The Holes in Part D: Gaps in the New Medicare Drug Benefit

(Part 1 of 2)

The new Medicare law—known as the Medicare Modernization Act or MMA—made the biggest changes to Medicare in the program's four-decade history. What Medicare beneficiaries may not realize is that this legislation left significant gaps or holes in the prescription drug benefit it created. For example, most beneficiaries will still have considerable out-of-pocket costs, including monthly premiums, an annual deductible, and copayments. Beneficiaries will also have to contend with a large gap in coverage—known as the doughnut hole—where they will have to pay all of their drug expenses on their own. What's more, the new Medicare Part D drug benefit will not cover several classes of drugs that beneficiaries may need. And finally, there is a gap that beneficiaries, advocates, and policy makers will all have to deal with—the gap in enrollment. Low enrollment has plagued both the (temporary) Medicare drug discount card program and the Medicare Savings Programs that have been around for more than a decade—will state governments be able to establish outreach, education, and enrollment procedures that can reverse this trend?

This brief discusses the three major kinds of gaps associated with the Part D benefit:

1. **The Financial Gap**: the high out-of-pocket costs many beneficiaries will still have to pay;
2. **The Drug Coverage Gap:** the categories of drugs that Medicare will not cover that beneficiaries will still need to obtain, as well as the potential barriers posed by plan formularies and pharmacy networks; and
3. **The Enrollment Gap:** federal and state governments have been only partially successful in getting beneficiaries to enroll in programs that help them pay for drugs or out-of-pocket costs—how can they improve their track record and get beneficiaries to enroll in the basic benefit and the low-income subsidy?

Our companion piece, *Filling the Holes in Part D: The Essential Role of State Pharmacy Assistance Programs* (Part 2 of 2), discusses what states can do through existing or new State Pharmacy Assistance Programs—SPAPs—to create wraparound programs to fill some of these gaps. That piece also discusses some of the major logistical challenges states will face as they deal with the ins and outs of the enrollment process, and it includes a brief look at what a few states are considering as 2006 approaches.

1. The Financial Gap

It is possible—and perhaps even likely—that beneficiaries will assume that the new drug benefit will eliminate the need to pay for most of their drug expenses on their own. Unfortunately, this is not the case. The cost-sharing rules of the drug benefit will require that most beneficiaries pay for a considerable share of their drug costs out of their own pockets. All beneficiaries, except certain people living in institutions such as nursing homes,[1] will have to pay something to receive drugs under Part D.

The new Medicare law is extremely complex, and what beneficiaries get—and how much they have to pay—will vary according to their incomes and assets. Medicare beneficiaries can be divided into three groups, each of which will receive its own level of benefits and have its own cost-sharing requirements.

1. **Full dual eligibles:** Medicare beneficiaries who also receive full Medicaid benefits—these are usually the lowest-income Medicare beneficiaries;
2. **Other low-income beneficiaries:** Medicare beneficiaries with incomes that are slightly higher (up to 150 percent of the federal poverty level)—this includes those who receive Medicaid benefits consisting solely of assistance from one of three Medicare Savings Programs that are administered by state Medicaid programs (also known as *partial dual eligibles*), as well as other low-income beneficiaries; and
3. **Everyone else:** Beneficiaries who receive only Medicare.

For more information on the benefit structure for different income groups, on income equivalents for the poverty levels listed, or on Medicare Savings Programs, please see the Appendix tables beginning on page 9.

Cost-Sharing for Full Dual Eligibles

Beneficiaries in this group will be eligible for extra financial help because their incomes and assets are low enough to meet the eligibility guidelines established for the low-income subsidy.

- **Premium**: None
- **Deductible**: None
- **Copayments/Co-insurance:**
  - For beneficiaries living in nursing homes or other institutions: None
  - For beneficiaries with incomes up to 100 percent of poverty: $1 for generics, $3 for brand-name drugs
  - For beneficiaries with incomes above 100 percent of poverty: $2 for generics, $5 for brand-name drugs
- **Coverage gap or "doughnut hole":** No coverage gap
- **Catastrophic limit:**
  - For beneficiaries living in nursing homes or other institutions: Drugs are free as long as the beneficiary is living in the institution
  - For other dual eligibles: After total drug expenses reach $5,100, drugs are free for the rest of the year

A Note about Copayments

Although these copayments may seem nominal, they could pose barriers for the lowest-income Medicare beneficiaries. First, the copayments for some dual eligibles are higher than those they currently pay under Medicaid. In addition, under Medicaid, if beneficiaries cannot afford to make a copayment, the pharmacist must still provide the prescription.[2] Under the MMA, individual pharmacists may decide whether to waive the copayment.[3] Finally, these copayments are indexed to inflation, meaning that they will go up steadily over time. The $1 and $3 copayments are indexed to the consumer price index, and the $2 and $5 copayments are indexed to Medicare's drug spending, which is expected to increase faster than consumer prices. As a result, out-of-pocket drug costs for most dual eligibles will probably be higher than they have been under Medicaid.

