

**COMMUNITY ROLES IN ASSURING
COVERAGE AND BENEFITS**

**Health Reform Implementation:
Opportunities for Place-Based Initiatives**

Issue Brief #3

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Community Roles in Assuring Coverage and Benefits

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Place-Based Initiatives and Health Reform

Increasingly, local community, city and county leaders committed to improving health outcomes are focused on “place” and are interested in how they can bring policy, practices and other resources together within neighborhoods and communities to improve the health and well-being of residents. This interest has led to a range of efforts – grouped here as “place-based initiatives”, or PBIs – that seek to strengthen prevention efforts, better integrate and coordinate services and achieve equity across populations. The aim is to create a community environment that promotes and protects health, while also addressing individual needs and choices. With their focus on population health and their roots in community change, PBIs and their champions have much to contribute as the nation takes action to implement health reform. This issue brief is part of a series prepared by the Center for the Study of Social Policy and supported by The California Endowment and its partner, the Community Clinics Initiative, to provide the leaders and advocates of place-based initiatives with the information they need to play a proactive and effective role as health reform unfolds.

Why is Coverage Important?

Assuring health coverage for all legal residents through implementation of the Affordable Care Act (ACA)¹ will be a major step toward improving health nationwide. Strong evidence connects the lack of health coverage with decreased access to care, poorer health status and premature death. Today, tens of millions of Americans lack health coverage and millions more have inadequate coverage.

Among vulnerable populations, access to affordable coverage currently depends on place of residence, age, gender, family status, employment status, and/or severity or type of health care

needed. For example, Medicaid coverage is generally not available to low-income adults under age 65 without children unless they have a severe disability or are pregnant. In addition, current Medicaid eligibility varies widely, with states such as Alabama, Indiana, Louisiana, Missouri and Texas offering Medicaid to non-parent adults only if their incomes are at or below one quarter of the federal poverty level.² Young adult women are more likely to be covered by Medicaid than low-income young adult men because they are more likely to live with their children. For adults working in low-wage jobs and small businesses, employer-based coverage is frequently not offered or not available at an affordable cost to the employee. The ACA seeks to extend coverage and reduce arbitrary variations by place and socio-economic status.

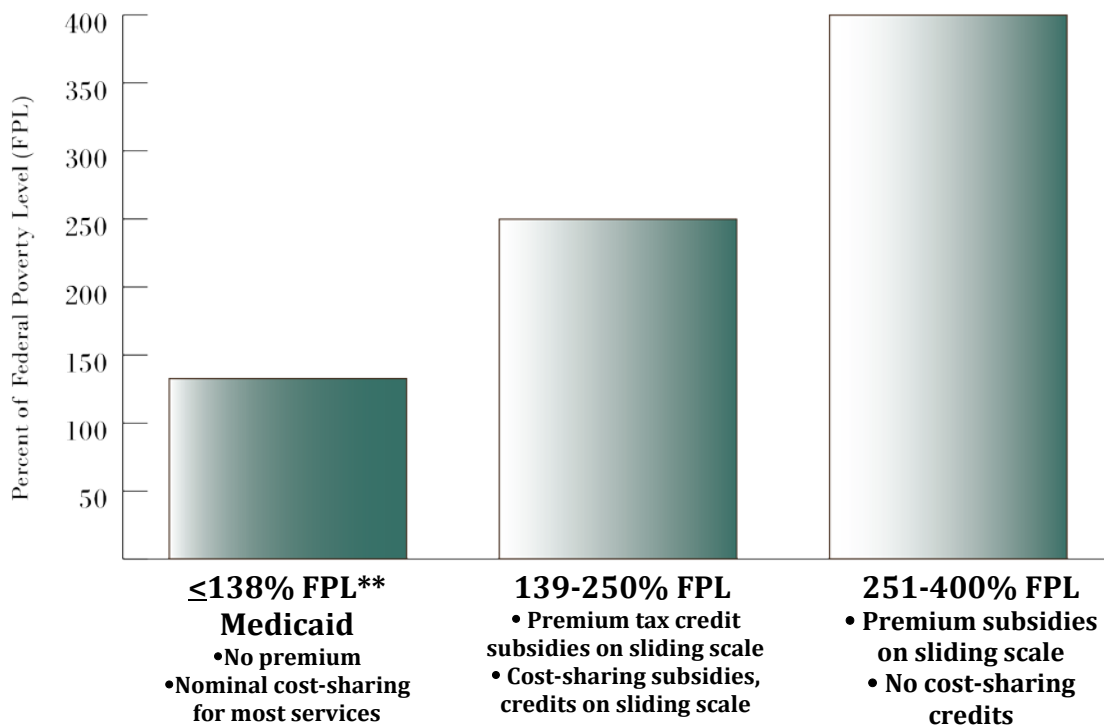
How Does the ACA Change Coverage?

