

November 14, 2012

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Director, Center for Consumer Information and Insurance Oversight

Cindy Mann
Director, Centers for Medicaid and CHIP Services

U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Consumer Advocate Recommendations for Federally Facilitated and Partnership Exchanges

We represent 161 consumer advocacy organizations in 38 states that are committed to ensuring that partnership and federally facilitated exchanges (FFE) meet consumer needs. Many of our states are likely to have a partnership or federally facilitated exchange in 2014. Some of us are in states that are actively pursuing state-based exchanges, but we also support principles to ensure that consumer needs are met in partnership and federally facilitated exchanges.

We understand that the Department of Health and Human Services (HHS) is planning to release further guidance on exchanges in the next few weeks. To inform that process, we have compiled recommendations for the implementation of consumer-friendly partnership and federally facilitated exchanges to provide quality, affordable coverage to consumers and small businesses in our states.

The organizations signed on to this letter have extensive experience working with state agencies, studying our insurance markets, and helping consumers in our states understand and enroll in coverage. Therefore, we provide these recommendations to help ensure that federally facilitated and partnership exchanges meet the needs of consumers and are prepared to begin enrolling people in coverage in October 2013.

To ensure that federally facilitated and partnership exchanges are designed, implemented, and operated in the most successful manner possible, we urge HHS to commit to inclusive, transparent administration and decision-making for federally facilitated and partnership exchanges that put the needs of health care consumers first. To help HHS accomplish these goals, we are providing the following recommendations:

- 1. Create a robust, meaningful, ongoing stakeholder engagement and planning process**
- 2. Ensure in-person consumer assistance programs meet consumers' needs**
- 3. Ensure that Qualified Health Plans (QHPs) protect consumers and meet their needs**
- 4. Release necessary guidance as soon as possible**

I. Create a Robust, Meaningful, Ongoing Stakeholder Engagement and Planning Process

State consumer advocates have submitted earlier [communication](#) to HHS about the critical need for meaningful stakeholder input into the implementation and operations of federally facilitated and partnership exchanges. We would like to expand upon those recommendations, as we view this stakeholder process, especially transparency of information for consumers, as necessary to the success of all exchanges.

Building upon earlier recommendations, we urge HHS to implement a stakeholder input process for federally facilitated and partnership exchanges as follows:

- Make information on FFE and partnership planning transparent.
Current policy requires only a few sections of states' exchange blueprints to be made available to the public, and only after the blueprint is approved by HHS. We recommend that HHS make information more accessible by publicly releasing, in full, any exchange declaration letters and blueprints received. If that is not feasible, then we request that complete blueprints and declaration letters become available publicly once blueprints are approved by HHS.

HHS should develop and publically release an FFE document (similar to the exchange blueprint) for each state in which it will operate an FFE. This document should demonstrate how each exchange function will be performed in the FFE, including a clear description of any functions that are customized for the given state. Stakeholders should have opportunities to review a comprehensive plan for their exchange, even in a partnership or FFE. This will make it possible for stakeholders to more easily follow the exchange's implementation process and hold officials accountable for fulfilling their obligations to consumers.

In addition to the exchange blueprint, information posted on CALT is not accessible to stakeholders outside of state and federal officials. CALT is CMS' centralized repository for storing, collaborating on, and sharing deliverables and artifacts from IT projects in support of Medicaid administration and exchange establishment. It contains critical guidance and support documentation, such as the FFE Verification Plan, the data elements of a consumer's electronic account that will be transferred between exchanges and Medicaid, and best practices in IT contracting. Consumer advocacy organizations have long supported state efforts to modernize their eligibility and enrollment systems and have important contributions to make in ensuring that these systems are easy-to-use and protect consumers'

personal information. We therefore urge HHS to make these documents available via an online portal that is accessible to all stakeholders.

- Ensure state and local input and governance in both partnerships and FFEs

We find it concerning that the stakeholder input requirements that apply to state-based exchanges in the exchange blueprint are not required for partnership states and that comprehensive guidance on how the stakeholder input process will work for FFE states has not been released.

