

# **The future of Healthy Families: Transitioning to 2014 and beyond**

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## Summary

Urban Institute researchers were asked to analyze the effects on low-income children of various possible scenarios for the future of the Healthy Families Program (HFP). After interviewing stakeholders and officials, reviewing state and federal data, and analyzing applicable literature, we concluded—

- If all HFP children moved to Medi-Cal, some would benefit and others would suffer, but the precise balance of gain and loss is uncertain.
- Low-income children would probably not benefit from keeping HFP as a separate program while moving HFP administration to the California Health Benefit Exchange (Exchange). With all of its other responsibilities, the Exchange Board is unlikely to give low-income children's unique issues the same focus that the Managed Risk Medical Insurance Board (MRMIB) now provides.
- If the Exchange's commercial plans furnish HFP-level benefits to HFP children, provider networks could greatly broaden, improving children's access to care. However, the feasibility of this arrangement is currently unknown.

Accordingly, we suggest the following approach:

- In the short term, shift the poorest HFP children into Medi-Cal. With incomes at or below 133 or 150 percent of the federal poverty level (FPL), these are the children most likely to benefit from the move, among other reasons because Medi-Cal will not charge them premiums or copayments. Most such children will be required, under federal law, to receive Medi-Cal beginning in 2014. We suggest accompanying this shift with measures for safeguarding access to care and rigorously monitoring the results.
- Do not move HFP children into the Exchange until it has a chance to master its mandated tasks. Monitor whether the Exchange can persuade commercial plans to accept HFP-level payments for providing HFP children with HFP-level coverage.
- If experience with the poorest HFP children suggests that the remainder would benefit from Medi-Cal, consider moving the entire HFP population to Medi-Cal. If the Exchange appears likely to improve access to care by offering commercial provider networks without cutting HFP benefits or increasing costs to HFP families, consider shifting HFP children into the Exchange. If neither alternative seems better than the current arrangement, keep the remaining children in HFP.

# The future of Healthy Families: Transitioning to 2014 and beyond

## Introduction

Health care policymakers in California and many other states have two pressing priorities: implementing the Patient Protection and Affordable Care Act (ACA), much of which becomes effective in 2014; and addressing state budget woes.

In both contexts, the state's leaders have been wrestling with the fate of the Healthy Families Program (HFP). Four basic scenarios were under consideration in spring and summer 2011:

1. ***The status quo: HFP continues as is, for children who will qualify in 2014 and thereafter.***
2. ***Full Medi-Cal shift: All HFP children move to Medi-Cal. Under this scenario, HFP ends.***
3. ***HFP administration shifts to the Exchange: HFP continues as it is today, a stand-alone program. However, it is administered by the California Health Benefit Exchange (Exchange) Board, rather than the Managed Risk Medical Insurance Board (MRMIB).***
4. ***Plans in the Exchange provide HFP coverage to HFP children. Under this scenario, HFP children enroll in the same plans that serve the Exchange's individual market. These plans provide HFP children with HFP benefits and cost-sharing protections.***

In mid-2011, the 100% Campaign, a collaborative effort of The Children's Partnership, Children Now, and Children's Defense Fund-California, commissioned researchers at the Urban Institute to analyze these scenarios and identify their advantages and disadvantages for low-income children. On February 15, 2012 (and on earlier occasions), researchers presented their findings, which are summarized here. The full, detailed presentation is available for download at <http://www.urban.org/publications/500264.html>.

We begin this Issue Brief by explaining our research methods and the policy context for this analysis. We then describe our findings about the effects of each scenario that involves a change from the status quo. We conclude by suggesting a policy direction that, in view of our findings, could safeguard and improve low-income children's access to essential health care.

## Research methods

We analyzed the advantages and disadvantages of each above scenario for low-income children. We generally did not focus on other factors, such as state budget effects, except where they made particular policy approaches clearly unfeasible.

Our primary research strategies were qualitative. We interviewed more than 20 key informants, who are listed in the appendix to this Issue Brief. They included current and former state and local officials, eligibility contractors, academic experts, and representatives of consumer advocacy groups, health plans, and providers. Structured interview protocols addressed each scenario. Lasting at least an hour, the interviews were conducted by telephone during July through September 2011. In addition, we reviewed federal and state administrative data and

reports about child health issues nationally and in California. We also conducted microsimulation modeling using the Urban Institute’s Health Insurance Policy Simulation Model (HIPSM) and obtained actuarial estimates from Towers Watson.

