

**Testimony on  
Medicare Advantage and the Federal Budget**

**Submitted By  
Mark McClellan, MD, PhD**

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Chairman Spratt, Ranking Member Ryan, and distinguished members of the Committee, thank you for the opportunity to testify today on Medicare Advantage and the Federal Budget.

My testimony makes a number of points. First, Medicare Advantage (MA) health plans play a critical role in bringing greater value to our overall health care system, in terms of enabling beneficiaries to get more up-to-date, higher-quality care at a lower cost. Second, policy reforms to address the looming Federal government entitlement crisis should not start with shifting costs from the Federal government to Medicare beneficiaries with limited means, and they should seek to avoid reducing access to benefits like preventive services, more comprehensive drug coverage, and care coordination services that both reduce costly complications and help beneficiaries lead healthier lives. In fact, such changes may meet the definition of reduced efficiency, properly defined from the standpoint of the overall value of the care provided in our health care system. Third, any differential payments for most types of MA plans may well be smaller in 2008 and beyond than some recent estimates based on 2007 data would suggest. As a result of recent changes in law and regulation, MA plans overall will have relatively modest payment increases in 2008 and possibly in subsequent years. Remaining differences in payment rates are largely the direct result of bipartisan Congressional action to address concerns about reduced access to up-to-date coverage options in rural and certain urban areas. Thus, any changes should be approached cautiously. Fourth, while the MA program is a key element in achieving the overall policy goal of improving the quality and efficiency of Medicare and our health care system, there are some important opportunities to improve it and help reduce Federal costs.

**The Value of the Medicare Advantage Program**

Before discussing the efficiency of Medicare Advantage plans, I would like to start with a comment on the importance of considering *value* – which is the way economists define efficiency – in the context of our health care system. Economic efficiency is not simply reducing costs to the government. For example, consider two kinds of health care coverage. One kind generally pays for complications of health problems after they

happen, but limits coverage of preventive care, services to help people with chronic disease stay well, and other benefits that improve health, resulting in higher costs to patients. The other kind of coverage is more in line with 21<sup>st</sup>-century health care: it provides more personalized medical services, such as helping people understand their risk factors, comply with drug therapies and other treatments to prevent complications, avoid duplicative services, and as a result it achieves better health outcomes. Even if these two kinds of coverage cost the same amount to the government, they are by no means equally efficient. Because the latter type of coverage achieves better quality for the same amount of government payment – because it delivers greater value – it is the more efficient approach. In fact, even if the more up-to-date coverage were somewhat more costly, because it delivers better health, it may still be the more efficient plan. Moreover, economic efficiency cannot be determined simply by looking at costs to the government. Efficiency depends on overall costs, including costs paid by beneficiaries as well as the government. Coverage that shifts costs to beneficiaries without lowering overall costs – or perhaps increasing them – does not increase efficiency.

If we want to achieve a high-value, efficient health care system, then Federal policies must encourage high-value health care. With this background in mind, I would like to describe how the Medicare Advantage program overall is performing.

Overall, compared to fee-for-service Medicare, beneficiaries in Medicare Advantage plans have much lower out-of-pocket costs; they receive significantly more preventive benefits, drug coverage, and services to help them better manage their chronic diseases; they have very high satisfaction rates; and in most cases, their overall care costs (Medicare plus beneficiary) are lower.

For example, Medicare Advantage beneficiaries receive preventive services like mammograms, colorectal cancer screening, prostate screening, and immunizations at significantly higher rates than beneficiaries in traditional fee-for-service (FFS) Medicare. In addition, compared to other Medicare beneficiaries without supplemental “Medigap” coverage, MA beneficiaries are only one-third as likely (6 percent versus 17 percent) to report delaying the use of needed care due to cost.<sup>1</sup>

MA beneficiaries also receive higher quality of care in many areas; for example, a study in the *Journal of the American Medical Association* found that beneficiaries in MA plans received higher quality of care than beneficiaries in traditional FFS Medicare in five of seven HEDIS quality measures studied.<sup>2</sup> Quality is reflected in overall high beneficiary satisfaction rates with their coverage: Consumer Assessment of Health Plans Surveys (CAHPS) generally rate MA plans highest among a range of types of health plans.<sup>3</sup>

These quality of care results are the consequence of how most MA plans provide coverage. Plans receive a single, risk-adjusted payment from Medicare, and they compete to attract and keep beneficiaries by using this subsidy to provide the most attractive benefits at the lowest overall cost. In contrast, in traditional FFS Medicare, benefits are determined by statute and cannot easily include many innovative approaches to benefit design, provider payment, care coordination services, and personalized support

for beneficiaries. Through MA plans, beneficiaries across the country have access to plans with lower or zero copays for preventive services; they have widespread access to wellness programs; they have access to dental and vision services that not only reduce costs but also help beneficiaries live better and improve their overall health.