We believe that there should be a formal, local, ongoing stakeholder input mechanism for each FFE and partnership exchange. This structure should include in-person meetings with major stakeholder groups, particularly consumers, and should be convened by a neutral entity such as HHS, a partnership state, or a non-profit organization or foundation. Partner states and states coordinating with an FFE should be required to have representation from relevant state agencies at these meetings and to do in-depth work with stakeholders on the exchange issues for which the states have oversight or operational roles. These state workgroups must also have a clear, direct line of communication with HHS. FFE officials and FFE vendors and agents should also be represented at all meetings. This should be a formal, regular process to review and discuss exchange design and policy issues with state-based stakeholder experts, a majority of who should be those who have experience and expertise in consumer health coverage issues.

Many of us are also interested in whether it would be possible for our states to implement state governing boards to make policy decisions about FFE and partnership exchange issues that are under state authority. These boards should have a direct relationship with and direct input to HHS.

- Establish public input standards and accountability for states to work with consumer representatives

In a number of states, especially those that will ultimately have FFEs, there is strong political opposition to the ACA. There are examples in these states of refusal to accept federal dollars for ACA programs, a lack of development of a public process for exchange or other ACA implementation, and insurance commissioners and other state officials who refuse to meet with consumers and other stakeholders. Given these challenges, it is critical that HHS create strong guidelines and ensure accountability for states to seek input from consumers for the functions over which states have authority. If states do not engage in sufficient input processes, then HHS should establish a process for communicating directly with consumer organizations and other stakeholders in the state, and HHS should also communicate directly with stakeholders regarding federally operated exchange functions. Both the partnership and FFE models need to ensure accountability in meaningful participation by consumer organizations in the design and operation of exchanges. More broadly, HHS should develop

a process for resolving problems with a state that is not meeting its obligations to consumers under the Affordable Care Act.

II. Ensure in-person consumer assistance programs meet consumers' needs

We are pleased that HHS is working to ensure that navigators and assisters will be available in all states. Transparent, accountable, and effective navigator and consumer assistance programs are essential to creating successful and accessible exchanges. We offer the following recommendations to make sure that navigators and in-person assisters can fulfill their critical role of connecting consumers to coverage:

- Utilize Stakeholder Input to Create Effective In-Person Assistance Programs
HHS should establish a process to receive input from community-based organizations in each state where the FFE is operating regarding community needs and appropriate navigator and in-person assistance program design to meet those needs. Specifically, HHS should gather input on the local community-based organizations that should be selected as navigators and in-person assisters, as these are the entities best suited for in-person assistance roles. Some states have refused to develop a public process to determine which exchange model they will adopt, and these states may also be unlikely to meaningfully engage community-based stakeholders in the design of consumer assistance programs. Therefore, HHS should not permit states to partner on consumer assistance unless they demonstrate that they are formally and meaningfully engaging community-based stakeholders. Further, once in-person assistance programs are operational, feedback on the performance of consumer assistance functions should be sought from key organizations that work with consumers.
- Assess in-person assistance needs initially and on an ongoing basis
In order to inform the selection of navigators and assisters with adequate capacity for federally facilitated and partnership exchanges, HHS (and, if applicable, a partnership state) should formally assess a state's in-person assistance needs, including through the use of demographic and language data.

After navigator and assister programs have been established, HHS and any partnership states should regularly evaluate their performance. HHS and/ or state partners should be prepared to supplement or redirect resources throughout the course of the year when necessary to meet the needs of underserved consumers. Thus, both the FFE website and call center should collect data about people seeking in-person assistance, whether they promptly receive assistance, and whether they are satisfied with the help they receive.

- Gather Feedback on Consumer Problems
Navigators and assisters can play an important role in spotting consumer problems with the application and enrollment process, and they should have a formal feedback loop to report

these problems to HHS (and state partners). Feedback mechanisms should include phone calls, regular meetings, and the ability to report anecdotal information about problems by email or by phone to appropriate contacts. (While collection and submission of quantitative data is helpful and necessary for tracking trends in consumer problems, the exchange should be able to respond promptly to problems that may not be captured in data and which can more easily be reported through narrative.) For example, in Massachusetts a group of advocates meet monthly in formal meetings with Medicaid and Connector staff about concerns and problems with the implementation of health care reform, and together they have prevented minor issues from becoming crises.

