



American Cancer Society ☿ Children's Defense Fund/New York ☿ Center for Working Families  
Community Service Society of New York ☿ Metro New York Health Care for All Campaign  
New Yorkers for Accessible Health Coverage ☿ New York Immigration Coalition  
Public Policy and Education Fund of New York/Citizen Action of New York

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Dear Deputy Superintendent Oechsner and Deputy Commissioner Bachrach:

Thank you for providing the Health Care for All New York ("HCFANY") Campaign with the opportunity to comment on the Partnership for Coverage draft Urban Institute Modeling Options document. HCFANY is a statewide campaign of more than 50 organizations which seeks to win affordable, comprehensive, high-quality health care for all New York state residents by 2010.

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HCFANY would like to commend the Departments of Health and Insurance for recognizing the importance of transparency by establishing this public comment process. HCFANY’s comments first describe certain elements of the modeling instructions that HCFANY believes represent fundamental components of the various models from which the Departments should not retreat. Second, we offer specific comments on the draft Modeling Options instructions, following the order in which they appear in the document.

### Draft Modeling Instructions that HCFANY Agrees Are Important

As a general point, HCFANY would like to commend the Departments for the obvious thought and care that went into the development of these draft Modeling Instructions. Specifically, HCFANY is particularly pleased to see that Departments made the following key determinations regarding the draft Modeling Options document:

- The inclusion of all state residents (including immigrants) in all proposals to be modeled;
- The adoption of the Family Health Plus benefit package as a floor for three of the proposals;
- The recognition of the importance of affordability concerns by the modeling of the Community Service Society’s *Cornerstone for Coverage* affordability schedule;
- The decision to model a Family Health Plus Buy-in programs for individuals and employers alike;
- The identification of important public insurance program simplification measures for modeling;
- The decision to model the employer mandate based on a payroll tax; and
- The determination to model the merger of individual and small group insurance markets in the third proposal.

### HCFANY’s Questions and Issues of Concern About the Draft Modeling Document

To facilitate our comments, HCFANY’s specific questions and concerns are presented in the order in which they appear in the draft Modeling Instruction document, as follows:

#### Page 2, §IIA—Generation of “State-Specific Baseline Database”

The document indicates that the Urban Institute will generate a **state-specific baseline database**.



*HCFANY Comment:* HCFANY believes that it is important that a process is set up so that key stakeholders and the public can understand the assumptions and value-based judgments that form the foundation of the State-specific database. A number of proposals for health reform in New York have failed to provide a detailed and transparent accounting of their assumptions, which leads to a general inability to compare the various proposals on an “apple to apple” basis.

To ensure the best set of assumptions and baseline data to guide the process, HCFANY urges the State to constitute a technical advisory committee or workgroup to discuss some of the methodological assumptions that will be used in the modeling process. By way of example of areas that require detailed methodological explanations, it would be helpful to understand how the Urban Institute will address the following issues:

- The number of immigrants who will be covered given the difficulties in distinguishing different types of immigrants through CPS. This point is important because health policy experts have traditionally clumped immigrant status categories together to generate an estimated number of “unauthorized” residents.<sup>1</sup> However, this approach could lead to serious modeling flaws in the New York context, given that the State already provides eligibility for public health insurance to immigrants who are excluded from federal Medicaid and SCHIP programs.<sup>2</sup> To prevent inflating the cost of a health reform proposal, the Urban Institute modeling should: adjust for immigrants who are considered PRUCOL for Medicaid/SCHIP purposes, the absence of the five year bar in our state health coverage programs, and the significant in-migration of foreign born individuals with a range of immigration statuses each year.
- The number of people who are in the direct pay market (e.g. UHF/Urban Institute annual data book “*Health Insurance Coverage in New York, 2005-2006*” indicates that the direct pay market comprises 4% of the State’s under 65 population, but the census counts of the standardized direct pay market (roughly 60,000) and Healthy NY (just over 100,000) do

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<sup>1</sup> Most researchers find that “unauthorized immigrants” include categories of immigrants without permanent resident status and who are Permanently Residing Under Color of Law (“PRUCOL”). See, e.g. Passel, J. Unauthorized Migrants: Numbers and Characteristics, Pew Hispanic Center, June 14, 2005; Passel J. The Size and Characteristics of the Unauthorized Migrant population in the U.S. estimates Based on the march 2005 current Population Survey, March, 2006.