Importantly, MA plans are also providing drug coverage that is more extensive and much less costly than in traditional FFS Medicare. This difference in generosity and cost, which increased between 2006 and 2007 and may continue to increase in the future, is likely the result of several factors. First, most MA plans can manage the use of prescription drugs more effectively, as part of their efforts to support the overall coordination of care for a patient's health. Second, higher compliance with drugs has been shown to reduce other health care costs,<sup>4</sup> and because MA plans have incentives to keep overall costs down that do not exist in traditional FFS, they can capture the savings in hospital, physician, and other costs from the greater compliance that comes with more comprehensive drug coverage. Again, this is a more efficient approach to health care coverage.

Finally, most MA plans provide much more support for patients with chronic diseases than is available in traditional FFS Medicare. This is critically important, since the vast majority of costs in Medicare – and most of the cost growth in Medicare – relates to treating the complications of a limited number of serious chronic diseases. Our health care system has huge and persisting quality gaps in the prevention and treatment of chronic diseases. There is no population in this country that needs such personalized services to improve coordination and prevent complications from chronic diseases more than Medicare beneficiaries.

All of these features – better preventive care, lower out-of-pocket costs, better drug coverage, better support for quality care for chronic diseases – are signs of more efficient health care. Not surprisingly, they add up to very large savings for beneficiaries – on average, out-of-pocket costs are \$86 a month less in MA, compared to traditional FFS Medicare with Medigap (counting beneficiary premiums) or no supplemental coverage. That's more than \$1000 a year in savings. This is why a recent analysis by Adam Atherly and Ken Thorpe of Emory University concluded that even though MA payments increase Medicare costs, “the size of the increase in costs will be less than the value of the supplemental benefits provided to beneficiaries” – that is, overall costs to beneficiaries and the Federal government are lower in the MA plans.<sup>5</sup> (Similarly, according to MedPAC testimony before the Ways and Means Committee in May, average bids across all Medicare Advantage plans for Part A and B services are lower than the average cost of traditional FFS Medicare<sup>6</sup> - and when Part D benefits are included, the cost differences are larger.)

To achieve the goal of reducing overall health care costs while improving quality – that is, to improve efficiency from the standpoint of our overall health care system, and to spend beneficiary as well as tax dollars more effectively – Medicare Advantage is providing very important options to Medicare beneficiaries.

## **Estimated Payment Differences Between MA and Traditional Medicare, and Implications for Payment Reforms**

While finding ways to reduce costs and improve value of the overall health care system is very important, so is finding ways to reduce Medicare spending growth. The best policy reforms will cause both Medicare expenditures and total health care expenditures to go down, without compromising beneficiary health. With all the overuse, underuse, and misuse of medical care in our health care system, there are plenty of opportunities to do this. But reductions in MA payment rates would not do it: they reduce Medicare spending by reducing the benefits and the beneficiary savings just described. So an important question is: what is the likely impact of reducing MA payments?

As a preliminary step, it's important to review what the overall Medicare payment differences are between MA plans and traditional Medicare. There are some reasons why the 12 percent estimate of cost differences from CBO and MedPAC may not be indicative the payment differences in 2008 and beyond, and thus the impact of payment reforms to "equalize" payments, especially for the coordinated care plans (HMOs and PPOs) that continue to make up the vast majority of MA enrollment. First, the estimated payment differences do not include a number of factors that affect the overall cost comparisons:

- The analyses generally focus on Part A and B benefits only.<sup>7</sup> But MA plans are providing Part D coverage at substantially lower costs than in traditional Medicare, for the reasons described above, and these cost differences are increasing. As a result, MA plans are likely to exert a growing impact on holding down the Part D "benchmark" and thus holding down Part D costs for the entire Medicare program. Accounting for the complete costs of A, B, and D benefits results in a significantly smaller difference in total Medicare costs.
- The analyses include the administrative costs of MA plans (these costs, along with care coordination and other patient management costs, are included in the MA bids) but the administrative costs (including the administrative costs to combat fraud and abuse) of traditional FFS Medicare are not included. These costs likely amount to 2 percent or more in additional traditional FFS costs.
- The forecasts of spending differences and savings for 2008 and beyond do not account for the artificially low forecasts for physician spending in traditional Medicare. The large spending reductions required under current law, including a 10 percent cut in payment rates for 2008, are not sustainable. Physicians cannot provide adequate services for beneficiaries with these payment reductions. When Congress addresses the physician payment reduction for 2008, payments in traditional Medicare will go up significantly, and would not be accounted for in the MA rates until 2009 (by which time Congress may have enacted another one-year physician payment "fix" that increases traditional FFS costs again).
- An important source of additional payments to MA plans right now, the so-called "budget neutrality" adjustment to the risk-adjusted payments to MA plans, is

being phased out. Other things equal, it will be substantially smaller in 2008 and beyond, particularly if MA plans continue to increase their efforts to design benefits that attract chronically ill beneficiaries.

In addition to these four factors, some reports have also pointed out other potential factors that may incrementally affect the estimated differences, such as costs not included in the county “AAPCC” amounts behind the traditional FFS payment estimates, and the way that payments for medical education are counted.<sup>8</sup>

From the standpoint of overall health care efficiency, another important factor to consider in evaluating the cost impact of the MA program is known as the “spillover effect” of a growing presence of plans that emphasize prevention and coordinated care. As every health care provider knows, how traditional Medicare pays is an important influence on how overall health care is delivered. For example, when providers are paid more when patients have more duplicative tests and more preventable complications – as is the case in fee-for-service payment systems – it is more challenging to take steps like adopting health IT or reorganizing practices in other ways to deliver care more efficiently. In reviewing a broad range of studies of the impact of managed care plans on *overall* health care spending in different regions of the country, Laurence Baker of Stanford University concluded that “despite some, generally early, studies that do not find strong effects, this literature as a whole suggests that managed care is capable of having broad influences on the health care delivery system, and that these effects have been in the direction of driving down health care costs. Some of this evidence, particularly that focused on traditional Medicare enrollees, clearly indicates the ability of managed care activity to influence spending patterns for patients well outside the boundaries of managed care plans.”<sup>9</sup> Thus, increasing access to coordinated care plans through higher payments is an important policy lever for the Federal government to help influence the overall efficiency of the health care system, with potentially important “external” efficiency benefits in traditional FFS Medicare and even beyond the Medicare program.

Similarly, the estimate of a \$2 higher Part B beneficiary premium resulting from MA payments is offset by the lower average Part D premiums resulting from MA plans. Indeed, reducing enrollment in MA plans would exacerbate another kind of inefficiency that increases overall Medicare spending and total beneficiary premiums. Most beneficiaries in traditional Medicare are also enrolled in “Medigap” supplemental coverage. This coverage, particularly the individual Medigap plans, is quite inefficient: not only does it have a high “load factor” – meaning beneficiaries have to pay much more in premiums than they get out in benefits – but the Medigap options are also designed in a way that encourages “first dollar” coverage that, according to the CMS Actuaries and CBO analysts, adds billions to Medicare costs each year.<sup>10</sup> Such Medigap plans not only promote inefficient spending; Medigap premiums have been rising rapidly, and are much higher than Part B and Part D premiums combined. Yet except for MA plans, the Medicare program gives beneficiaries in traditional FFS Medicare few options besides this costly and inefficient approach for lowering their out-of-pocket medical costs and protecting themselves against devastatingly high expenditures.

Finally, the principal MA payment policy associated with this year's increase in CBO's forecast of cost savings from revising MA payment rates is the higher payment rates in rural and urban "floor" counties. These payment rates were the result of explicit, bipartisan policy decisions in several Medicare laws preceding the Medicare Modernization Act. The stated goal of the Congress in creating and increasing the floor county payment rates was to promote access to more comprehensive health plan choices, and a broader range of choices, in areas that might not otherwise have MA plan availability. With the competitive reforms enacted in the MMA, these law changes are finally having that effect: for the first time ever, virtually all Medicare beneficiaries have a choice of health plans, including HMO and/or PPO plans and private FFS plans, and access to other options like MSA plans is increasing as well.