- Assure Coordination Between Consumer Assistance Functions

Coordination between navigators, other in-person assisters, and other consumer assistance functions (including the call center, website, and consumer assistance programs that handle appeals) must be required for federally facilitated and partnership exchanges. When the federal government operates other consumer assistance functions, it must ensure that navigators and in-person assisters have easy in-roads for reaching them promptly, making appropriate referrals, and getting information about a consumer's eligibility and enrollment status or the outcome of a consumer's case when they have made a referral. For example, SHIPs that serve Medicare beneficiaries have ID numbers that enable them to access information about the status of a consumer's eligibility determination and to talk to Medicare customer representatives who can help them resolve consumer issues. HHS should similarly develop protocols for providing information to navigators and assisters. HHS should also ensure that referrals from the website or call center to in-person assisters and navigators take place in a timely and seamless fashion.

Additionally, HHS must ensure that the public education and outreach messages used by the FFE and in-person assistance programs are consistent, and that contact information for navigators and assisters is prominent on all FFE materials and the exchange website.

Navigators- Notice, Selection, and Technical Assistance

We understand that HHS will be awarding grants to navigators in states where there is a federally facilitated or partnership exchange. While the statute requires that at least two types of entities be selected as navigators, HHS should provide grants to enough entities to reach the populations needing assistance. In many places, localized community-based organizations reach consumers that are not reached by statewide programs. In order to ensure that HHS has good information about community needs and about organizations that might be capable of meeting those needs in each state, HHS should have formal process for states and state stakeholders (particularly consumer groups) to nominate navigators for federally facilitated and partnership exchanges.

Community-based organizations will need to prepare themselves before they apply to become navigators. Some service organizations may need to raise their traditional income guidelines to serve everyone eligible for affordability programs. Organizations may also need to brief themselves on health reform and the required navigator duties, or consult with their boards about taking on a navigator role. If HHS plans to contract only with state-wide organizations, requiring those organizations to seek local partners, the task will require even more time. Organizations should therefore have ample time to prepare to meet program requirements before navigator grant applications are due. We thus suggest that HHS provides well-publicized calls and written information for community-based organizations regarding upcoming requests for proposals for the navigator program even before grant applications are available.

Once established, navigators will all need regular training, technical assistance, and updates on FFE operations that relate to their work. They will also need a forum through which they can share problems and best practices. A centralized entity should be available to provide technical assistance and to convene navigators and state and federal partners. Convenings should occur through meetings and conference calls at both the state and federal level for navigators in all exchange models. In similar consumer assistance efforts, we have found that technical assistance and support through entities that are external to government, in addition to training and assistance sponsored by HHS, are crucial.

Navigators in a Partnership Exchange

There is some confusion about what a state's role will be in the navigator program if the state adopts a consumer assistance partnership exchange. Guidance indicates that partner states will have an oversight and monitoring role for navigators, but it is our understanding that HHS intends to operate the navigator selection process. Some of our state policymakers have indicated that they do not have enough clarity about these roles to allow them to opt into a consumer assistance partnership exchange. Specifically, they have indicated that they would like guidance on what liability, if any, the state will have for navigator actions if they will not be selecting navigators, and clarification that they will not bear expenses for the navigator program in a partnership exchange. Many of us are urging our states to adopt a consumer assistance partnership role and therefore encourage HHS to quickly release guidance with this information and an outline of what roles the state and federal governments will each perform in a navigator program for a partnership exchange.

In-Person Assisters- Standards and Training

It is our understanding that in-person assisters in partnership and federally facilitated exchanges will be required to comply with the same conflict of interest and training standards that apply to the navigator program. We strongly support this requirement and recommend that it be outlined officially in guidance. This guidance should also clearly state that, like navigators, in-person assisters must provide fair, accurate, and impartial information. In partnership states, it will be

important for the federal government to provide appropriate oversight of state-run in-person assistance programs to ensure that the programs comply with these standards. For federally facilitated exchanges, HHS should develop a robust process for monitoring compliance in the in-person assistance programs for which the federal government will be directly accountable. In-person assisters should effectively supplement navigators in providing assistance to hard-to-reach and vulnerable consumers. It will therefore be important to use regularly updated data on the populations likely to be eligible for coverage and the populations that are targeted by navigator programs to determine where in-person assister capacity is most needed. It is critical that all entities with in-person assister contracts have sufficient knowledge of and relationships with the communities they serve and have adequate training even if they only have funding to provide services for a limited time. If contracts are awarded to state or regional-level entities to administer in-person assistance programs, these entities must sub-contract with local community-based entities that have existing relationships with the populations that need assistance.