<sup>2</sup> New York State’s highest Court has held that all lawful immigrants—including those who are in the process of adjusting their status or are permanently residing under color of law (PRUCOL)—cannot be precluded from public health coverage solely due to their immigrant status. See *Aliessa v. Novello*, 96 N.Y.2d 418, 730 N.Y.S.2d 1 (2001).



not come close to 4%). Because respondents often incorrectly identify their insurance status, we believe many researchers tend to overstate the number of individuals in the direct pay market and understate the number of people in Medicaid or other public insurance products.

- In addition, note 2 states that the Urban Institute will use a single year of “un-blended” CPS data. We understand three year blended data provides a more reliable result and are interested in further clarification about the Urban Institute’s methodological choice in this regard.
- Finally, HCFANY would like further clarification about how the Urban Institute intends to generate an estimate of premium rates and out-of-pocket costs. Does it plan to use data from the State Insurance Department, from the Medical Expenditure Panel Survey, or some other data set? Will they make adjustments to reflect the increase of medical costs over time (i.e. will they trend older data sets forward?) Could the Urban Institute share their methodology for this analysis with key stakeholders and the public?

These examples are illustrative rather than exhaustive. Our concern is that a number of key assumptions will have to be made and we would appreciate both: (1) a process (such as a technical advisory committee or workgroup) that will ensure that the assumptions accurately reflect New York conditions; and (2) a mechanism for making the assumptions transparent to the public so that we can provide informed commentary on the modeling process and ultimate outcomes.

### Page 3, §IIA, “Reform Module”

The HIPSM reform module will used to compare the four core models.

*HCFANY Comment:* Little detail is provided in the specifications about how this analysis will be performed and what questions will be answered. Our first concern is the assumptions in this module. To the extent its assumptions influence the outcome of the various proposals, it would be helpful to have this module made public.

Second, no matter what the assumptions, the modeling should lead to answers to some key questions, set out in a way that New Yorkers can readily understand: 1, 5 and 10 years after implementation of the model, how many New Yorkers will be insured? How many will be uninsured? Who will the uninsured be? How might various constituencies of New Yorkers (such as women, the elderly, people with disabilities and/or chronic conditions or serious illnesses) be differently affected? How will the proposals afford portability of coverage, should a New York lose or change employment? How will the costs of medical care be divided among individuals, employers, and local, state and national governments?



Third, to make the results fully comprehensible, HCFANY believes that it is very important to show how each reform model would affect a series of hypothetical New Yorkers, so that New Yorkers can evaluate the proposals as they affect people who share their circumstances. For example, how would each module affect the following families and individuals:

- *A family of four with income of \$80,000 per year in Nassau County, one child has diabetes and the father sees a psychotherapist weekly. Coverage is through a small business.*
- *A 32-year old sole proprietor designer living with HIV in Manhattan, who makes \$50,000 per year.*
- *A farming family of two adults (he farms, she works part-time at a Stewart's Shop) and three children in Schoharie County who make \$45,000.*
- *A 45-year old single private school teacher in Rochester earning \$35,000 per year who had breast cancer two years ago.*
- *A 25-year old single bond trader who lives in Brooklyn, works in New Jersey, and makes \$100,000 per year.*
- *A married immigrant couple, he 30, she 28, neither one in legal status, living in Riverhead, working as day laborers (he yard work, she housekeeping) in the informal economy in the Hamptons, earning \$30,000 per year off the books, combined, with one undocumented immigrant child and one citizen child.*
- *A retired 62-year old man in Erie County with high blood pressure, living on retirement benefits of \$22,000 per year, with no access to a retiree benefit plan, married to an actively employed 57-year old spouse earning \$28,000 per year, covered by her employer but whose plan does not include dependent coverage.*
- *A 34-year old single woman in Rockland County with Multiple Sclerosis and receiving \$18,000 per year in disability payments, not yet on Medicare. She has significant drug costs on the order of \$36,000 per year and requires bi-weekly physical therapy. She expects to need a motorized wheelchair in the next few years.*
- *A 30-year old single mother in Binghamton, working full time at Wal-Mart and earning \$26,000 per year with two minor children (one with asthma)*
- *A group of 24 employees, ages ranging from 22 to 61, of a bakery operation in Glens Falls, NY, median income of \$27,000, ranging from \$10,000 to \$65,000, mix of full- and part-time employees.*