Cost-Sharing for Other Low-Income Beneficiaries

Beneficiaries in this group will be eligible for extra financial help because their incomes and assets are low enough to meet the eligibility guidelines established for the low-income subsidy.

- **Premium:**
  - For beneficiaries with incomes under 135 percent of poverty and few assets*: None
  - For beneficiaries with incomes no higher than 150 percent of poverty and/or moderate assets**: Sliding scale based on income
- **Deductible:**
  - For beneficiaries with incomes under 135 percent of poverty and few assets: None
  - For beneficiaries with incomes no higher than 150 percent of poverty and/or moderate assets: $50
- **Copayments/Co-insurance:**
  - For beneficiaries with incomes under 135 percent of poverty and few assets: $2 for generics, $5 for brand-name drugs
  - For beneficiaries with incomes no higher than 150 percent of poverty and/or moderate assets: After the deductible is met, 15% of the cost of covered drugs
- **Coverage gap or "doughnut hole":** None
- **Catastrophic limit:**
  - For beneficiaries with incomes under 135 percent of poverty and few assets: After total drug expenses reach $5,100, drugs are free for the rest of the year
  - For beneficiaries with incomes no higher than 150 percent of poverty and moderate assets: After total drug expenses reach $5,100, $2 for generics and $5 for brand-name drugs

* For these beneficiaries, "few assets" means assets under $6,000 for an individual or $9,000 for a couple.

** For these beneficiaries, "moderate assets" means assets under $10,000 for an individual or $20,000 for a couple.

A Note about Premiums

Low-income beneficiaries will receive a full or partial subsidy for their monthly Part D premium.[4] However, it is important to note that these subsidy amounts are based on the *average* premium for Part D plans in the beneficiaries' geographic region. It is likely that, in many regions, the price of Part D plans will vary somewhat—the more expensive plans will have higher premiums, and the premiums for the less-expensive plans will be lower. Because the subsidy will be based on the *average* of the premiums in a region, low-income beneficiaries will only be able to join plans with average or below average premiums—unless they can somehow afford to pay the difference themselves.

Cost-Sharing for Everyone Else: The Basic Benefit

All remaining Medicare beneficiaries—everyone with incomes above 150 percent of poverty (see Apendix Table 4) or with assets that exceed the limits for the low-income subsidy—are eligible only for the basic Medicare Part D benefit. Beneficiaries who are only eligible for Medicare and who do not qualify for the low-income subsidy will have to pay the most out of pocket.[5]

- **Premium**: To join a plan, beneficiaries will have to pay a monthly premium, which is expected to average $37 in 2006 (as noted previously, actual premiums will vary by plan).
- **Deductible:** Once beneficiaries enroll in a plan, they will have to pay a deductible of $250.
- **Copayments/Co-insurance:** Once an enrollee has met the deductible, he or she will have to pay 25 percent co-insurance for the next $2,000 in drug expenses for drugs on the plan's formulary.
- **Coverage gap or "doughnut hole":** Once beneficiaries' total drug expenses in their plan reach $2,250 for a year, beneficiaries enter the coverage gap, also known as the "doughnut hole." While in the doughnut hole, beneficiaries have no drug coverage for their next $2,850 in drug expenses.
- **Catastrophic limit:** Finally, once a beneficiary has paid $3,600 out of pocket for prescription drugs (in 2006)—that would be $5,100 in drug costs for someone with no other drug coverage—catastrophic coverage kicks in. At that point, they pay only 5 percent of their drug costs for the remainder of the year. In Medicare jargon, this $3,600 out-of-pocket limit is called the *True Out-of-Pocket Limit* or "TrOOP."