III. Ensure that Qualified Health Plans (QHPs) protect consumers and meet their needs

We understand that states that opt to serve as plan management partners have the authority to use various policy tools, ranging from state-specific QHP standards to selective contracting, to ensure that plans sold through the exchange meet consumer and small business needs and provide good quality and value. We believe it is critical that these options be made clear to partner states and are easy for them to implement.

Consumers and small businesses who shop for coverage through an FFE should also be protected from an overwhelming number of plan choices, which can make shopping confusing, and from enrolling in lower-quality, lower-value plans. Therefore, we recommend that the FFE enact policies to ensure that the number of QHP choices is reasonable, that choices are meaningfully different, and that plans sold are of high quality and value. Specifically, the FFE should:

- **Consider engaging in active purchasing to procure the highest-value, highest quality plans for FFE consumers, taking each FFE state’s insurance market conditions into account.** If this policy is not enacted in 2014, it should be considered for 2015, and in the interim the FFE should conduct a study of the potential benefits of active purchasing.
- **Standardize the cost-sharing and benefit limit variations allowed for QHPs at each metal level to ensure that plan designs make care affordable and accessible and that shoppers are not overwhelmed by excessive plan choices.** To do this, the FFE should consider adopting policies like these that state-based exchanges are currently considering:
 - The California exchange plans to “standardize major cost-sharing components of benefit plans and allow limited customization: Issuers would be required to offer standardized major cost-sharing components, such as deductibles, copays, coinsurance, and out-of-

pocket limits.” California also plans to standardize major benefit limits and exclusions in benefit plans, allowing limited customization.¹

- The Oregon exchange plans to require participating carriers to offer a standard plan in the bronze, silver, and gold tiers, in each service area in which it participates. Beyond that, each carrier can offer two additional, non-standard plans per metal tier per service area and, with exchange approval, two additional plans that demonstrate innovation through the use of networks, wellness programs, or other options that do not include premiums or benefits. Finally, each carrier in the Oregon individual market exchange may offer up to one catastrophic plan.²

The FFE’s standardization policies should also ensure that QHPs meet the requirement of Section 1311(c)(1)(A) of the Affordable Care Act. This section requires that QHPs do not employ “benefit designs that have the effect of discouraging the enrollment in such plans by individuals with significant health needs.” Therefore, the FFE should standardize cost-sharing variation to ensure that QHPs do not charge unreasonably high copayments for services used by sicker individuals (such as hospital visits or chemotherapy), but meet actuarial value requirements by lowering cost-sharing for services used by healthier individuals. This type of practice has presented problems in Medicare Advantage³ and the FFE should prohibit it.

- **Enact network adequacy standards that ensure a sufficient number of providers.** The multi-state plan created under Section 1334 of the Affordable Care Act will employ Medicare Advantage standards for network advocacy, and we recommend that the FFE do so as well. In addition, the FFE should supplement these with specific standards to ensure sufficient access to pediatric providers, mental health providers (including providers in addition to psychiatrists), and substance abuse treatment providers, as well as other categories of specific providers that may be needed by exchange enrollees but are not sufficiently addressed in Medicare Advantage standards. It is also critical that FFE network

¹ California Health Benefit Exchange, *Qualified Health Plan Policies and Strategies to Improve Care, Prevention, and Affordability: Options and Final Recommendations* (Sacramento, State of California, August 23, 2012), available online at: http://www.healthexchange.ca.gov/BoardMeetings/Documents/August_23_2012/IX_FinalBRB-QHPoliciesandStrategies_8-23-12.pdf.

² Cover Oregon, *Request for Application: Qualified Health Plans* (Salem, Oregon Health Insurance Exchange Corporation, October 2012), available online at: http://www.coveroregon.com/pdfs/carrier_RFA/Cover_Oregon_Application.pdf.