## **The policy context**

After the ACA is fully implemented, two groups of children will be affected by today’s decisions about the future of HFP:

- HFP children whom the ACA will not require moving to Medi-Cal; and
- Medi-Cal children whose income, under the ACA’s new eligibility methodologies, will exceed Medi-Cal’s maximum income thresholds and so will transfer to HFP.

Under the ACA, some HFP children will shift to Medi-Cal in 2014. Medicaid eligibility nationally will rise to 138 percent of the federal poverty level (FPL), causing Medi-Cal to become responsible for the lowest-income children who qualify for HFP under current law.

At the same time, some Medi-Cal children will move to HFP, because current methods will no longer determine family income. Instead, income will be defined in terms of modified adjusted gross income (MAGI), which is based on federal income tax principles. Accordingly, some of today’s Medi-Cal children will be found to have higher family income that qualifies them for HFP.

Because the federal government has yet to finalize applicable rules, we do not yet know how many children will move in each direction. The ACA’s maintenance-of-effort (MOE) provisions require Medi-Cal to continue its 2009 eligibility for children until 2019. To accomplish this goal while shifting income determination methods to MAGI, the Center for Medicare and Medicaid Services (CMS) will produce guidelines for states to develop “MAGI-equivalent standards.” These standards will limit the number of children who lose Medi-Cal because of the change to MAGI. Only after CMS’s guidelines are published can Californians determine the precise income level at which Medi-Cal eligibility will end and HFP eligibility will begin. Once that threshold is known, it should be possible to estimate the number of children who would move in each direction if HFP coverage is preserved to the maximum extent permitted by the ACA.

## **Findings**

Based on our interviews with key informants as well as our analysis of available data and documents, we made the following findings about each scenario.

### ***Scenario 1: Status quo***

The first scenario—the “status quo”—is the baseline against which we compared all other scenarios.

## **Scenario 2: Full Medi-Cal shift**

If all HFP children shifted to Medi-Cal, some would gain and others would lose. It is not clear whether, on balance, benefit or harm would predominate. Following are some potential advantages and disadvantages of shifting all HFP children into Medi-Cal.

### **Advantages for low-income children**

#### ***Affordability***

Medi-Cal coverage would be more affordable than HFP for many children. Those in families with incomes at or below 150 percent of FPL would no longer be charged premiums and copayments, which could improve participation levels and access to care. Much research finds that even modest cost-sharing can reduce enrollment and delay or prevent utilization of necessary care. Those above 150 percent of FPL will be charged premiums, whether they stay in HFP or move to Medi-Cal. However, such children will be relieved of copayments unless CMS approves California's proposed waiver to charge copayments to children in this higher income band.

#### ***Filling gaps in employer-based coverage***

HFP disqualifies children who receive employer-sponsored insurance (ESI) either at the time of application or during the three previous months. By contrast, Medi-Cal supplements ESI benefits and pays ESI cost-sharing. In 2007, 5.5 percent of Medi-Cal children also had ESI, so this is not an uncommon situation. If Medi-Cal's income threshold rose to HFP levels, children who receive ESI and so are now barred from HFP would instead qualify for Medi-Cal supplementation of ESI, which could yield important gains:

- Children with special health care needs (CSHCN) would receive Medi-Cal benefits that are not covered by employer plans.
- Most children would qualify for much broader coverage of dental and vision care than what ESI typically provides.
- Medi-Cal would lift financial burdens from low-income families by paying their ESI-related premiums and out-of-pocket cost-sharing, which have generally risen in recent years.

#### ***Mental health care***

Compared to HFP, Medi-Cal provides better coverage of and access to mental health treatment. As guaranteed by federal law, Medi-Cal covers "early and periodic screening, diagnosis, and treatment," or EPSDT. This includes coverage of all medically necessary care that is potentially reimbursable under the federal Medicaid statute. EPSDT provides a broader scope of mental health coverage than is offered by HFP. This comparative assessment includes not just HFP health plans but also HFP's contracts with county mental health departments to provide additional services to children with serious emotional disturbance (SED). In addition to EPSDT's broader coverage, state officials report that county SED programs prioritize treatment of Medi-Cal children over treatment of HFP children.

### ***More comprehensive benefits***

Going beyond mental health care, EPSDT offers broader coverage than is available through HFP. That said, most Medi-Cal services, including preventive care, are also covered by HFP health plans. The latter plans' benefits meet the needs of most children, who are healthy. When CSHCN need additional benefits, they can often obtain them through HFP's supplemental "carve-out" contracts with counties to serve SED children and with the California Children's Services (CCS) program. Outside the mental health context, it is not known how many HFP children would benefit from EPSDT because they need services that are covered neither by HFP health plans nor the SED and CCS carve-outs.

