

# REPORT

FINAL REPORT

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## **On the Road to Universal Children's Health Coverage: An Interim Report on the KidsWell Campaign**

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## EXECUTIVE SUMMARY

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The Patient Protection and Affordable Care Act (ACA), enacted in 2010, held great promise for expanding insurance coverage to millions of uninsured Americans. Starting in 2014, it expanded Medicaid eligibility to low-income adults with family income below 138 percent of the federal poverty level. It also offered premium subsidies to people with income up to four times the poverty level so they could purchase private insurance through federal or state health insurance exchanges. While most of those expected to gain insurance coverage for the first time are adults, children stand to gain as well, since children are more likely to have health care coverage when their parents do too (DeVoe et al. 2015). In 2014, about 3.9 million children were estimated to be eligible but not enrolled in Medicaid or the Children's Health Insurance Program (CHIP), representing roughly two-thirds of all uninsured children (Kaiser Family Foundation 2015).

**The KidsWell Campaign.** Recognizing the ACA as a crucial opportunity to close the children's coverage gap, the Atlantic Philanthropies created the KidsWell Campaign to try to achieve universal children's health care coverage, as well as to support an enduring infrastructure that would remain after Atlantic's funding ended. The primary goal of the KidsWell Campaign was to ensure access to health insurance for all children, which in turn was expected to lead to improved health outcomes. KidsWell sought to achieve this aim through a two-fold strategy: by protecting and expanding children's health insurance coverage and by building a lasting child advocacy infrastructure to maintain gains in children's health care coverage. Due to the complexity of the ACA, Atlantic believed that effective implementation of its numerous provisions would require careful coordination of ACA implementation efforts with existing public insurance programs for children—Medicaid and CHIP—which are jointly financed and administered by federal and state governments.

KidsWell was therefore designed as a multilevel effort to coordinate state and federal advocacy efforts by national and state children's health advocates. KidsWell supported two clusters of work: (1) nearly \$10 million in grants went to state-based advocacy organizations in seven strategically selected states—California, Florida, Maryland, Mississippi, New Mexico, New York, and Texas; and (2) nearly \$19 million in grants went to 10 national organizations to provide support to strengthen advocacy campaigns in these seven states, disseminate information and resources to support campaigns in other states, and advocate for federal health policies to ensure access to health insurance for children. Atlantic purposely chose lead organizations in the seven states that had strong advocacy capacities, so that grantees could start on the work immediately. In each state, Atlantic also funded other advocacy and grassroots organizations whose advocacy skills complemented those of the lead grantees. Because ACA reforms would take many years to implement, KidsWell grants extended for at least three and as many as six years.

**Evaluating KidsWell.** Atlantic contracted with Mathematica Policy Research to evaluate the KidsWell campaign. This report presents descriptive, interim findings on two evaluation research questions: (1) to what extent has state grantees' participation in KidsWell strengthened advocacy networks and capacities so far? and (2) which advocacy activities do grantees believe to be most effective in securing policy advances for children's health care coverage? Our

approach to this evaluation uses a mix of data sources and analytic methods, including review of key program documents and independent sources of information on state health policy developments; thematic analysis of focus groups held during the summer of 2014 with representatives from the state and national grantee organizations; a temporal analysis that assessed the proximity in time of the advocacy campaigns with policy gains reported by grantees and independent sources; and descriptive analysis of a survey of all grantees fielded during the summer of 2014, which asked grantees about their organization and partner organization strengths and weaknesses, children’s health policy campaigns and activities used in those campaigns, use and value of the KidsWell grants and resources, and state-national grantee interaction, among other topics.