The new health law contains a series of provisions designed to move the nation toward health coverage for all. Together these provisions outline the major building blocks needed to assure coverage, including changes in the roles and responsibilities of public and private sector stakeholders. Among other provisions, the ACA:

- ***Assures and requires health coverage for all U.S. legal residents (Section 1501).*** Under the ACA, mechanisms and mandates for individuals to secure affordable health coverage go into effect January 1, 2014, allowing an estimated 30 million additional individuals to gain health coverage.³ Each U.S. legal resident will be required to select and secure health insurance coverage (i.e., “to maintain minimum essential coverage”). The law phases-in a penalty for individuals and families that do not obtain mandated coverage; however, the law also provides for special consideration for those determined to have a “hardship” related to obtaining health coverage.
- ***Encourages employers to share responsibility for health coverage (Section 1513).*** Employers with more than 50 employees will be required in essence to “pay or play,” that is, be obligated to offer coverage for their employees or pay the government for those employees who use a tax-credit subsidy. In addition, effective January 1, 2010, the ACA offers new tax credits worth up to 35% of the employer’s contribution to help small businesses (less than 25 Full-Time Employees) offer coverage.⁴ Additional small businesses will qualify for assistance under a phased-in approach. Employers, unions, and other organizations operating employee benefit plans also may apply to participate in the Early Retiree Reinsurance Program and receive financial assistance (i.e., premium and cost offsets) to continue coverage to individuals who retire between ages 55 and 65.⁵

- Requires states to expand Medicaid coverage up to 133% of the federal poverty level** (Sections 2001 and 2002). States will be required to expand Medicaid eligibility with a benchmark benefit package to individuals and/or families with incomes at or below 133% of the federal poverty level by no later than January 2014. Notably, while the ACA sets the income eligibility level at 133% of poverty, it also includes a standard “income disregard” of 5%, making the income eligibility level effectively 138% of the federal poverty level. (See figure on page 4.) Under the ACA, Medicaid eligibility is to be based on an individual’s or family’s Modified Adjusted Gross Income (MAGI), as reported on income tax forms. Under provisions that went into effect in April 2010, states already have the option to expand Medicaid coverage to childless adults, but states will not receive enhanced federal support for expanded coverage until 2014.

**Publicly Subsidized Health Coverage Under the Affordable Care Act,
By Income* as a Percent of Federal Poverty Level, Effective 2014**



*The ACA calls for use of Modified Adjusted Gross Income (MAGI) to determine eligibility for Medicaid and tax credit subsidies. **ACA sets level at 133% but effectively it is 138% with standard 5% income disregard.

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- ***Makes coverage more affordable for those between 133% and 400% of poverty (Sections 1401-1402).*** The ACA includes provisions to make coverage more affordable by both capping out-of-pocket spending and providing subsidies in the form of tax credits to individuals seeking to purchase coverage through new “marketplaces” called Health Insurance Exchanges (See figure). Tax credits on premiums and cost-sharing subsidies will be available on a sliding scale to individuals with incomes between 133% and 400% of the federal poverty level (capped at 9.5% for individuals). Those on the lower end of the income scale (between 133% and 250% of poverty) will benefit from more subsidies and protections in plan design. Under the ACA, an individual (or family) “Modified Adjusted Gross Income” (MAGI) will be used to determine eligibility for all publicly subsidized health coverage.
 - ***Increases coverage for young adults (Section 1001).*** Effective in 2010, young adults may remain on their parents' private health insurance policy as a dependent until age 26. This can assist young adults who are entering the workforce at lower wages, unemployed, or students in college. This change is starting to have impact, with an estimated 1 million young adults gaining health insurance in the first three months of 2011.⁶ Until 2014, however, “grandfathered” group health plans do not have to provide this coverage if a young adult is eligible for group coverage outside his/her parent’s plan. (Visit <http://www.healthcare.gov/law/features/choices/young-adult-coverage/index.html> to learn more.)
 - ***Increases coverage for individuals with pre-existing conditions (Section 1101).*** Between 2010 and 2014, the ACA sets up mechanisms to help individuals with pre-existing conditions find affordable health coverage. Effective July 1, 2010, a new federal program – the Pre-Existing Condition Insurance Plan – was created to make health coverage available to individuals who have been denied health insurance by private insurance companies because of a pre-existing condition. This provision applies to legal residents of all ages who have been uninsured for at least six months. Just over half of states, including California, operate their own programs, while other states rely on the federal program. (Visit www.pcip.gov to find more detailed information about the federally-run program.) As of September 23, 2010, federal law prohibits pre-existing condition exclusions for children under age 19, and beginning January 1, 2014, the law will prohibit pre-existing condition exclusions for adults.
 - ***Creates a system of health insurance “marketplaces” called Exchanges (Section 1311).*** The Health Insurance Exchanges as defined under the ACA are new structures intended to serve as competitive “marketplaces” where individuals and small businesses can buy affordable health care coverage in a manner similar to that used by large businesses today.⁷ Starting January 1, 2014, Exchanges will help individuals and small businesses compare the terms and coverage offered by Qualified Health Plans (QHPs), choose and enroll in a plan,