### **Reductions in MA Payment Rates Will Increase Beneficiary Costs and Reduce the Overall Efficiency of the Health Care System**

Reductions in payments to the MA plans would increase beneficiary health care costs, reduce the overall availability and use of preventive services and care coordination services in Medicare (and likely in the overall health care system), and reduce many aspects of the quality of care received by millions of Medicare beneficiaries. According to estimates by Adam Atherly and Ken Thorpe,<sup>11</sup> these impacts may be large: limiting MA payment increases to 1 percent would increase MA beneficiary costs by \$412 by 2009, and approximately 1.8 million beneficiaries would lose HMO/PPO coverage and face out-of-pocket cost increases of \$825 per year. In considering these impact analyses, it is important to note that statutory and regulatory changes in MA payment rates are already holding down MA payment increases. For 2007, the relatively small payment increases accounted for a negligible share of the increase in the Part B premium, and for 2008, plan payment increases will generally be well under the rate of overall medical inflation and Medicare FFS spending growth.

Moreover, the beneficiaries who enroll in Medicare Advantage plans are those who most need lower-cost, efficient coverage options. According to another analysis by Ken Thorpe,<sup>12</sup> as well as other studies, MA enrollees are more likely to have limited means (i.e., incomes under \$20,000 to \$30,000), are much less likely to have employer-provided supplemental coverage, and are more likely to be racial and ethnic minorities. For these beneficiaries, the alternative choices of the gaps and financial exposure of traditional FFS Medicare alone or of the high costs of traditional Medicare plus Medigap are not good choices.

If our nation is going to close the huge gap in prevention and in quality of care for chronic diseases, it is essential that we promote access to coverage like that available in most MA plans, which emphasizes preventing illness in the first place, avoiding preventable complications of chronic diseases, and using health services more efficiently. As Administrator of CMS, I was a strong supporter of greater prevention and greater focus on prevention and improving care for chronic diseases within the traditional Medicare program as well. Over the past several years, CMS has implemented many steps in traditional FFS Medicare to improve quality and efficiency. These steps include

a major “My Health, My Medicare” prevention initiative to encourage beneficiaries take advantage of the expanded coverage of preventive services, the Medicare Health Support program to pilot the availability of disease and care management programs in traditional FFS Medicare, and initial steps toward providing better information on quality and efficiency and paying more for better care not just more care, to encourage better health and greater efficiency. But progress has been slow, because it is challenging to encourage the kinds of care coordination and integration that promote quality and efficiency, and that get the right care to the right patient at the right time, in a FFS payment system. In contrast, as described above, most MA plans have clearly demonstrated the capacity to achieve higher levels of quality without increasing overall health care costs, and in many cases reducing overall costs.

I am particularly concerned that, in the current policy debate about MA plans, there has been little discussion of alternative policies that can improve prevention, care coordination, and overall health care costs and that could achieve similar savings for Medicare beneficiaries. For example, some have proposed using MA payment reductions to “pay for” increased Part B payments to physicians. If Congress took this step, Medicare beneficiaries would face a “double hit” on their out-of-pocket costs, first from their loss of MA benefits and savings and second from the higher copays and premiums for Part B services. Medicare physician payment needs to be addressed, but there are better alternatives than taking away benefits and savings from seniors, particularly the many beneficiaries with limited means who can least afford this kind of Medicare reform.

### **Private Fee-for-Service Plans**

Understandably, Members of the Committee and many other Members of Congress have been particularly concerned about trends in private fee-for-service (PFFS) enrollment. PFFS plans were created by Congress in the Balanced Budget Act of 1997 to fulfill an important role: giving beneficiaries access to coverage that would not impose substantial utilization review or other regulatory restrictions on access to care. PFFS plans are the least efficient kind of MA plans and they are now growing rapidly, spurred by selectively entering “floor” counties with very favorable reimbursement rates and offering essentially the same fee-for-service payment schedule as traditional Medicare, plus some additional benefits and cost sharing reductions. Some of these plans have claimed that they are implementing a multi-year strategy to serve beneficiaries effectively in areas that previously have not had much if any private plan participation. That is, when they have started enrolling beneficiaries, they look very similar to traditional FFS Medicare; but over time, they expect to build beneficiary familiarity, provider networks, and other features that will enable them to increase the quality and efficiency of care. Other plans appear simply to be mimicking traditional FFS Medicare with some additional cost savings, which does not create the same kind of quality improvements and overall efficiency gains as other types of MA plans and is not what extra Federal spending should be supporting in the years ahead.