Finally, all four reform models should be fully comparable. Although there will be no base-line “benefit package” in the Freedom Plan model, the model should assume a certain level of use of medical care, and the report should show how the costs of that care would be divided among various payer groups.



### Page 3, §IIA, The “Behavioral Module”

HCFANY assumes that the “Behavioral Module” is the module which would address “crowd out” and “take up” issues, both of which rely on a series of value-based assumptions. HCFANY urges the State to require that the Urban Institute share what assumptions they will use in both these areas.

*HCFANY Comment:* First, for “crowd out” assumptions, HCFANY believes that it is important to note that the real-world experience in Massachusetts appears to be very different than what UHF/Commonwealth Fund and CSS have predicted (all organizations assumed approximately 50% crowd out at various income levels). In fact, two recent *Health Affairs* articles—one of which was authored by a researcher from the Urban Institute—indicate that crowd-out concerns are overstated in the context of major state health reform.<sup>3</sup> Accordingly, we believe that the modeling should reflect these recent lessons learned.

Second, to the extent that a “combined public/private” proposal integrates a Family Health Plus employer buy-in or further expansion of the Healthy NY program for employers, HCFANY believes that “crowd out” is a misnomer, since employers are paying for much of the public insurance product in question.

Third, “take up” assumptions will similarly need to be carefully calibrated. In Massachusetts, for example, take up was much higher than expected for low-income individuals and yet much lower than expected for moderate-income individuals—in fact nearly 20% of the eligible but uninsured had to be exempted from the program for affordability reasons alone. If the same exemption waiver process were to be used in New York, between 380,000-516,000 New Yorkers would not have coverage.<sup>4</sup> In addition, it is unclear how “take up” will play a role in either the single payer or the NY Health Plus proposals if they are adopted in one fell swoop.

Fourth, another “take up” issue that requires unique consideration here relates the significant numbers of immigrants in New York. The proposals that use the tax system or employer verification to track or trigger enrollment in health coverage should take into account the special issues facing the large number of New York State residents who work in the informal economy and cannot produce evidence of their employment status or income. It would be helpful for models to address how participation rates in various coverage programs could be affected by

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<sup>3</sup> See Sharon K Long, “On the Road to Universal Coverage: Impacts of Reform in Massachusetts at One Year,” *Health Affairs*, 3 June 2008; see also Jon R. Gabel, “Report from Massachusetts: Employers Largely Support Health Care Reform, And Few Signs of Crowd-Out Appear,” *Health Affairs*, web exclusive 14 November 2007.

<sup>4</sup> Analysis of the impact of the “affordability” exemption in the New York context is available upon request from the Community Service Society.



employer documentation requirements, and to take into account the effect these requirements could have in excluding New Yorkers from coverage due to documentation hurdles.

In conclusion, HCFANY urges a rigorous and public discussion of these assumptions across the four reform proposals (perhaps through a technical advisory committee or workgroup, as mentioned above) as different assumptions about these “behavioral” issues will significantly affect the modeling outcome.

### Pages 3-4, §III, “Reform Proposals Selected for Modeling”

Section III describes the four proposals and assumes that each of four reform proposals would integrate the following “common parameters.”

*HCFANY Comment:* Generally, HCFANY is unclear how the Urban Institute will be able to walk these common parameters across all four proposals. HCFANY’s specific concerns are set forth below.

First, how will quality and access to care be fairly evaluated across the four proposals? The first paragraph on page four states that “each proposal will be analyzed for its ability to: rapidly provide health coverage to the citizens of New York, control the cost of health insurance and health care.”<sup>5</sup> However, this section does not really address how quality or access to care will be evaluated across the four proposals, or how control of healthcare costs will be assessed through the modeling.