### ***Continuity of coverage***

Serving low-income children through one rather than two programs would prevent children from "falling through the cracks" when they transition between programs. Such transitions happen today when families apply to one program but qualify for the other; when family income changes and eligibility shifts between programs; and when 5-year-olds with family incomes between 100 and 133 percent FPL celebrate their sixth birthdays and move from Medi-Cal to HFP. However, the number of children who currently lose coverage during such transitions is unknown, and the ACA's more streamlined and electronic administrative methods are likely to reduce the coverage gaps that accompany transitions between programs.

### ***Stronger appeals mechanisms***

Grievance and appeal procedures are more rigorous in Medi-Cal than in Healthy Families. Medi-Cal hearings are immediately available when families want to challenge a decision, and families can use those hearings to question decision-makers and review the records on which adverse decisions were based. However, it is not clear how many HFP children need these safeguards. According to several informants, HFP's hands-on approach to resolving beneficiary grievances leaves very few families with unresolved problems.

## **Disadvantages for low-income children**

### ***Reduced access to providers***

Many HFP children would see their access to providers diminish under Medi-Cal. The latter program's provider participation shortfalls result in significant part from Medi-Cal's lower reimbursement rates. Outside of children's hospitals and CCS, fewer private physicians and specialists participate in Medi-Cal than HFP. Nearly 50,000 HFP children in rural areas would experience reduced access to providers if they moved from HFP managed care to Medi-Cal fee-for-service care. In addition, Kaiser Permanente covered 174,221 HFP children—20 percent of all HFP children—during the average month in 2010, more than any other plan. Kaiser may not continue to participate in caring for these children at the same level if they move to Medi-Cal.

On the other hand, differences between Medi-Cal and HFP payment levels eroded in recent years. Between 2008 and 2011, Medi-Cal capitation rates increased by approximately 3 to 4 percent annually, while HFP rates fell by a total of 9 percent. Our informants disagreed about which program provides superior access to dental care and the extent to which plans that participate in both programs have significantly different provider networks for Medi-Cal and HFP; available data do not resolve these disagreements. And while the ACA more than doubles reimbursement levels for Medi-Cal coverage of certain primary care services in 2013–2014, it is

not clear how much impact this time-limited and targeted “bump” will have on Medi-Cal’s delivery system.

### ***More cumbersome enrollment and retention procedures***

For most families, enrollment into and retention of coverage is harder with Medi-Cal’s county-based eligibility system than with HFP’s single point of entry. Much of this difference results from county obligations to administer a significantly broader range of eligibility categories than applies to HFP. County-based enrollment and retention is likely to improve under the ACA, but the full extent of that improvement is not yet known.

### ***The loss of MRMIB***

If HFP were replaced by Medi-Cal, children would lose the benefit of MRMIB, which most informants saw as a positive force for children. With HFP as its largest program, MRMIB has a focus on children’s needs that is not possible for the Department of Health Care Services (DHCS), given the latter’s multiple, complex responsibilities. MRMIB’s monthly, public meeting structure promotes transparency and accountability, and as a small and independent agency it has been nimble and innovative throughout much of its history.

### ***Risks of transition***

Whether or not children would ultimately be better off in Medi-Cal, the transition process will be disruptive and potentially problematic for many children. More than a quarter of HFP children will need to change health plans (and perhaps providers as well). In addition, some children will experience gaps in coverage as the state and counties attempt to transfer them between programs.

## **Factors that are not highly consequential**

### ***Medi-Cal as an entitlement program***

Medi-Cal is an entitlement program, which means that eligible people are guaranteed benefits and cannot be placed on waiting lists. But under the ACA’s MOE requirements, HFP cannot, until 2019, put children on a waiting list, increase premium charges above a specified level, or take other steps that would reduce enrollment. So long as the MOE remains in place, it is the functional equivalent of entitlement status for HFP.

### ***Currently reported performance measures***

To the limited extent that publicly reported quality and access measures for Medi-Cal and HFP allow “apples to apples” comparisons, such measures do not show significant differences between the two programs.

### **Scenario 3: HFP administration shifts to the Exchange**

Moving HFP administration to the Exchange while retaining HFP as a separate program has disadvantages for low-income children that outweigh applicable advantages, based on what we know today.