In total, beneficiaries not eligible for low-income assistance will pay $3,600 out-of-pocket, plus premiums, before their catastrophic coverage begins. However, catastrophic coverage will last only for the remainder of the year. When the next plan year starts, every beneficiary will have to pay a deductible, copayments, co-insurance, and will have a new coverage gap. And every year the deductible amount, where the doughnut hole begins, and the out-of-pocket maximum will all increase based on inflation in Medicare's spending on prescription drugs. This means that beneficiaries will have to spend more and more money on prescription drugs over time, and the amount that beneficiaries will have to spend out of pocket before their catastrophic coverage begins will increase every year at a rate projected to increase much faster than inflation.

The Harmful Impact of Cost-Sharing on Beneficiaries

Even the relatively modest copayments imposed on most low-income beneficiaries can significantly reduce their access to drugs. As noted previously, under the new Part D benefit, many dual eligibles will face higher copayments than they did under Medicaid, and unlike in Medicaid, these copayments will increase in future years because they are indexed to inflation. Moreover, there is no requirement that copayments be waived if a beneficiary cannot pay. This is especially troubling in light of research showing that dual eligibles in poor health who face even nominal copayments under Medicaid are less likely to fill prescriptions than similarly ill dual eligibles who do not have copayments.[6]

Likewise, beneficiaries with incomes or assets just above the eligibility levels for low-income assistance may find the basic Part D benefit prohibitively expensive. For example, a single elderly woman with a yearly income of $14,451 (151 percent of poverty in 2005) could spend 28 percent of her income ($444 in premiums and $3,600 on Part D drugs) before reaching her catastrophic benefit. Like her lower-income counterpart, she may decide that some drugs are simply too expensive and forgo them altogether, putting her health at risk. In these cases, state wraparound programs that help beneficiaries with their cost-sharing could make a big difference in preserving and improving beneficiaries' health.

2. The Drug Coverage Gap

Classes of Drugs Not Covered

Some drugs will not be available at all under the Part D benefit. The MMA excludes coverage of certain drugs, including benzodiazepines, weight loss or weight gain drugs, and over-the-counter drugs.[7] These drugs can be vital for maintaining the health of beneficiaries who are elderly or who have disabilities. For example, benzodiazepines include anti-anxiety drugs like Xanax and Valium, which help with anxiety and seizures. Weight gain drugs can be important for people dealing with chronic illnesses like HIV or with cancer.

Even when a plan does cover a class of drugs, however, there are other issues that may make it difficult for beneficiaries to obtain the drugs they need.

Formularies

All Part D plans are likely to develop formularies—lists of drugs that the plan covers. Beneficiaries will need to choose their drug plans carefully, taking into consideration which plans cover the drugs they need. Those who take multiple drugs may find that there is no plan that covers all their drugs. The rules governing Part D do require that plans cover a range of drugs, and they require plans to establish procedures that members can use to ask for exceptions and file appeals if they need a drug that is not on their plan's formulary. Ultimately, however, plans are not required to cover drugs not on their formularies. As a result, some beneficiaries will likely have to change their medications if they do not have an additional source of coverage, such as a state wraparound program.

Low-income beneficiaries may have a particularly hard time finding—or affording—a plan that covers all the drugs they need. This is because, as noted previously, their choice of plans will be limited to those of average or lower cost because their premium subsidy will only equal the *average* premium in

their region. So, if the drugs they need are only available through higher-cost plans, they will not be able to join these plans without additional financial help. State wraparound programs could enable such beneficiaries to pay a higher premium and either join another plan or pay out-of-pocket for specific drugs not covered by their plans. For low-income enrollees, then, wraparound assistance from the state would be an invaluable help in maintaining their health.

Pharmacy Networks

All plans are also expected to create pharmacy networks. Beneficiaries will have to obtain their drugs from pharmacies that participate in their plan's network, and their Part D card will not be honored at non-network pharmacies. In addition, plans may designate preferred and non-preferred pharmacies within their pharmacy network. Beneficiaries could pay higher prices at non-preferred pharmacies.[8] This situation can create a barrier for beneficiaries because the pharmacies closest to where a beneficiary lives may not be in-network, preferred pharmacies. Beneficiaries may therefore have to drive a long distance—or arrange for some other type of transportation—to get to the pharmacies that participate in the benefit. If a beneficiary cannot get to an in-network pharmacy, he or she will have to pay the full drug costs out of his or her own pocket.