This is of special concern for the “Freedom Plan,” where both quality of care and access to care will presumably be compromised for the portion of the population who will elect cheaper limited benefit products because these are all that are affordable. It would be helpful to model projected out-of-pocket costs and potential medical debt for individuals who enroll in the freedom plan who either have high medical needs or who incur high medical costs. For example, what would be the quality and access to care implications for a young woman in the Freedom Plan who develops a chronic health condition that requires numerous physician visits, hospitalizations, tests and prescriptions? What would be the implications for a young man who suffers a devastating accident?

Finally, this section should address the concern that pent up demand for services and limited provider capacity might affect the overall health care system if an overnight solution or mandate system is adopted.

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<sup>5</sup> Partnership for Coverage, Modeling of Options for Expansion of Health Insurance Coverage for New Yorkers, Call for Public Comment, June 30, 2008, at 4.



Second, the “**Target Population**” parameter includes anyone not eligible for Medicare.

*HCFANY Comment:* HCFANY agrees that, for the purposes of assessing the incremental cost of expanding coverage it makes sense to exclude Medicare beneficiaries, but notes that any policy proposals to provide a base line of comprehensive benefits to all New Yorkers must integrate this population. Indeed, Medicare beneficiaries technically should be included (with agreement of the Federal government) in any true single payer plan. We also note that the exclusion of Medicare enrollees is inconsistent with both Assemblymember Gottfried’s New York Health Plan (the single payer) and his New York Health Plus proposal, and that Medicare currently coordinates and coexists with employer and other individual coverage, and would therefore affect the “combined public/private” and Freedom Plan models.

In any event, the modeling should not exclude all New Yorkers over 65 on the assumption that they are eligible for Medicare. Immigrants and others who are over 65, but have not earned 40 quarters to qualify for Medicare, should be included among the population in need of coverage under all four proposals.<sup>6</sup> We strongly urge their inclusion in the modeling process.

HCFANY would also like clarification about how “dual eligibles” would be treated in the modeling process.

Third, in the “**Public Programs**” parameter, Medicare, Medicaid, FHP, CHP are assumed to continue to serve existing populations.

*HCFANY Comment:* As mentioned above, HCFANY is concerned that this provision changes the intent of both New York Health Plan and New York Health Plus and ignores the reality of how the existing private market intersects with Medicare.

HCFANY also seeks to clarify whether HealthyNY will be considered a “public program” that will continue to serve the existing population. Although HealthyNY is not specified here, the State in other documents (notably the FSHRP waiver) has counted this as a public program.

Fourth, in the “**Benefit Package**” parameter, HCFANY lauds the state for using the Family Health Plus benefit package with mental health parity for the first three proposals.

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<sup>6</sup> One study, co-authored by an Urban Institute employee, has found that as many as 16-20% of New York City’s population age 65 and older is not covered by Medicare. See. Gray, B, et al, “Aging without Medicare? Evidence from New York City,” *Inquiry*, 43:211-221 (Fall 2006).



*HCFANY Comment:* HCFANY urges the State to direct the Urban Institute to make an additional adjustment for maternity benefits when calculating the cost of this benefit package.<sup>7</sup>

In addition, we are concerned, as stated above, that no level of health care usage is assumed in evaluating the Freedom Plan, making comparison impossible. Accordingly, the Urban Institute should compute costs of accessing care out of pocket for families under the Freedom Plan, in order to have an “apples” to “apples” comparison. In addition, the Urban Institute should be directed to estimate the costs of forgone care and the increased costs to the State (e.g. through Charity Care pools) and other health providers because of limited benefits and high-deductible under the Freedom Plan.

Fourth, the “**Cost Outlook**” is supposed to model 1, 5, 10 years for consumer, employer, government.

*HCFANY Comment:* HCFANY believes that this modeling should use representative sample families across the different plans, and also sample employers (at least sole proprietor, small business, and large employer).

In addition, the Urban Institute is likely to calculate certain “costs offsets” under each of the four proposals for various system design and administrative costs under the various programs. For example, the single payer proposal will presumably have very large administrative savings. These “cost offsets” and their presumable implications for financing should be made transparent.