Some policy reforms have been discussed which might address concerns about the impact of PFFS growth on program efficiency without eliminating access to this option, and

reduce Medicare costs without undermining the positive features of the MA program. One step, which CMS has already initiated, is aggressive enforcement of proper marketing practices. Satisfaction rates overall in MA remain high, but keeping them high will require ongoing, effective Federal oversight and responses to beneficiary complaints, especially when patterns of abuse are apparent. The AMA and other physician organizations have also criticized the availability of “physician deeming” to PFFS plans. While new PFFS plans may need this authority to establish a market presence and “get off the ground” with beneficiaries and health care providers, the long-term use of deeming authority may not be necessary for a well-run PFFS plan. To address this, deeming authority for a PFFS plan might end after an initial plan startup period, perhaps several years, or after a substantial presence of PFFS, PPO, MSA, and other plans that do not impose strict utilization management techniques has been established in an area. Similarly, PFFS plans might be required to establish contracts with providers and post the resulting provider lists after a reasonable time period. Finally, PFFS plans might be required to undertake steps that go beyond simply replicating traditional FFS benefits with lower cost-sharing, such as providing wellness services or support services for beneficiaries with chronic diseases. Properly implemented, steps like these would help avoid excess Medicare costs and assure that PFFS plans are both available to beneficiaries who want them and are a good investment for the Federal government.

### **Special Needs Plans**

Another rapidly growing component of the MA program is Special Needs Plans (SNPs), which are MA plans that target beneficiaries with particular, distinctive health needs that offer services tailored to those needs. Today, the largest number of such plans are designed for “dual eligible” Medicare-Medicaid beneficiaries, who have much to gain from care coordination services. However, plans for beneficiaries with institutional levels of care needs and for beneficiaries with particular kinds of chronic diseases are also growing rapidly; for example, 23 organizations are offering 83 chronic-disease SNPs this year.

Clearly, these plans create important opportunities to customize services, improve care, and reduce costs for beneficiaries who have the most to gain from such services. SNPs for dual-eligible and institutionalized patients have enabled beneficiaries to simplify their medication regimens and avoid costly, preventable hospitalizations, while reducing costs and improving quality in state Medicaid programs. Chronic-care SNPs help beneficiaries with chronic illnesses manage their conditions more effectively, through more generous drug coverage and assistance with medication compliance, diet and behavior changes, information technology (IT) support for care coordination, and other steps intended to prevent costly complications and disease progression. None of these benefits and services is available in traditional FFS Medicare, and many states have turned to SNPs to provide these services to their dually eligible beneficiaries. By focusing on high-cost, complex patients, SNPs show that – with proper payment incentives and oversight that promotes effective competition to serve even the most vulnerable Medicare beneficiaries – the traditional criticism that private plans only want healthy patients is being turned on its head. Because the beneficiaries served by these plans account for a large share of

Medicare spending, the SNP program can have an important impact on the overall quality and efficiency of Medicare and our health care system's ability to serve those who need the most help.

While the initial experience with SNPs has had many positive features, indicating that the program should be reauthorized, the proliferation of a diverse range of SNP plans is beginning to provide a richer basis for evaluating the SNP program and improving it. For example, CMS is working with outside expert groups to develop improved performance measures for the various types of SNPs. In addition, some SNPs may be targeting conditions like high cholesterol that, by themselves, may not represent a truly distinct cluster of patient health needs where specialized benefits and management can achieve significant improvements in quality and efficiency. And some of these plans may not offer many specialized, targeted services compared to typical MA plans that must market and provide appropriate services for the general Medicare population. CMS or Congress should consider minimum standards for the conditions and types of beneficiaries treated by SNP plans. In particular, the plans should be targeted to beneficiaries where distinctive, complex health care needs create a real opportunity to achieve significant overall cost savings and quality improvement, and the plans should be expected to provide significant specialized benefits and services. Conditions like congestive heart failure, diabetes, chronic lung disease, HIV/AIDS, and certain cancers, as well as high-cost combinations of such conditions, are examples of clinical areas where targeted, specialized services and expertise are likely to be appropriate.