3. The Enrollment Gap

Over the years, Medicare beneficiaries have been offered help in paying for their health coverage or their drugs. The two most prominent forms of help are:

1. Medicare Savings Programs (MSPs): Since 1986, three programs have been created to help low-income Medicare beneficiaries pay out-of-pocket costs such as premiums. These programs (which are actually administered by state Medicaid programs) are known as the Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), and Qualified Individual (QI) programs (see Appendix Table 5).

   Historically, many low-income Medicare beneficiaries have never signed up for these programs even though they qualified for them and would benefit substantially from enrolling. Despite significant outreach efforts, fewer than three out of five of those eligible for Medicare Savings Programs actually sign up for them.[9]

2. Medicare-Approved Drug Discount Cards: From June 2004 through the end of 2005, Medicare beneficiaries have been able to purchase Medicare-approved discount cards sold by private companies. These cards enable all beneficiaries to get discounts on many prescription drugs. Low-income Medicare beneficiaries whose incomes are below 135 percent of poverty (see Appendix Table 4), including full and partial dual eligibles, are also eligible to receive additional financial assistance. Those who qualify do not have to pay for a discount card and could receive a $600 subsidy for both 2004 and 2005. The subsidy is prorated for those who applied after March 15, 2005.

   About 7 million low-income Medicare beneficiaries were eligible for the $600 subsidy associated with the discount card. The Bush Administration estimated that 4.7 million of these individuals would apply for the subsidy. However, reports indicate that fewer than 1.8 million—about 25 per-

cent—of those eligible for the subsidy actually applied for it.[10] One advocate commented that "The enrollment process itself was so complicated it stopped even people who wanted to get signed up from completing it."[11] This was despite extensive educational and outreach efforts on the part of the federal government, advocacy groups, community groups, and card sponsors.

Clearly, the task of getting even low-income beneficiaries—those who need the most help—enrolled in programs that can assist them is a formidable one, and one where the federal government has had limited success. So, what are the prospects for enrolling millions of seniors and people with disabilities in the appropriate Part D plan and, if applicable, the low-income subsidy? While automatic enrollment will address part of this issue, there is much that the states can do to maximize enrollment.

- **Automatic Enrollment**
  Some low-income beneficiaries will be automatically enrolled in either a Part D plan or the low-income subsidy, or both. Full dual eligibles will be automatically enrolled by CMS into a Medicare Part D plan and are automatically eligible for the low-income subsidy. Partial dual eligibles—those in MSPs—will be automatically eligible for the low-income subsidy as well.

  In addition, CMS has stated that MSP beneficiaries who do not join a Part D plan during the initial enrollment period that ends May 15, 2006 will be enrolled by CMS into a Part D plan.[12] However, when CMS automatically enrolls both full and partial dual eligibles into plans, it will choose at random from among the low-cost plans in a region *without regard for beneficiaries' specific drug needs*. This should serve as an added incentive to getting low-income Medicare beneficiaries to actively choose the plan that best suits them and get them enrolled. And this is one place where state advocates and policy makers can step in, ensuring that the appropriate state agencies have set up the necessary outreach, education, and enrollment procedures to get beneficiaries into the right plan the first time around.

- **Voluntary Enrollment**
  For all other Medicare beneficiaries, enrollment in both the Part D drug benefit and the low-income subsidy is voluntary. This means that the remaining beneficiaries will have to sign up on their own with a Part D plan and, if applicable, enroll in the low-income subsidy. The voluntary nature of this process—together with the enormous task of educating and guiding so many beneficiaries, some of whom have cognitive impairments—will likely make it harder to achieve high enrollment.

In short, ensuring enrollment into Part D and the low-income subsidy will be a significant challenge for states. What can states do to address this challenge? Fortunately, more than 25 states already have some kind of State Pharmacy Assistance Program (SPAP) in place. These programs have helped Medicare beneficiaries, and sometimes others, obtain drugs in the absence of a Medicare drug benefit. State Pharmacy Assistance Programs can be the basis for "wrapping around" the Part D benefit—for example, covering some or all of beneficiaries' out-of-pocket costs, or paying for drugs not covered by a plan's formulary. What's more, these programs already have experience in identifying and serving low-income Medicare beneficiaries, and they usually already have information about these beneficiaries' incomes and prescription drug needs. CMS has provided financial grants to State Pharmacy Assistance Programs

for transition costs, so these programs should be built into any state plan to fill in holes in Part D. In states that do not have Pharmacy Assistance Programs, advocates and policy makers should consider what new initiatives they could launch to fill the gaps in Part D. For specifics on what states can do to maximize enrollment and provide wraparound coverage, see our companion piece, *Filling the Holes in Part D: The Essential Role of State Pharmacy Assistance Programs*.