#### **Advantages for low-income children**

##### *A higher-profile administrative agency*

HFP might benefit from being housed in a larger, more powerful entity. In 2014 and beyond, the Exchange is likely to be a much bigger force than MRMIB, which will probably have fewer responsibilities than it does today.

##### *Fewer agencies determining eligibility*

Moving HFP administration to the Exchange would reduce the number of entities determining eligibility. Rather than DHCS, MRMIB, and the Exchange each playing a role, only DHCS and the Exchange would be involved. However, under the ACA, California may implement a single, integrated system of eligibility determination. Such a system could limit disruptions in coverage that otherwise might result from one additional administrative agency.

#### **Disadvantages for low-income children**

##### *Less focus on children*

The Exchange is unlikely to give the kind of attention to children's issues that MRMIB now provides, as HFP is MRMIB's largest program. The Exchange will have a broader mission, wider-ranging responsibilities, and a daunting workload in preparing to "go live" by late 2013. Unique issues involving low-income children's health care could easily suffer from relative inattention.

##### *An administrative agency that has not been observed in operation*

The Exchange does not yet have a track record. Shifting program administration to an entity whose performance has not yet been observed is inherently risky. If MRMIB were performing poorly, the risk might be worth considering, but the vast majority of our informants viewed MRMIB as doing a good job with HFP.

#### **Factors unrelated to low-income children's health care needs**

Although our research focused on each scenario's effects on low-income children, our key informants touched on other issues as well.

##### *Increased leverage for the Exchange*

If the Exchange Board became responsible for HFP administration, the Exchange would thereby gain control over additional covered lives that appeal to insurers. This added leverage could help accomplish the Exchange's ambitious objectives for transforming California's insurance markets and health care delivery system.



### *Administrative efficiency*

Administrative efficiencies could result from moving HFP administration into the Exchange, as common functions could be performed centrally. However, important aspects of HFP are unique and will probably require distinct administrative systems. For example, federal Medicaid requirements increasingly apply to HFP health plans. These requirements are quite different from the rules that govern private markets.

### *Simplicity*

Health coverage programs in California would be simpler with just Medi-Cal and the Exchange, rather than Medi-Cal, HFP, and the Exchange. However, simplicity's advantages can be overstated. For example, Massachusetts's health benefits are highly complex, including multiple programs for children and many different programs for adults, in a state with two-thirds the population of Los Angeles County. But that state has been quite effective in covering its residents, despite those complications. In Massachusetts, 98 percent of nonelderly residents are insured, including more than 99 percent of children; and 67 percent of residents support the state's reform efforts.

#### ***Scenario 4: Plans in the Exchange provide HFP coverage to HFP children***

Under this scenario, the health plans that offer individual coverage through the Exchange would give HFP children HFP-level benefits and cost-sharing protections. Supplemental services would remain available through the same SED and CCS carve-outs that today “backstop” HFP’s capitated plans.

The factors listed above in connection with Scenario 3 would apply to this scenario as well. But additional factors, described below, create the possibility of significant net gains for low-income children. The main question about this scenario involves its feasibility.

#### **Advantages for low-income children**

##### ***Broader provider networks***

The most important potential advantage is that commercial coverage could substantially broaden the provider networks that are available to HFP children. This is suggested by HIPSMM modeling results, described below. However, additional research is needed to confirm the differences between provider participation in HFP and the kind of commercial coverage that will be offered in the Exchange.

##### ***Branded commercial coverage***

This scenario would likely increase children’s access to “mainstream” commercial plans, which many low-income families value.

##### ***All family members within the same health plan***

This scenario would permit a family with income above Medi-Cal levels to enroll both parents and children in a single health plan. While this result has considerable intuitive appeal, the extent to which children actually benefit from such “family unity” is unclear. Much research shows that children gain when their parents receive coverage. No research shows any added benefit from serving children and parents through the same plan, rather than two different health plans.

Despite the absence of conclusive research, some children would gain from being covered together with their parents. It is true that many if not most families have children and parents who see different providers. However, with family practitioners, general practitioners, community health centers, and staff-model health maintenance organizations (HMOs), the identical or colocated providers may serve all family members. In such cases, covering parent and child in the same plan may allow simultaneous family visits. Care might improve, based on a provider’s knowledge of total family dynamics. If a parent needs to learn just one health plan’s procedures for obtaining covered services, access barriers would be lowered. And health reform may enjoy more credibility with the public if it does not force parents and children into different plans or coverage systems. On the other hand, such bifurcation of coverage did not preclude public support in Massachusetts, as indicated earlier.

