO	N/A	147,635	N/A
MSA	N/A	2,261	N/A
PFFS	208,990	1,558,371	645.7%
Other[a]	755,061	738,393	-2.2%
Total Enrollment[b]	**6,121,678**	**8,622,976**	**40.9%**

Source: Families USA calculations based on Kaiser Family Foundation, *Tracking Medicare Health and Prescription Drug Plans* data for December 2005 and May 2007.

[a] All other private plans in Medicare including cost plans, demonstration projects, pilot projects, PACE, and HCPP contracts.

[b] Enrollment numbers include individuals enrolled in private plans in Puerto Rico and the Virgin Islands. In January 2007, Medicare Advantage enrollment in these territories exceeded 335,000.

Traditional Medicare: Still the Choice of Seniors

In spite of the rapid growth in Medicare Advantage plans over the past few years, traditional Medicare is still overwhelmingly the choice of seniors: 80 percent of Medicare beneficiaries choose traditional Medicare over private plans. This is true across the board, regardless of income, race, or ethnicity:

- Lower-income seniors (with incomes under $10,000 a year) are nine times more likely to choose traditional Medicare than Medicare Advantage;
- African American seniors are seven times more likely to choose traditional Medicare than Medicare Advantage;
- Asian seniors are six times more likely to choose traditional Medicare than Medicare Advantage; and
- Hispanic seniors are three times more likely to choose traditional Medicare than Medicare Advantage (Table 3).

Table 3

Enrollment in Medicare Advantage and Traditional Medicare, by Population

Population	Enrollment in Medicare Advantage	Enrollment in Traditional Medicare	Preference of Traditional Medicare to Medicare Advantage
Hispanic Seniors	25%	75%	3X
Asian Seniors	14%	86%	6X
African-American Seniors	13%	87%	7X
White Seniors	13%	87%	7X
Lower-Income Seniors	10%	90%	9X

Source: Families USA calculations based on America's Health Insurance Plans, Center for Policy and Research, *Low-Income & Minority Beneficiaries in Medicare Advantage Plans* (Washington: AHIP, February 2007).

An Advantage for Beneficiaries?

Proponents of Medicare Advantage have not offered much evidence disputing that private plans are generously subsidized to lure members away from traditional Medicare. Instead, they contend that the extra benefits and reduced premiums that private plans frequently offer are worth the added costs. In fact, while beneficiaries may receive extra benefits and may pay reduced premiums or cost-sharing through Medicare Advantage plans, the extent and value of these benefits are unclear.

Medicare Advantage Plans Are Not Necessarily a Good Value

Medicare Advantage plans claim that they offer substantial additional benefits to members. There is no evidence, however, that beneficiaries in these plans actually receive these supplementary benefits. The Centers for Medicare and Medicaid Services (CMS), which administers Medicare, does not publish any data that show how many additional services have actually been provided to Medicare Advantage members.

Moreover, these "extra benefits" may come at a substantial price. A Medicare Advantage plan could offer, for example, a plan with basic vision and dental coverage, no premiums, and flat $20 copayments for doctors' visits. Such a plan would be a good deal for someone who has few health care needs and who expects to remain healthy. But what happens if an enrollee has unexpected health problems during the year and needs to be admitted to the hospital? She could discover that her plan has high cost-sharing for extended hospital stays, for example, or for other services that she needs. As a result, she could end up with substantially higher out-of-pocket costs than she would have had if she had remained in traditional Medicare.

This example highlights a fundamental problem with Medicare Advantage plans: They can be tremendously financially risky for beneficiaries. Beneficiaries must navigate complex benefit packages and guess which one they think will serve them best during the coming year. This financial risk, coupled with the profusion of plan options available in many areas, makes it difficult for beneficiaries to select the best plan when they enroll. Moreover, if the beneficiary's health care needs change over the course of the year, the plan that seemed to offer the best selection of benefits at the time of enrollment may no longer be the best option.

Widespread Marketing Abuses

Medicare Advantage's high payment rates provide quite an incentive for insurers to attract beneficiaries to their plans. This rush to attract lucrative new members has led to numerous illegal and unethical marketing practices. A recent survey conducted by the National Association of Insurance Commissioners found that 39 out of the 43 states that were interviewed reported receiving complaints about misrepresentations and inappropriate marketing practices. These marketing abuses ranged from beneficiaries being provided with misleading information about a plan's network to the forging of seniors' signatures.[18]

Although marketing abuses have been reported across all Medicare Advantage plan types, they have been the most egregious among PFFS plans.[19] With high payment rates and complicated plan structures, these plans epitomize the potential harm of combining substantial incentives to insurers and their agents with plans that lack necessary consumer protections and appropriate oversight.

In response to the profusion of complaints about marketing abuses among PFFS plans, CMS announced recently that the seven insurers with 90 percent of the PFFS market have entered a voluntary agreement to suspend marketing of these plans until they comply with a range of consumer protections.[20] It will be important to see if the problems are actually corrected before the suspension is lifted.