³ See, for example, Medicare Rights Center, *Too Good to be True: The Fine Print in Medicare Private Health Plan Benefits* (Washington: MRC, April 2007); Brian Biles, Lauren Hersch Nicholas and Sturat Guterman, *Medicare Beneficiary Out-of-Pocket Costs: Are Medicare Advantage Plans a Better Deal?* (New York: The Commonwealth Fund, May 2006); Government Accountability Office, *Medicare Advantage: Increased Spending Relative to Medicare Fee-for-Service May Not Always Reduce Beneficiary Out-Of-Pocket costs* (Washington, GAO, February 2008).

adequacy standards provide for ongoing monitoring of provider networks to ensure consistent provider accessibility. The FFE should employ “secret shopper” programs to determine whether listed providers are truly available to see patients in a timely manner, along with a robust system to track and address enrollee complaints about provider access.

- **Enact policies to ensure that QHP provider directories are up-to-date.** The FFE should require QHPs to conduct regular (such as quarterly) updates to their electronic and hard copy provider directories with information on both the providers that are in the QHP’s network generally and which providers are accepting new patients. Additionally, the FFE should require QHPs to make a good faith effort to update directories more frequently when they know that a provider has left their network. If a provider or facility indicates plans to leave a QHP network, the FFE should require the QHP to notify enrollees under active treatment of the termination and help enrollees make alternative plans for treatment or arrange for them to pay in-network costs for continued care with the provider or facility.
- **Enact policies to ensure that FFE enrollees can receive care from out-of-network providers at a cost no greater than what they would pay for services from an in-network provider if no in-network provider is accessible for the needed benefit in a timely and accessible manner.**
- **Require QHPs in the FFE to contract with all essential community providers (ECPs) in their service area that serve predominantly low-income, medically underserved individuals, including community mental health providers and women’s health clinics, on an “any willing provider” basis.** The FFE may want to examine the State of Minnesota’s law requiring all carriers to offer contracts to all ECPs in their service area as a starting point.⁴ Additionally, the FFE should require QHPs to contract with ECPs for the full range of covered services that each ECP can provide.
- **Ensure that clear, easy-to-compare information about QHP quality is presented to consumers on FFE websites starting in 2014.** We understand that delays to required quality reporting are being considered. We fear that if consumers do not have quality information at their disposal during the first year of exchange enrollment, they will never use this information in selecting plans, as many will likely remain in their initially selected QHPs for years to follow. Therefore, QHPs should be required to post existing quality data on FFE websites starting in 2014, even if the standardized quality rating system for exchanges is not yet established.

⁴ Minnesota Statute 62Q.19, Essential Community Providers, available online at: <https://www.revisor.mn.gov/statutes/?id=62Q.19>.

- **Require QHPs that are not already accredited by an HHS-recognized entity to secure accreditation within one year of FFE certification.**
- **Enact a broad prohibition against unfair or deceptive marketing practices by all QHP issuers and their officials, agents, and representatives.** Additionally, the FFE should prohibit certain marketing tactics that have been abused in programs such as Medicaid managed care and Medicare Advantage, such as cherry picking enrollees through targeted outreach in some geographic areas and not others, targeted door-to-door, telephone, and cold-call marketing, and offering gifts or activities to potential enrollees. Employing a “secret shopper” program like CMS has for Medicare Advantage and reviewing QHP marketing materials for violations can ensure that plans consistently comply with requirements.
- **In implementing Section 1003 of the Affordable Care Act as it pertains to exchanges, the FFE should prohibit plans deemed to have an unreasonable rate increase from selling coverage at the unreasonable rate in the FFE.** If such a prohibition is not enacted, the FFE should post a consumer notification that the plan has implemented an unreasonable rate increase anywhere plan cost and benefit information is presented.
- **Ensure that consumers have access to affordable dental coverage choices in the FFE.** FFEs should allow dental benefits to be offered both in conjunction with medical benefits and as separate, stand-alone plans. Consumers may benefit from lower premiums, better coordination of care, and easier tracking of out-of-pocket expenditures when dental benefits are provided by the same plan that provides medical benefits. Additionally, QHPs that want to offer dental benefits in conjunction with health benefits or integrated into benefit packages should not be required to price and offer dental benefits separately.
- **Develop a robust, rapid response to plans that fall out of compliance with QHP standards.** When a QHP violates QHP standards, the FFE should ensure that the plan comes into compliance within a limited time period. Plans that do not come into compliance should be subject to sanctions, and the FFE must remove plans’ QHP certification if they do not remedy the situation in a timely manner.