## Findings

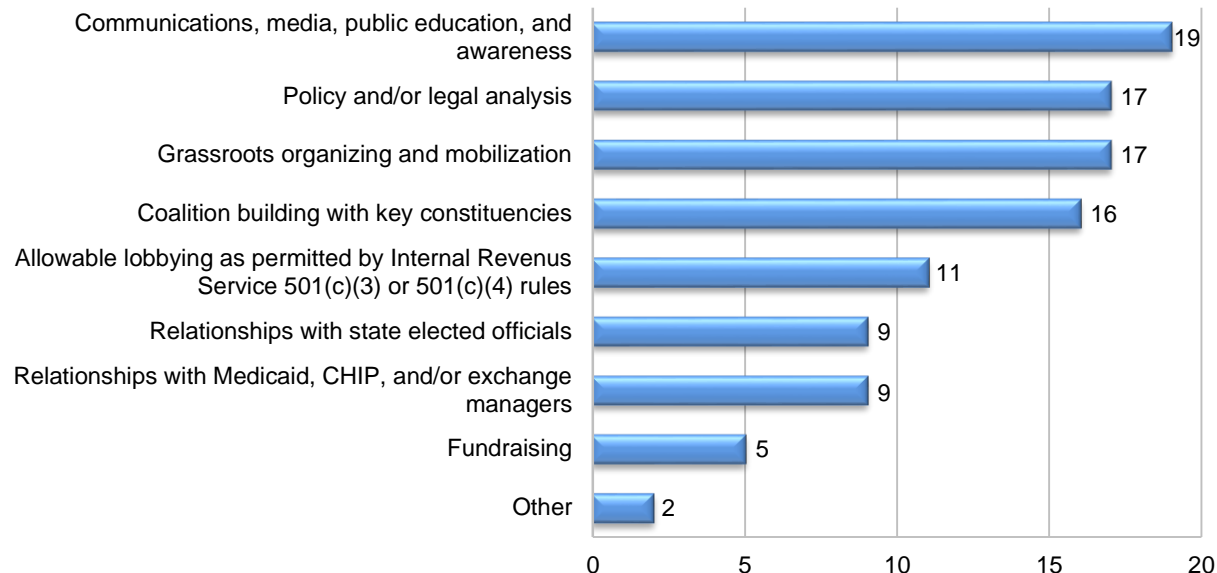
Key findings from this interim assessment include:

**Careful vetting of grantee organizations helped ensure that the organizations given grants were capable of undertaking strong advocacy campaigns and combining their knowledge and skills.** Atlantic sought to maximize its investment by intentionally funding capable children’s advocacy organizations with different strengths who could partner to advance ACA implementation within the target states. According to grantee representatives, at least one organization in each state reported having strength in each of the core advocacy capacities (shown in Figure ES.1) with one exception (in one state, neither grantee had a strong relationship with the state Medicaid agency). In a few states, the desire to fund organizations that in combination had all advocacy skills led to “arranged marriages” of partners that had not worked together previously, creating challenges for groups with different approaches to advocacy. Tensions were apparent in a few states at the outset, but over time these strains seem to have abated as groups learned to collaborate and leverage each other’s strengths, sometimes with the help of project-provided technical assistance. At the time of the survey in mid-2014, grantees in all states reported consistent policy goals, strategies, wins, losses, and assessment of partner strengths within state coalitions, indicating strong alignment.

KidsWell partners leveraged each group’s advocacy strengths; as one grantee said, “*It [required] finding out what everyone does best and piecing that together to achieve policy.*”

**Nearly all state grantee respondents believed that KidsWell funding enhanced their organizations’ advocacy skills.** In the 2014 survey of grantees, all but one of the 29 state grantee respondents believed that KidsWell resources enhanced their organizations’ advocacy capacities. Those that were most enhanced included communications and media (19 respondents), policy and/or legal analysis (17 respondents), grassroots organizing and mobilization (17 respondents), and coalition building (16 respondents) (Figure ES.1).



**Figure ES.1. Advocacy capacities enhanced by KidsWell funding or resources**

Source: Survey of 20 KidsWell state grantees (N = 29). Respondents could select as many responses as applied.

Note: Other responses included training opportunities and enhanced relationships with business and community leaders.