and apply for premium subsidies and cost-sharing assistance. States will be allowed to operate state-based Exchanges or can opt to have the federal government provide Exchange services for their residents. In some states, such as California, counties will play an active role in carrying out some duties of the Exchange related to eligibility, enrollment, and the use of navigators.

- ***Defines and standardizes tiers of coverage (Section 1302(d) and (e)).*** In order to improve the affordability of coverage and to make it easier for consumers to compare plans, the ACA creates four levels of coverage for QHPs offered through the Exchanges, and in both the individual and small group markets. These are named bronze, silver, gold, and platinum. The levels reflect the “actuarial value” of the coverage.¹ In practice, these plan levels will be reflected in premiums and cost-sharing; however, they are only averages. The amount that individual consumers would pay will vary substantially by the amount of services they use and, thus, how much they would pay in out-of-pocket costs. (To learn more and practice seeing how cost-sharing and premium rules would affect different individuals and families, visit <http://healthreform.kff.org/SubsidyCalculator.aspx>.)⁸ In addition to offering plans at the four levels, states may also opt to offer a more limited, catastrophic plan for individuals under 30 years old or those who are certified to have a hardship buying another level of coverage. (See below under *Coverage*.) Additional protections will be available through the cap on out-of-pocket expenditures.
- ***Supports Consumer Operated and Oriented Plans (Section 1322).*** The ACA creates a new type of non-profit health insurer called a Consumer Operated and Oriented Plan or CO-OP. This is a consumer-owned health plan that is designed to promote integrated models of care. The federal government is offering loans to help non-profit organizations establish member-run CO-OPs, and the Centers for Medicare and Medicaid Services (CMS) is accepting loan applications quarterly through December 31, 2012. The grant notice can be found at: <http://www.grants.gov/search/search.do;jsessionid=yR2TTxyLKtFvCPzLqm8Zd7qjf7N102tGMT1ZRm42gmXQTpl56smq!1170416000?oppId=109093&mode=VIEW>. CO-OPs can be offered through Exchanges and will be required to meet the same federal and state standards as other insurance plans.⁹

¹ The actuarial value is an estimate of the percent of covered medical expenses a health insurance plan is likely to pay across a typical population. Under the ACA, the levels have different “actuarial value standards”. These are bronze (60%), silver (70%), gold (80%), and platinum (90%). For example, an actuarial value of 70% means the plan is likely to pay 70% of the covered expenses on average, while the remaining 30% is the average paid by enrollees through cost-sharing (e.g., premiums and co-payments) or subsidies.

Why are Benefits Important?

The Affordable Care Act (ACA) not only aims to provide coverage to all legal residents, it also gives specific attention to the type of coverage that will be available. In particular, it lists broad categories of “Essential Benefits” for plans purchased through the Exchanges. The ACA also emphasizes preventive benefits, with requirements for new plans to cover certain evidence-based clinical preventive services without cost sharing (i.e., charging a deductible, co-pay, or co-insurance). These provisions will go a long way toward making coverage more equitable for low and moderate income individuals and families. (Visit <http://healthconsumer.org/brochures.htm#newlaw2> to see fact sheets that show how the ACA and state decisions affect individuals and families.)

How Does the ACA Change Benefits?

Among other provisions, the ACA:

- ***Eliminates cost sharing for preventive services (Section 2713).*** With the exception of some plans defined by the ACA as “grandfathered” plans, the ACA requires all private health plans – individual, small group, large group, and self-insured employer plans – to cover a range of preventive services without any patient cost sharing. Four categories of services are covered:
 - *Evidence-based screening, counseling, and services* (based on the recommendations of the U.S. Preventive Services Task Force Recommendations A and B),
 - *Routine immunizations* for children and adults (as recommended by the Advisory Committee on Immunization Practices),
 - *Children’s preventive services* (based on Bright Future’s guidelines and the Secretary’s Advisory Committee on Heritable Disorders in Newborns and Children), and
 - *Preventive services for women* (based on Institute of Medicine recommendations).