IV. Release Necessary Guidance As Soon As Possible

We appreciate that states have been given initial guidance on FFE and partnership exchanges, allowing a number of them to initiate and make progress on exchange planning. However, we have heard that many of our states would find exchange planning easier, with improved prospects for progress and completion, if they had some additional guidance.

Specifically, many of our states need further information on the financing mechanism for partnership exchange functions. It is our understanding that the federal government will reimburse states if they perform partnership functions. However, without written details on how this will work, some states fear that they will face financial obligations for functions such as the in-person assistance program in partnership exchanges, making them hesitant to design robust partnership programs. We therefore recommend that HHS provide complete information on the specific financing mechanism to pay states for performing partnership functions as soon as possible. As described earlier, states are also very eager for specific guidance on the roles that they will play in the navigator and in-person assistance programs in a partnership exchange. For both federally facilitated and partnership exchanges, we and many of our states are also interested in more guidance on how our Medicaid programs will interact with federally operated exchange components. We urge HHS to release more guidance on this, including on how memorandums of understanding (MOUs) between the federal government and our states will work and how together federal and state governments can ensure that eligibility determinations are made in a seamless, timely manner.

In addition to guidance, it would be very helpful to both our state officials and to us and other stakeholders to have a clear point of contact with HHS for federally facilitated or partnership exchanges. We urge HHS to announce a federal FFE or partnership administrator and office for each FFE or partnership state, which can be recognized by the state, stakeholders, and the public as the HHS point of contact regarding exchange implementation in the state.

Finally, we strongly urge HHS to hold firm on the November 16, 2012 deadline for declaring a state-based exchange. Further, we urge HHS to begin on-the-ground FFE development immediately in any state that does not submit a declaration letter by that date, with the recognition that many states will be simultaneously working on planning and implementation of partnership functions. These steps are critical to ensuring that exchanges will be fully functional and meet consumers' needs in every state by the October 1, 2013 enrollment date.

With exchange enrollment starting in less than one year, it is clear to us that a large share of states will adopt partnership or federally facilitated exchanges. We therefore share our recommendations on the processes, standards, and guidance that are needed to make partnership and federally facilitated exchanges work for consumers and small businesses. We believe that by considering the recommendations in this letter and increasing transparency and stakeholder input in the federally facilitated and partnership exchange development processes, HHS can work well with states and stakeholders to ensure that federally facilitated and partnership exchanges successfully meet the needs of consumers and small businesses.

Sincerely,

Alabama

Alabama Appleseed Center for Law & Justice, Inc.
Alabama Arise

Arizona

Children's Action Alliance

Arkansas

Arkansas Advocates for Children and Families

California

Black AIDS Institute
Family Voices of California
L.A. Gay & Lesbian Center

Colorado

C2EA Mountain Region

Connecticut

PATH Parent to Parent/Family Voices of CT

District of Columbia

START at Westminster

Florida

Florida CHAIN
Florida Child Healthcare Coalition

Georgia

Georgia Equality
Georgia Rural Urban Summit
Georgians for a Healthy Future

Illinois

AIDS Foundation of Chicago
AIDS Legal Council of Chicago
Alivio Medical Center
Campaign for Better Health Care
Champaign County Health Care Consumers
Chicago Hispanic Health Coalition
Chicago Recovery Alliance
Division of Adolescent and Young Adult Medicine, Stroger Hospital
Doctors Council SEIU
Health & Disability Advocates
Health & Medicine Policy Research Group

Heartland Alliance for Human Needs and Human Rights
Howard Brown Health Center
Illinois Alliance for Sound AIDS Policy
Illinois Maternal and Child Health Coalition
Illinois Network of Centers for Independent Living
Illinois Public Health Association
Planned Parenthood of Illinois
SEIU Healthcare Illinois Indiana
Shriver Center

Indiana

AIDS Task Force of Northeast Indiana
Covering Kids & Families of Indiana
Family Voices Indiana

Iowa

Child and Family Policy Center

Kansas

Kansas Action for Children
Kansas Health Consumer Coalition

Louisiana

Louisiana AIDS Advocacy Network - LAAN
Louisiana Consumer Healthcare Coalition
New Orleans Regional AIDS Planning Council

Maine

Consumers for Affordable Health Care
Disability Rights Center of Maine
Eastern Area Agency on Aging
Maine Children's Alliance
Maine Equal Justice Partners
Maine Hospice Council
Maine Parent Federation
The Maine Association of Mental Health Services
The Maine Association of Substance Abuse Programs, Inc.