Fifth, the draft Modeling Instruction delay addressing “**Financing**” issues.

*HCFANY Comment:* HCFANY agrees that the financing mechanisms do not have to be considered in the analysis of the first two models, which assume financing through governmental entities, until cost and savings estimates under these plans have been calculated. However, neither of the last two models can be analyzed without specifying the financing mechanisms—premium costs, the level and type of subsidies, and so forth—that will determine who will bear what share of the costs of medical care. Accordingly, we believe that certain fundamental financing principles must be established for those models in order to make the exercise meaningful. We would be pleased to have the opportunity to comment on the financing mechanisms that are proposed, and/or to participate in the technical advisory committee suggested earlier.

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<sup>7</sup> When calculating the cost of the Family Health Plus benefit package, the modelers may also need a premium adjustment for additional maternity benefits (because many pregnant Family Health Plus beneficiaries transfer into PCAP coverage). See Community Service Society, Letter to Elisabeth Benjamin from Milliman Consultants and Actuaries, dated October 30, 2008 at 3. Available upon request from the Community Service Society.



## Page 5, §IV. Proposals to be Modeled

### A. Single Payer “Medicare-for-All” Model

*HCFANY Comment:* This description of the Single Payer proposal seems to assume that many of the public insurance programs (e.g. Medicaid, Family Health Plus, Child Health Plus and Healthy NY) would continue as stand-alone programs under this reform proposal. We believe that this is not accurate for this proposal. In a Single Payer proposal, no private managed care companies would be paying providers, as they do in all these public programs listed above.

This description should also specify that there is no cost-sharing (premium, deductibles, or co-pays) for those enrolled. Since Medicare has cost-sharing, Single Payer and Medicare-for-All are not synonymous. Perhaps the draft Modeling Instructions should clarify whether the Urban Institute will model a Single Payer program (without cost-sharing) or a “Medicare-for-All” program (with the existing cost-sharing structure).

### Page 6, §IV B. New York Health Plus Model

*HCFANY Comment:* HCFANY is concerned about the 80% tax credit provision, which, in effect, would provide a tax credit to the rich to keep current private coverage. HCFANY is of the belief that Assembly Member Gottfried has committed neither to a particular tax credit percentage nor to a definite tax credit. HCFANY believes that lower tax credits (or no tax credits) should also be modeled.

In addition, we have a few minor points: (1) we understand that under this proposal, Child Health Plus and Family Health Plus would be one program; and (2) we do not believe that there is any “coinsurance” (as indicated on page 6). Rather, the proposal includes modest co-payments.

### Page 6, §IVC. Public/Private Model

This proposal describes a hybrid approach to universal health reform.

*HCFANY Comment:* Generally, the method by which each of the components of the public/private reform is evaluated is critical, as the order in which reforms are added may affect each subsequent calculation. This should be made clear in the final report.

HCFANY also has a series of specific comments under this section.

First, in the community rating “**adjustments,**” on page 7, the parameters indicate that an adjustment to community rating will be modeled under this model, and later in the document age banding is suggested as the modification.



*HCFANY Comment:* HCFANY is unclear why age banding is being considered as a “reform,” what if any other adjustments to community rating are being considered (e.g. gender, disability), and whether the private market reforms will be modeled with the current pure community rating system as well. We believe that adjustments to community rating, which would be more consistent with the Freedom Plan model, should be not be viewed an essential component of this model.

Second, in “**Public program buy-in**” three buy-in programs are described.

*HCFANY Comment:* HCFANY does not understand this section. Does the state wish to model only an aggregate buy-in for all three groups, or to model the buy-in of each group separately? (In other words is that “or” intended to mean an “and” in the first sentence in the final paragraph on page 8?). HCFANY strongly encourages the State to direct the Urban Institute to model the individual buy-in.

Third, “**Public program expansions**” describes modeling the expansion of Family Health Plus to a maximum of 200% of the federal poverty level.