Conclusion

Medicare's private plans were introduced decades ago in the hope that they would control spending and increase the coordination of care. Today, Medicare Advantage plans are paid more than ever, and PFFS plans, which do not even attempt to coordinate care, have seen the overwhelming majority of growth in enrollment. This has resulted in billions of taxpayer dollars being spent on private coverage without any of the promised efficiency. Meanwhile, millions of seniors and people with disabilities who rely on traditional Medicare are paying extra money out of their own pockets to subsidize these plans. Reducing these costly overpayments to Medicare Advantage plans would strengthen Medicare, and it would generate substantial savings that could be used to improve programs that serve America's low-income seniors and fund health coverage for uninsured children. The choice before Congress is clear: a continued—and growing—windfall to insurance companies, or health coverage for low-income children and seniors?

Endnotes

[1] Medicare Savings Programs include the Qualified Medicare Beneficiary (QMB) program, which currently helps beneficiaries with incomes at or below the federal poverty level; the Specified Low-Income Medicare Beneficiary (SLMB) program, which currently helps beneficiaries with incomes between 100 and 120 percent of poverty; and the Qualified Individual (QI) program, which currently helps beneficiaries with incomes between 120 and 135 percent of poverty. Generally, these programs cover out-of-pocket costs for beneficiaries, such as paying for premiums.

[2] Robert Berenson, "Medicare Disadvantaged and the Search for the Elusive 'Level Playing Field'," *Health Affairs* Web Exclusive, December 15, 2004.

[3] Medicare Payment Advisory Commission (MedPAC), *Report to the Congress: Medicare Payment Policy* (Washington: MedPAC, March 2007).

[4] Ibid.

[5] Testimony of Peter R. Orszag, Director of the Congressional Budget Office, before the Senate Finance Committee, *The Medicare Advantage Program: Enrollment Trends and Budgetary Effects*, April 11, 2007, available online at http://www.cbo.gov/ftpdocs/79xx/doc7994/04-11-MedicareAdvantage.pdf.

[6] Testimony of Richard Foster, CMS Chief Actuary, before the House Ways and Means Subcommittee on Health, April 25, 2007.

[7] According to Richard Foster, CMS Chief Actuary, Medicare Advantage overpayments will shorten the life of the Part A Hospital Trust Fund by two years. Under current projections, the trust fund will be exhausted by 2019. Simply eliminating Medicare Advantage overpayments would extend the projected life of the trust fund to 2021.

[8] Medicare Payment Advisory Commission (MedPAC), op cit, and Medicare Payment Advisory Commission, *Report to the Congress: Promoting Greater Efficiency in Medicare* (Washington: MedPAC, June 2007).

[9] Kaiser Family Foundation, *Medicare Chart Book 2005, Section 5: Medicare Spending* (Washington: Kaiser Family Foundation, July 2005).

[10] Sarah Lueck, "Insurers Fight to Defend Lucrative Medicare Business," *The Wall Street Journal*, April 30, 2007.

[11] Ibid.

[12] Families USA calculation based on the Kaiser Family Foundation, *Tracking Medicare Health and Prescription Drug Plans, Monthly Report for December 2005* (Washington: Kaiser Family Foundation, January 6, 2006), and Kaiser Family Foundation, *Tracking Medicare Health and Prescription Drug Plans, Monthly Report for May 2007* (Washington: Kaiser Family Foundation, June 8, 2007).

[13] Families USA calculation based on the Kaiser Family Foundation, *Tracking Medicare Health and Prescription Drug Plans, Monthly Report for December 2005* (Washington: Kaiser Family Foundation, January 6, 2006), Kaiser Family Foundation, *Tracking Medicare Health and Prescription Drug Plans, Monthly Report for May 2007* (Washington: Kaiser Family Foundation, June 8, 2007), and Medicare enrollment data from Brian Biles and Emily Adrion, *The Cost of Privatization: Extra Payments to Medicare Advantage Plans, Updated Tables for 2007* (Washington: George Washington University, May 1, 2007).

[14] Marsha Gold, "Medicare Advantage in 2006-2007: What Congress Intended?" *Health Affairs* Web Exclusive, May 15, 2007.

[15] Ibid.

[16] Kaiser Family Foundation, *Tracking Medicare Health and Prescription Drug Plans, Monthly Report for December 2005* (Washington: Kaiser Family Foundation, January 6, 2006) and Kaiser Family Foundation, *Tracking Medicare Health and Prescription Drug Plans, Monthly Report for May 2007* (Washington: Kaiser Family Foundation, June 8, 2007).

[17] Families USA calculation based on the Kaiser Family Foundation, *Tracking Medicare Health and Prescription Drug Plans, Monthly Report for December 2005* (Washington: Kaiser Family Foundation, January 6, 2006), and Kaiser Family Foundation, *Tracking Medicare Health and Prescription Drug Plans, Monthly Report for May 2007* (Washington: Kaiser Family Foundation, June 8, 2007).

[18] Testimony of Sean Dilweg, Commissioner of Insurance for the State of Wisconsin, before the House Ways and Means Subcommittee on Health, May 22, 2007.

[19] Testimony of David Lipschutz, California Health Advocates, before the House Ways and Means Subcommittee on Health, May 22, 2007.

[20] Centers for Medicare and Medicaid Services, *Plans Suspend PFFS Marketing: Plans Adopt Strict Guidelines in Response to Deceptive Marketing Practices* (Washington: CMS, June 15, 2007).

SPECIAL REPORT

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Families USA Publication No. 07-105

This publication is available online at www.familiesusa.org.

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