Maryland

AIDS Action Baltimore
Maryland Citizens' Health Initiative
Moveable Feast

Massachusetts

Centro Latino Inc

Michigan

AIDS Partnership Michigan
CARES
Center for Civil Justice
HIV/AIDS Alliance of Michigan
Michigan Consumers for Healthcare
Michigan League for Public Policy
MichUHCAN

Minnesota

Park House
Positive Care Center at Hennepin County Medical Center

Mississippi

Mississippi Human Services Coalition
Community Impact, Inc.

Missouri

Communities Creating Opportunity (CCO)
Disability Coalition on Healthcare Reform
Jackson County Community Mental Health Fund
Legal Services of Eastern Missouri
Missouri Budget Project
Missouri Health Advocacy Alliance
Missouri Recovery Network
Paraquad
Saint Louis Effort for AIDS
The Whole Person

Montana

Montana Women Vote

Nebraska

Center for Rural Affairs
Institute for Health Law
NH Voices for Health

New Jersey

Advocates for Children of NJ
New Jersey Policy Perspective
New Jersey Primary Care Association
NJ Citizen Action
NJ Main Street Alliance

Statewide Parent Advocacy Network

New Mexico

Health Action New Mexico
Interfaith Worker Justice - New Mexico
New Mexico Center on Law and Poverty
New Mexico Public Health Association
New Mexico Voices for Children
NM Alliance for Retired Americans
Youth Development, Inc./Elev8 New Mexico

New York

Health People: Community Preventive Health Institute
Parent to Parent of NYS

North Carolina

Action for Children
Catawba Valley Medical Center
Disability Rights NC
Legal Services of Southern Piedmont
NCSB Progress
North Carolina AIDS Action Network
North Carolina Justice Center
North Carolina State AFL-CIO
Southern HIV/AIDS Strategy Initiative (SASI)

Ohio

ACTION OHIO Coalition For Battered Women
AIDS Resource Center Ohio
Legal Aid Society of Southwest Ohio
National Alliance on Mental Illness of Ohio
National Association of Social Workers, Ohio Chapter
Nightsweats & T-cells, Co
Ohio AIDS Coalition
Ohio Asian American Health Coalition
Ohio Poverty Law Center
Toledo Area Jobs with Justice and Interfaith Worker Coalition
UHCAN Ohio
UMC AIDS Task force

Oklahoma

American Cancer Society Cancer Action Network
Oklahoma Therapeutic Foster Care Assoc.

Oregon

Cascade AIDS Project

Pennsylvania

Consumer Health Coalition
Health Federation
Pennsylvania Health Access Network
Pennsylvania Health Law Project
Pennsylvania Partnerships for Children
Public Citizens for Children and Youth
Women's Law Project

South Carolina

Catawba Care
South Carolina Appleseed Legal Justice Center

Tennessee

East Tennessee HIV Planning Council
Friends For Life
Nashville CARES
Shelby County Ryan White Program
Tennessee Health Care Campaign
Tennessee Justice Center

Texas

Alamo Breast Cancer Foundation
Center for Public Policy Priorities
Harris Health System
La Fe Policy Research and Education Center
Legacy Community Health Services
Methodist Healthcare Ministries
National Association of Social Workers/Texas Chapter
Texans Care for Children
Texans Together
Texas Interfaith Center for Public Policy

Utah

Utah Health Policy Project
Voices for Utah Children

Vermont

Voices for Vermont's Children

Virginia

The Commonwealth Institute for Fiscal Analysis
Virginia Consumer Voices
Virginia Organizing

Virginia Poverty Law Center

Washington

Lifelong AIDS Alliance

West Virginia

West Virginians for Affordable Health Care

WV FREE

WV Ryan White Part B Programs

Wisconsin

Wisconsin Alliance for Women's Health

Wisconsin Council on Children and Families

Wyoming

Wyoming Comprehensive Care and Prevention Planning Alliance