**KidsWell funding and resources helped grantees develop effective advocacy campaigns by strengthening partnerships within states.** Grantees cited the most important contribution of KidsWell support as building strategic partnerships within their states. The KidsWell grants permitted grantees to hire new staff to enhance their own organizations' skills to carry out advocacy; facilitated internal collaborations to help groups leverage and capitalize on members' strengths; and supported information sharing between national and state grantees and across states.

**KidsWell created opportunities for national-state collaboration, although the strongest national-state partnerships predated KidsWell.** State grantees reported that when they worked

One state grantee noted the contribution of national grantees to their work: *"The support from national organizations has truly been valuable....The national KidsWell grantees share with us what is going on in other parts of the country, letting us know new ways of doing things, which we can then pull down to our coalition to work on."*

with national grantees, the technical assistance they received expanded their skills or knowledge, helping them to become more effective in their work. There was more collaboration between state and national partners who had worked together prior to KidsWell. Nonetheless, state grantees' exposure to national organizations during the KidsWell grant period may enhance future collaboration.

**The state grantees together set state-specific policy priorities, some of which directly related to ACA implementation and others related to state policies governing children's health care coverage.** Common priorities included defending Medicaid and CHIP from state

budget cuts; Medicaid and CHIP enrollment and renewal policies; and, after the ACA Supreme Court decision in 2012, advocating for the adoption of the ACA-authorized expansion of Medicaid eligibility to low-income adults (see details in Table ES.1). In three states, advocates supported development of state exchanges, rather than letting the federal government manage the exchange for their states' residents, based on the expectation that state exchanges would give advocates a stronger voice in influencing exchange policies and benefits affecting children's health care coverage.

**Table ES.1. Overview of KidsWell states' political environments, grantee policy priorities, and most effective advocacy activities**

	CA	FL	MD	MS	NM	NY	TX
State political environment (2012–2014)							
Governor	D	R	D	R	R	D	R
Senate control	D	R	D	R	D	D	R
House control	D	R	D	R	D	R	R
KidsWell grantees' policy priorities							
Policy priorities, 2011-2014	Protecting Medicaid and CHIP budgets, Medicaid eligibility issues, exchange design, Medicaid expansion	Medicaid and CHIP enrollment and renewal, in particular covering children of lawfully residing immigrant residents	Exchange benefit design, Medicaid expansion, avoiding a coverage gap for youth aging out of foster care, open enrollment	Medicaid and CHIP enrollment and renewal, Medicaid eligibility expansion, Medicaid or CHIP outreach and application assistance	Medicaid eligibility expansion, Medicaid/ CHIP enrollment and renewal procedures, outreach and application assistance, state budget decisions	State exchange design, Basic Health Program	Medicaid eligibility expansion, outreach, application assistance
KidsWell grantees reports of most effective activities used to achieve a policy win or defend against a policy loss							
Coalition building (N=7)	•	•	•	•	•	•	•
Direct contact with elected officials (N=7)	•	•	•	•	•	•	•
Administrative advocacy (N=4)	•	•		•		•	
Policy analysis (N=3)	•		•		•		
Grassroots organizing/ social media (N=1)				•			
Public education/ mass media (N=1)							•

Source: Survey of 20 KidsWell state grantees (N = 29).

CA = California; D = Democrat; CHIP = Children's Health Insurance Program; FL = Florida; MD = Maryland; MS = Mississippi; NM = New Mexico; NY = New York; R = Republican; TX = Texas.

**Since 2011, KidsWell state grantees reported important policy wins as well as setbacks for children's health care coverage in their states.** Major state policy wins reported by the KidsWell grantees included the establishment of state-based exchanges in California, Maryland, and New York; Medicaid expansion in California, Maryland, New Mexico and New York; and

sustaining coverage for children amidst state budget cuts in Texas. KidsWell grantees in Florida and Mississippi saw no state-level policy wins for children, although they reported expanding advocacy capacity and public support for issues that they hope will translate into positive change in the future.