Finally, many if not most HFP children will be in different plans from their parents, whether HFP remains separate or moves to the Exchange. At HFP income levels, parents are frequently offered ESI that meets the ACA’s standards for affordability and minimum value. These parents will be ineligible for subsidies in the Exchange and so, as a practical matter, will be limited to employer plans, which may or may not be available to their children in the Exchange.

## Disadvantages for low-income children

### *Diminished access to safety-net coverage*

In addition to the disadvantages described above in connection with Scenario 3, this scenario could reduce HFP children's access to safety-net plans that do not join the Exchange. According to some observers, such plans offer unique expertise in meeting the needs of lower-income families.

## Feasibility

The biggest concern about this scenario involves its feasibility. It is not realistic to fund HFP-level benefits at current commercial provider rates, given state budget constraints. HIPSM estimates show this approach would increase state HFP costs by between 40 percent and 75 percent. However, the Exchange might be able to persuade its individual market plans to accept HFP-level capitated payments to provide HFP children with HFP-level coverage through the plans' standard commercial networks, using SED and CCS as residual sources of additional coverage for which plans are not responsible. It is currently unknown whether insurers would find this arrangement acceptable; whether the Exchange would view this as a priority in negotiations; and whether the Exchange's overall negotiating leverage would suffice to obtain health plans' agreement.

## A suggested policy direction

Based on the above analysis, a three-step approach could maximize low-income children's gains and limit their risks.

### ***Step 1: Shift the poorest HFP children to Medi-Cal, with safeguards to protect access to care and lay the groundwork for a successful transition to the ACA's streamlined eligibility procedures***

The lowest-income HFP children—namely, those with incomes, as currently measured, at or below 133 or 150 percent FPL—would soon move to Medi-Cal under our suggested approach. These are the HFP children most likely to benefit from Medi-Cal's absence of premiums and copayments. Shifting such children into Medi-Cal would also improve continuity of coverage, since children would no longer be forced to move from Medi-Cal to HFP on their sixth birthday. Further, the ACA will require transferring most of these children to Medi-Cal in 2014.

Our suggested shift of the lowest-income HFP children to Medi-Cal would be accompanied by the following policies to safeguard access to care and ease the transition to 2014:

- Medi-Cal managed care expands to include rural counties, perhaps using primary care case management or building on existing Blue Cross contracts with HFP and the County Medical Services Program.
- DHCS develops arrangements with Kaiser Permanente that continue the insurer's current general level of service to low-income children.
- County performance standards are updated to facilitate the transition to ACA's streamlined procedures for enrollment and retention, and each county's performance is publicly reported.

- The HFP provider search function extends to Medi-Cal, allowing both consumers and policymakers to assess the breadth of provider networks.
- A public process at DHCS—for example, an “Advisory Council for Children and Families” that includes key legislators, stakeholders, and experts—meets monthly and incorporates the transparency, accountability, and focus on children’s needs now provided by MRMIB’s regular monthly meetings.
- Disruptive transitions are avoided by—
  - For children with chronic or complex conditions, retaining former providers and treatment regimens for a defined period after the children move from HFP to Medi-Cal;
  - Increasing county capacity to handle the transition by providing adequate state funding for increased staffing, sufficient time to process incoming children, and, perhaps through Express Lane Eligibility, determining children’s eligibility based on MRMIB’s prior findings rather than requiring counties to reevaluate each case;
  - Supporting a strong system of consumer assistance, public education, and outreach to parents and providers; and
  - Offering fee-for-service care as an interim “fallback system” for children who temporarily lack other sources of coverage.
- To lay groundwork for the streamlined eligibility that ACA will require as of 2014—
  - Use the Medi-Cal/HFP eligibility interface to test and refine strategies for the future, much larger interface between Medi-Cal and the Exchange; and
  - Analyze both strengths and weaknesses of current county-based eligibility and MRMIB’s single point of entry, then design 2014’s new systems to replicate prior successes and avoid past problems.

## ***Step 2: Intensively monitor Medi-Cal’s transition and the Exchange***

With intensive monitoring of what happens to the low-income children who shift from HFP to Medi-Cal, policymakers could learn whether, on balance, such a change is helpful or harmful. The suggested monitoring includes collection and public reporting of Medi-Cal data illuminating access to care, such as information about enrollment and retention, wait times, and utilization. In addition, independent evaluators could assess what happens to children shifted from HFP to Medi-Cal, comparing these children to slightly higher-income children who remain in HFP. This comparison could include health plan encounter data, consumer focus groups, surveys of providers and plans, and key informant interviews.