The list includes preventive care such as: diabetes tests, cancer screening (e.g., mammograms and colonoscopies), smoking cessation counseling, well-child visits, children’s developmental screening, well-woman visits, prenatal care, and family planning.¹⁰

The provisions that eliminate co-payments, co-insurance, and deductibles for benefits are effective for plan years beginning on or after September 23, 2010, except for the women’s health provisions which become effective August 1, 2012. These prohibitions on cost

sharing apply to employer-based or individual health policies created after March 23, 2010, which do not have “grandfathered” status.

Despite the grandfathering provision, the federal Department of Health and Human Services (HHS) anticipates that 45% of large employer plans and 66% of small employer plans may relinquish their grandfathered status by 2013, as a result of plan modifications.¹¹

Separate cost-sharing protections for preventive services are in place for Medicaid and Medicare, as defined by federal law.¹² The Children’s Health Insurance Program (CHIP) also has cost sharing protections, which were enacted in 2009 before the ACA, including a requirement for a 30-day grace period for premium payment before terminating coverage. States that operate CHIP under Medicaid cannot impose cost sharing on children below 150% of poverty and have no cost sharing on preventive services.^{13,14}

- ***Establishes a minimum standard of benefit coverage (Section 1302(b)).*** By January 1, 2014, the Qualified Health Plans (QHPs) offered through the Exchange and certain other plans will be required to include coverage of “Essential Health Benefits.” An estimated 68 million Americans will be affected by these new benefit standards.¹⁵ However, some plans will not be subjected to these standards.ⁱⁱ Essential Health Benefit categories include: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services including oral and vision care. While the ACA outlines the general categories of coverage that QHPs will be required to provide, the details of the essential health benefits package will ultimately be described through the regulatory process. (See box.) On October 7, 2011, the Institute of Medicine released recommendations to HHS for the criteria and methods to be used by federal agencies in determining and updating the essential health benefits packages offered through QHPs.¹⁶

The regulatory process to determine how the essential health benefits package will be defined and implemented is ongoing. In December 2011, the US Department of Health and Human Services (HHS) proposed an approach to ensure that all plans offered through Exchanges offer coverage across the categories of “essential health benefits” listed in the ACA.¹⁷ The

ⁱⁱ Plans not subject to Essential Health Benefits Requirements include: self-insured employer-sponsored plans; grandfathered employer-sponsored plans, small group market plans, and individual plans in the non-group market; and existing Medicaid plans. Medicaid operates under federal benefits rules, which are typically more comprehensive in terms of meeting the needs of children and/or people with disabilities.

proposed approach would give states authority to define the specifics of covered benefits under the federally listed broad categories and using federally defined criteria and/or benchmark plans (e.g., the Federal Employees Health Benefits Program – FEHBP – Blue Cross Blue Shield Standard Option). The aim would be to reflect typical employer health benefit plans, account for diverse health needs across populations, and balance comprehensiveness and affordability for purchasers.¹⁸

- ***Creates a basic health plan approach for low-income individuals (Section 1331).*** In addition to the metallic tiers, the ACA permits states to offer a “basic health” plan (BHP) instead of coverage in an Exchange. BHPs can provide low-income individuals better value than Exchange coverage. These plans would be available to those who qualify for a premium tax credit (i.e., citizens with income between 134% and 250% of the federal poverty level, as well as legally resident immigrants with income at or below 133% of poverty who are ineligible for Medicaid). The plans would provide at least essential health benefits and have premiums no greater than the corresponding silver plan.¹⁹ This option allows a state to reduce enrollee costs, offer coverage for immigrants, give emphasis to reducing disparities, and coordinate with Medicaid and CHIP to increase efficiency.

Opportunities for Action: Take-Away Messages for Place-Based Initiatives and Their Partners

The coverage and benefits provisions in the ACA provide a blueprint for helping millions of Americans obtain the healthcare coverage they need, but previously could not afford. Translating this blueprint into a consumer-friendly, effective and efficient system of coverage will require considerable expertise at the federal, state and local levels, and will need to incorporate a strong and informed consumer voice. In addition, once systems are up and running, considerable efforts will be needed to reach out to all legal residents so that they have the information they need to obtain coverage and regularly access preventive and other needed health services. With their focus on underserved communities and emphasis on resident engagement, many PBIs are in an ideal position to bring a consumer voice to the design of new coverage systems, and to inform and connect consumers to new coverage resources as they are developed. PBIs and their partners at the neighborhood, city and county level might use the following as starting points for advancing and assuring coverage and benefits under the ACA:

1. **Be part of the design process.** In many states, design decisions regarding health reform implementation are already underway or will be launched in 2012 (e.g., California, Vermont).²⁰ A starting point is design of the Exchange. States make the primary decisions about whether to establish their own Exchange or to participate in the federal

Exchange. Those states setting up their own, state-based Exchange will have responsibility for certifying QHPs, making uniform consumer information available through a website and toll-free hotline, and facilitating enrollment into plans.²¹ Defining benefits, setting eligibility processes, and designing approaches to consumer information are among the other decisions states will be making. In addition to state officials, consumers and their advocates have a role to play in the development of the Exchange and structuring its designated responsibilities. Place-based initiatives can help to assure representation of the consumer voice in the design of these new health systems. This might take the form of community forums, testimony, or consumer representatives on the boards that govern the Exchange.

2. **Directly inform community residents about new coverage and benefits options.** City and county governments, particularly those operating eligibility and enrollment sites, as well as community organizations that serve low-income and vulnerable populations can play an important role in providing direct, face-to-face information about the plans and benefits available under the new health law. Local leaders can help to assure that states' consumer assistance programs, consumer information materials, and related activities are created with consumer input and are culturally and linguistically accessible.
3. **Help consumers navigate new resources to choose and obtain coverage.** The target population for coverage through the Exchange is more likely to be uninsured, have low income, have less formal education, be more racially and culturally diverse, and be young and healthy than those covered by private insurance.^{22, 23} A PBI could enhance and enrich projects that use health navigators, community health workers, and others who provide outreach and information to consumers. Some PBIs are well positioned to formally adopt roles as Navigators (a designated function under the Exchange). Community and consumer-focused non-profit groups that are part of PBIs, in particular, may want to seek funding to become Navigators in their communities
4. **Monitor implementation at the community or population level.** Another role for PBIs is to serve as a hub or center for monitoring the performance of a newly reformed health system. For example, building on their existing outcome monitoring approaches, PBIs might add measures of insurance coverage, out-of-pocket costs, and/or health care utilization.
5. **Become the hub for a Consumer Operated and Oriented Plan.** PBIs that are non-profit organizations might become the hub for a Consumer Operated and Oriented Plan (CO-OP). Other place-based initiatives might identify a non-profit organization that could lead and operate a CO-OP. This would require the capacity to engage community

members, apply for authority from the federal government, and manage the fiscal responsibility of a health plan. For some place-based initiatives, this might be a way to better integrate service delivery and coverage across a population.

PBIs are in an ideal position to influence the design and implementation of coverage and benefits under the ACA, particularly by helping to assure consumers in the communities they serve have access to the information they need. From work on health reform design to monitoring outcomes, PBIs have both knowledge of communities and community service systems. By partnering with other PBIs and with state policy advocates, they have even greater potential for impact statewide and at the federal level.

Developing a Broader ACA Action Agenda

PBIs – and those supportive of place-based approaches – may want to integrate consumer protection activities into a broader agenda related to implementation of health reform. “Beyond Coverage,” *Issue Brief #1* in this CSSP series on *Health Reform Implementation: Opportunities for Place-Based Initiatives*,²⁴ outlines four starting points for PBIs and their partners:

- 1. Define the changes to health service delivery, systems of care, and community environments that would be most effective at the community level to improve the health of children, families, low-income populations, boys and men of color, and other populations of particular interest.**
- 2. Develop an ACA Action Agenda by cross walking these desired changes and related place-based priorities with opportunities provided by the ACA.**
- 3. Develop and strengthen partnerships at the local, state and national levels to advance the community-specific, place-based Action Agenda.**
- 4. Look for opportunities to coordinate actions with other place-based initiatives as a learning community and as an advocacy voice for further federal actions to support place-based efforts to improve health.**

Endnotes

¹Patient Protection and Affordable Care Act (Pub.L. 111-148), as amended by the Health Care and Education Reconciliation Act (Pub.L. 111-152).

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About this Brief

This brief is one in a series exploring health reform implementation opportunities for place-based initiatives (PBIs). It is part of a broader project at the Center for the Study of Social Policy (CSSP) that explores how PBIs can advance implementation of health reform and how health reform implementation can further the work of PBIs. The California Endowment and its partner the Community Clinics Initiative have provided generous funding for this project.

CSSP seeks to secure equal opportunities and better futures for all children and families, especially those most often left behind. Based in Washington, DC, with strong ties to communities and policymakers nationwide, the Center's work focuses on three broad areas: system reform, public policy and community change. Underlying all of CSSP's work is a strong commitment to racial equity.

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