## **Conclusion**

Mr. Chairman, Mr. Ranking Member, and Distinguished Members, we are living in an era when the opportunities for preventing diseases and their complications have never been greater, and at the same time, when the challenge of promoting effective and efficient use of all of the increasingly diverse and sophisticated treatments available has never been greater. Increasingly, efficient health care is about prevention, personalization, and coordination of services around the needs of each individual patient. How we pay for health care has an important impact on how quickly and effectively we can create a health care system that fulfills the promise of modern medicine at the lowest possible overall cost. With Americans generally and Medicare beneficiaries in particular getting only about half of the preventive care they need, and with poor care coordination and preventable complications accounting for more and more spending in the Medicare program, it is more urgent than ever for Medicare payment policies to promote high-value, personalized care. To achieve a high-value health care system – the most important kind of “efficiency” in health care – Congress should continue to support the Medicare Advantage program, which is our best, proven avenue for improving prevention and chronic disease management in Medicare.

At the same time, there are promising approaches to improve the performance of Medicare Advantage, and of traditional FFS Medicare as well. Effective marketing enforcement and oversight, improving the availability of information on plan quality and costs (including better measures for traditional FFS Medicare and Medigap, as well as all

types of MA plans, to help beneficiaries make more informed choices about their coverage), providing more support for beneficiaries to use this information to make informed decisions about their coverage and their care, and adjusting the rules affecting PFFS plans and SNPs are all examples of such policies. Similarly, there are many opportunities to improve the efficiency of payments in traditional FFS Medicare. All of these steps can help achieve greater efficiency in Medicare, leading to budgetary savings without raising beneficiary costs substantially.

The best solution to Medicare's financing problems isn't to take away innovative coverage options and shift costs to beneficiaries – particularly those with limited means who are struggling with out-of-pocket costs today. There are better ways to address the long-term sustainability of the Medicare program while promoting more efficient health care, and I look forward to supporting the Committee's efforts to achieve this critical public health and fiscal goal.

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<sup>1</sup> Centers for Medicare and Medicaid Services, *Overview of the Medicare Advantage Program*, May 2007.

<sup>2</sup> Jencks, SF, et al., *Journal of the American Medical Association*, 289: 305-312, Jan. 15, 2003.

<sup>3</sup> CMS, *op. cit.*

<sup>4</sup> Sokol, MC, McGuigan, KA, Verbugge, RR, Epstein, RS. *Impact of Medication Adherence on Hospitalization Risk and Healthcare Cost*. *Medical Care* 2005; 43: 521-530.

<sup>5</sup> Atherly, A, and Thorpe, KE, *The Impact of Reductions in Medicare Advantage Funding on Beneficiaries*. Atlanta, GA: Emory University Rollins School of Public Health, April 2007.

<sup>6</sup> Miller M, *Private Fee-for-Service Plans in Medicare Advantage*. Statement on behalf of MedPAC before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, May 22, 2007.

<sup>7</sup> MedPAC, *Medicare Advantage Benchmarks and Payments Compared with Average Medicare Fee-for-Service Spending*, June 2006.

<sup>8</sup> See, e.g., the detailed report in Centers for Medicare and Medicaid Services, *Medicare Advantage in 2007*. Baltimore, MD: May 2007,

<http://www.cms.hhs.gov/MCRAAdvPartDENrolData/Downloads/MedicareAdvantageIn2007.zip>.

<sup>9</sup> Baker L, "Managed Care Spillover Effects," *Annual Review of Public Health* 24: 435-56, 2003.

<sup>10</sup> According to CBO's *Budget Options* (February 2007), replacing the current first-dollar Medigap coverage options with supplemental coverage that required limited cost sharing (with an out-of-pocket spending limit) to levels more like that seen in MA plans would save over \$14 billion.

<sup>11</sup> Thorpe, *op. cit.*

<sup>12</sup> Atherly, A, and Thorpe, KE, *Value of Medicare Advantage to Low-Income and Minority Medicare Beneficiaries*. Atlanta, GA: Emory University Rollins School of Public Health, 2005.