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[1] Full dual eligibles are people who receive both Medicare and the full Medicaid benefit. Dual eligibles living in institutions will have no copayments for drugs on their plans' formularies. Institutions are defined in 42 C.F.R. 423.772. Partial dual eligibles are people who participate in Medicare Savings Programs (Qualified Medicare Beneficiary, Specified Low-income Medicare Beneficiary, and Qualified Individual programs). Medicaid pays for some or all of their Medicare cost-sharing.

[2] 42 C.F.R. § 1396o(e).

[3] This option is mentioned in the Preamble to the final regulations. 70 *Federal Register,* p. 4,387 (January 28, 2004).

[4] Beneficiaries with incomes at or below 135 percent of the federal poverty level and who meet an assets test will receive the full subsidy. Those with higher incomes (up to 150 percent of poverty) and/or assets (up to $10,000 for an individual or $20,000 for a couple) will receive a partial premium subsidy on a sliding scale based on income.

[5] For a complete description of who qualifies for what coverage under the low-income subsidy, see Part 1 of this series, Marc Steinberg, *Is your State Ready for 2006? An Introduction to What the New Medicare Part D Prescription Drug Benefit Means for Medicaid* (Washington: Families USA, September 2004).

[6] Bruce Stuart and Christopher Zacker, "Who Bears the Burden of Medicaid Drug Copayment Policies?" *Health Affairs* 18, no. 2 (March/April 1999): pp. 201-212.

[7] Section 1860D-2(e)(2) of the Social Security Act, as added by the MMA (Pub. L. No. 108-173). The following 10 drugs or categories of drugs are not covered by Part D: 1) benzodiazepines; 2) weight loss and weight gain drugs; 3) over-the-counter drugs; 4) barbiturates; 5) drugs for symptomatic relief of coughs and colds; 6) prescription vitamins, except prenatal vitamins and fluoride; 7) drugs to promote hair growth; 8) fertility drugs; 9) cosmetic drugs; and 10) drugs that must be monitored by testing services that only the manufacturer provides, such as certain anti-psychotic medications. This list is taken from Section 1927(d)(2) of the Social Security Act.

[8] Low-income beneficiaries will have the same copayment at non-preferred pharmacies as long as the pharmacies are in the Part D plan's network.

[9] General Accounting Office, *Medicare Savings Programs: Results of Social Security Administration's 2002 Outreach to Low-Income Beneficiaries* (Washington: General Accounting Office, March 2004).

[10] Bruce Japsen, "$600 on the Table, but Few Takers; Medicare Drug Benefit Confusing, Critics Say," *Chicago Tribune*, March 24, 2005.

[11] Ibid.

[12] This process is called "facilitated enrollment," as it will take place after the initial enrollment period is over. CMS is expected to issue details of this policy at a later date. Preamble to the final regulations, 70 *Federal Register* 4,209 (January 28, 2005).

Appendix Tables

Appendix Table 1: Low-Income Part D Benefits for Full Dual Eligibles

Beneficiaries do not pay an annual premium and are not subject to an assets test.[6] Coverage is arranged in the following tiers:

Beneficiary Status or Income	Coverage
Beneficiaries in nursing homes or other institutions	• Premium: none • All drugs in plan are free • No copayments
Families with incomes up to 100% of the federal poverty level	• Premium: none • Copayments: $1 for generics, $3 for brand-name drugs • No copayments after total drug costs reach $5,100 for the year
Families with incomes over 100% of the federal poverty level	• Premium: none • Copayments: $2 for generics, $5 for brand-name drugs • No copayments after total drug costs reach $5,100 for the year
After 2006, $1 and $3 copayments will increase with the consumer price index. After 2006, $2 and $5 copayments will increase based on increases in Medicare's drug spending. After 2006, the catastrophic limit of $5,100 will increase based on increases in Medicare's drug spending.	