At the same time, the approach we suggest would keep children out of the Exchange until it has had a chance to master its basic responsibilities and has been observed in operation. Particularly important issues to track include the breadth of provider networks offered by the Exchange’s commercial plans; and whether the Exchange successfully negotiates with these plans to accept HFP-level payments for providing HFP children with HFP-level benefits and cost-sharing protections.

### ***Step 3: Make a broader decision about the fate of HFP children***

The suggested monitoring will help policymakers make a wise decision about the coverage that would best serve HFP children over the long term. If it turns out that the HFP children transferred to Medi-Cal experience an overall improvement in access to care, policymakers could consider moving the remaining children to Medi-Cal. If it turns out that the Exchange's commercial plans offer provider networks significantly broader than HFP networks and that the Exchange can persuade such plans to use these networks as the delivery system for HFP-level coverage, policymakers could improve HFP children's access to care by moving them into the Exchange's individual market. If both alternatives appear superior to the current HFP, policymakers would need to weigh their comparative advantages in deciding which direction to take. But if it turns out that HFP children would not benefit, on balance, from being switched to Medi-Cal and the Exchange does not offer realistic prospects for higher levels of provider participation, HFP could remain in place for low-income children who are not moved to Medi-Cal by the ACA.

### **Conclusion**

Most of our interviewees viewed HFP as a successful program that does a good job meeting the needs of low-income children. Policymakers interested in safeguarding such children's access to essential health care would thus do well to move conservatively in restructuring HFP coverage, particularly given the limits on current knowledge about the relative merits of HFP, Medi-Cal, and the Exchange.

Our suggested approach would shift some children from HFP to Medi-Cal in the near term, carefully monitoring how such children fare and how the Exchange unfolds. This would strengthen the state's knowledge base to allow a better-informed future decision about how best to meet HFP children's health care needs in the transformed health coverage system that will operate in 2014 and beyond.

## About the author and acknowledgements

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## About the Urban Institute

The Urban Institute builds knowledge about the nation's social and fiscal challenges, practicing open-minded, evidence-based research to diagnose problems and figure out which policies and programs work best, for whom, and how.

## About the 100% Campaign

The 100% Campaign ([www.100percentcampaign.org](http://www.100percentcampaign.org)) is a collaborative effort of The Children's Partnership, Children Now, and Children's Defense Fund-California, created in 1998 to ensure that all of California's children obtain the health insurance they need to grow up strong and healthy.

## Appendix: List of interviewees

- Current and former government officials and eligibility contractors
  - ❖ Lanee Adams, MAXIMUS
  - ❖ Kim Belshé, California Health Benefit Exchange Board Member
  - ❖ Janette (Lopez) Casillas and Laura Rosenthal, Managed Risk Medical Insurance Board
  - ❖ Toby Douglas and Len Finocchio, Department of Health Care Services
  - ❖ Richard Figueroa, Managed Risk Medical Insurance Board Member, The California Endowment
  - ❖ Cathy Senderling-McDonald, County Welfare Directors Association
  - ❖ Sandra Shewry, California Center for Connected Health
  - ❖ Srija Srinivasan, San Mateo County
- Consumer advocacy groups
  - ❖ Beth Capell, Health Access California
  - ❖ Jack Dailey, Legal Aid Society of San Diego
  - ❖ Erin Aaberg Givans, Children’s Specialty Care Coalition
  - ❖ Marilyn Holle, Disability Rights California
  - ❖ Elizabeth Landsberg, Western Center on Law and Poverty
  - ❖ Alison Lobb and Suzie Shupe, California Coverage & Health Initiatives
- Health plans
  - ❖ Susan Fleischman and Bill Wehrle, Kaiser Permanente
  - ❖ Patrick Johnston and Abbie Totten, California Association of Health Plans
  - ❖ John Ramey, Local Health Plans of California
- Providers
  - ❖ Tahira S. Bazile, California Primary Care Association
  - ❖ Charity Bracy, California Children’s Hospital Association
- Academic experts: Andrew Bindman and Catherine Hoffman, University of California at San Francisco
- Philanthropy: Eugene M. Lewitt and Liane Wong, David and Lucille Packard Foundation

**Important note:** Inclusion in this list should not be construed as representing agreement with any of the above findings or suggestions. In addition to the individuals and organizations listed in this appendix, Urban Institute researchers interviewed staff from each of the 100% Campaign’s partner agencies—The Children’s Partnership, Children Now, and Children’s Defense Fund-California.