*HCFANY Comment:* HCFANY urges the state to additionally direct the Urban Institute to model an FHPlus expansion to the recently enacted CHPlus level of 400% of the federal poverty level.

In addition, HCFANY would like to note that the proposed program simplifications to be modeled—the Enrollment Center, auto-enrollment and auto-renewal from other public benefits, the elimination of the face-to-face interview at application, consolidating categorical eligibility, eliminating the finger imaging requirement for single and childless couples, and less frequent renewals—will make it considerably easier for families to apply for and maintain their coverage. We applaud the fact that these core simplification measures were chosen to be modeled by the Urban Institute and look forward to the results of this endeavor.

Fourth, the instructions also seek to model an “**Insurance Exchange.**”

*HCFANY Comment:* The description of the insurance exchange indicates that insurer participation in any exchange would be voluntary. Is this statement accurate? We note that all HMOs are required to participate in HealthyNY and the direct pay markets. We believe that an exchange with mandatory participation should be modeled as well.

In addition, HCFANY also urges the modeling to assume that the insurance exchange could (or should) also fulfill an unmet need for an insurance “ombudsprogram” or enforcement role. Finally, the “young invincible” package should not be in the Insurance Exchange section, but should be in the Freedom Plan.



Finally, HCFANY urges the modeling instructions to explicitly direct the Urban Institute to identify the cost attributable to establishing the Insurance Exchange.

Fourth, the modeling instruction outlines two **“Premium Support Mechanisms.”**

*HCFANY Comment:* HCFANY is pleased to see that the state is modeling the Community Service Society’s *Cornerstone for Coverage* affordability schedule.

Fifth, the modeling Instructions describe an **“Individual Mandate”** and **“Employer Assessment.”**

*HCFANY Comment:* HCFANY is generally supportive of the use of a percentage of payroll as the vehicle for the employer assessment. However, HCFANY suggests that another employer assessment proposal should be modeled which excludes those employers whose average wage levels are less than 200% of the federal poverty level.

Finally, without understanding the precise nature of the penalties contemplated either for individuals or employers, HCFANY is unclear how the mandates will actually affect the results of the modeling.

#### Page 10, §IVD. The Freedom Plan

The Freedom Plan uses HDHPs, the expansion of Healthy NY, and the elimination of insurance mandates, including the relaxation of New York’s community rating laws.

*HCFANY Comment:* HCFANY is concerned that the modeling instructions only require the Urban Institute to evaluate the cost of implementing the Freedom Plan, without reflecting the external costs which implementation of the Plan will have on various core areas of health care delivery, including effects on the uncompensated care system and on the health costs borne by individuals. The effect on quality of care, access to care, and personal finances of the Freedom Plan’s shifting of costs to the consumer should be accounted for as part of the model. For comparability, it should be assumed that the population covered would use a basket of services covered in the Family Health Plus program at the average rate that basket of services is used by the average New Yorker.

Finally, it is unclear why the Freedom Plan model does not follow the contours contemplated by advocates for free market systems. Expansion of Healthy New York would not generally be contemplated by those who advocate for an unregulated market, as presumably the market itself would provide low cost, low benefit products. If reinsurance mechanisms were used, they would likely be private, not public, and would be more purely in the nature of reinsurance, without the large “donut holes” (where risk remains with the carriers) contemplated by this modeling proposal.



## Summary comments

The modeling proposal (with its reference to HIPS and “reform” and “behavioral” modules), does not specify how the results of the modeling will be reported.

HCFANY suggests that the State ask the Urban Institute to include at least three perspectives on the various models: (1) a report on what percentage of the state population will be covered under each model, who will remain uncovered, and how and at what cost medical care will be provided to those left uncovered (or underinsured); (2) a report on each model for the total cost to federal, state and local governments, to employers, and to individuals, and a total overall cost for providing care to all New Yorkers; (3) as stated above, “impact” snapshots of how the four proposals will effect a variety of individuals or families, given typical income, occupation and health situations, and what the health costs for those individuals or families would be under each model.

Thank you very much for the opportunity to provide comments on the draft modeling instructions. Should you have any questions, kindly contact: Elisabeth Benjamin at: (212) 614-5461.

Very truly yours,

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