Appendix Table 2: Low-Income Part D Benefits for Other Low-Income Beneficiaries

Beneficiaries are subject to an assets test. The amount of subsidy provided varies according to beneficiaries' income and assets. Coverage is arranged in the following tiers:

Beneficiary Income and Assets		**Coverage**
Income below 135% of the federal poverty level . . .		
. . . and	Assets below $6,000 for an individual or $9,000 for a couple	• Premium: none • Copayments: $2 for generics, $5 for brand-name drugs • No copayments after total drug costs reach $5,100 for the year
. . . and	Assets between $6,000-$10,000 for an individual or $9,000-$20,000 for a couple	• Premium: premium on sliding scale from $0-$35/month; premiums will increase annually • Beneficiaries must pay a $50 annual deductible • Beneficiaries must pay 15% coinsurance of drug costs up to $5,100 • After total drug costs reach $5,100 for a year, beneficiaries pay copayments of $2 for generics and $5 for brand-name drugs for the rest of the year
Income between 135%-150% poverty; assets less than $10,000 for an individual or $20,000 for a couple		• Premium: premium on sliding scale from $0-$35/month; premiums will increase annually • Beneficiaries must pay a $50 annual deductible • Beneficiaries must pay 15% coinsurance of drug costs up to $5,100 • After total drug costs reach $5,100, beneficiaries pay copayments of $2 for generics and $5 for brand-name prescriptions for the rest of the year
After 2006, asset limits will increase with the consumer price index. After 2006, copayments and the catastrophic limit of $5,100 will increase based on increases in Medicare's drug spending.		

Appendix Table 3: The Basic Medicare Part D Prescription Drug Benefit

Under the new Part D, Medicare beneficiaries will be able to join a prescription drug plan. Beneficiaries will pay a monthly premium, estimated at $35 a month in 2006. The coverage they receive, shown in the tiers below, depends on the amount of a beneficiary's drug expenses:

Coverage	Drug Costs	Part D Pays	Beneficiary Pays	Beneficiary's Cumulative Total Out-of-Pocket Payment
Deductible	$0-$250	0	100%	$250
Initial Benefit	$251-$2,250	75%	25%	$750
"Doughnut Hole"—no coverage	$2,251-$5,100	0	100%	$3,600
Catastrophic Benefit	Over $5,100	95% of all remaining costs	5% of all remaining costs	$3,600 plus 5% of costs above $5,100
After 2006, the deductible, the point where the doughnut hole begins, and the point where catastrophic coverage begins will all increase based on increases in Medicare's drug spending.				

Appendix Table 4: Poverty Level Income Equivalents for Individuals and Couples, 2005

Percent of Federal Poverty Level	Annual Income, Individual	Annual Income, Couple
100%	$9,570	$12,830
135%	$12,920	$17,321
150%	$14,355	$19,245

Appendix Table 5: Medicare Savings Programs for Low-Income Beneficiaries

Program Name	Income*	Assets*	What's Covered?
Qualified Medicare Beneficiaries (QMBs)	Equal to or less than 100% of the federal poverty level	Up to $4,000 for individuals or $6,000 for couples	All Medicare premiums and all Medicare cost-sharing
Specified Low-Income Medicare Beneficiaries (SLMBs)	Between 100% and 120% of the federal poverty level	Up to $4,000 for individuals or $6,000 for couples	Medicare Part B monthly premiums
Qualifying Individuals 1 (QI1s)**	Between 120% and 135% of the federal poverty level	Up to $4,000 for individuals or $6,000 for couples	Medicare Part B monthly premiums (Here, enrollment is not an entitlement—it is limited by a federal funding cap.)

*States can broaden coverage by using "less restrictive methodologies" in calculating income and assets under Section 1902(r)(2) of the Social Security Act: see Andy Schneider, *The Medicaid Resource Book* (Washington: Kaiser Commission on Medicaid and the Uninsured, 2002).

**The QI-1 program expires on September 30, 2004. Congress is considering whether to extend the program.

Credits

This issue brief was written by:

Marc Steinberg,
Health Policy Analyst,
Families USA

with
Ingrid VanTuinen
Writer-Editor,
Families USA

The following Families USA staff contributed to the preparation of this issue brief:

Kathleen Stoll, Director of Health Policy
Dee Mahan, Deputy Director of Health Policy
Leila Babaeva, Villers Fellow
Dennis Barrett, Emerson National Hunger Fellow
Peggy Denker, Director of Publications
Nancy Magill, Design/Production Coordinator

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Families USA Publication No. 05-102

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

1201 New York Avenue NW, Suite 1100 ▪ Washington, DC 20005
Phone: 202-628-3030 ▪ Fax 202-347-2417
E-mail: info@familiesusa.org
Web site: www.familiesusa.org