**In all seven states, grantees reported coalition building and direct contact with elected officials to be their most effective activities, while administrative advocacy, mass media, and grassroots organizing were viewed as less effective in four states each.**

More than 70 percent of the 29 state grantee survey respondents reported that coalition building, lobbying, policy analysis, and relationships with elected officials were most effective in securing policy advances to date (see Table ES.1). However, which advocacy activities work best in any given situation appears to depend on state context and the specific policy goal. For example, where key policymakers were seriously considering Medicaid eligibility expansion and state exchange sponsorship, as in California, Maryland,

New Mexico, and New York, policy analysis was more likely to be cited as an important input to the debate. In Florida, Mississippi, and Texas, where state policymakers were overwhelmingly opposed to these policies, advocates focused on trying to make it easier for eligible children to enroll in and renew coverage under existing Medicaid and CHIP programs. Along with coalition building and contact with elected officials, grantees in these states viewed administrative advocacy (in Florida and Mississippi), grassroots organizing (Mississippi) and public media campaigns (Texas) as the most effective strategies to achieving these goals.

Talking about the benefits of working in coalition to achieving the group's goals, one state KidsWell grantee reported, "*We have found that working with partners—both in coalitions and work groups—to produce concise, timely comments that are signed onto by multiple stakeholder groups is a particularly effective strategy for getting policymakers to pay attention to our issues. Collaboration is key!*"

## Discussion and next steps

When KidsWell began in 2011, there was uncertainty about how federal and state governments would execute all ACA provisions and coordinate those implementation efforts with Medicaid and CHIP. As of early 2015, there has been enormous progress in reducing the number of people without health insurance: states and the federal government have set up exchanges, and despite a rough start with operations of the federal exchange and some state exchanges, over 11 million people have signed up for new coverage or renewed existing coverage for plans purchased in those exchanges (with subsidies for those who qualify) and another 9 million have gained coverage through expanded Medicaid eligibility in 28 states and the District of Columbia (Rattner 2015). More children have gained coverage in this period as well, with the rate of uninsured children dropping from 7.5 percent in 2011 to 7.1 percent in 2013 (Alker and Chester 2014).

While gains in children's health insurance coverage throughout the last decade are important, the complexity and variability of public insurance programs across states, as well as the future of national policy regarding children's coverage, place these advances at risk. First, the legality of premium subsidies for those who enroll through the federal exchange is in question, as

the U.S. Supreme Court prepares to decide *King v. Burwell* in 2015, and the Department of Health and Human Services has announced it has no backup plan if the ACA premium subsidies are struck down. Second, the ACA authorized funding for CHIP only through September 2015, and while Congress recently preserved and extended CHIP funding through fiscal year 2017, its future is uncertain past this date. Moreover, there is no transition plan for ensuring that CHIP-enrolled children will be covered after 2017 should funding not be reauthorized.

With the policy environment in continued flux, advocacy at both national and state level is needed to ensure that gains in children's coverage are not lost and that progress continues toward insuring all children. Atlantic Philanthropies provided generous funding and technical resources for this advocacy effort over an extended period to try to strengthen grantees' capacities and networks in the hopes of achieving lasting systems change so that universal children's coverage can become a reality. The KidsWell grantees have nearly two years of funding remaining to continue advocating for policies that guarantee health coverage for all children.

In the final report to be issued in 2016, we will compare grantee perceptions with those of key policymakers and other stakeholders in the seven target states regarding the role of consumer advocacy groups in shaping policies for children's health coverage, the effectiveness of the grantees' advocacy activities, and which issues and advocacy activities they expect to be important in the future. The final report will present overall conclusions about and lessons drawn from the contribution of the KidsWell initiative to policies that expand and maintain children's health care coverage. It will also draw conclusions about what can help to sustain these gains and networks after the end of KidsWell funding.

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## I. INTRODUCTION

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The Atlantic Philanthropies launched the KidsWell Campaign in 2011 to capitalize on the policy opportunity created by the Patient Protection and Affordable Care Act (ACA) to achieve universal children's health care coverage and to build an enduring children's health care coverage advocacy infrastructure. This report presents descriptive, interim findings from an evaluation of KidsWell, focusing on two research questions: (1) to what extent has state grantees' participation in KidsWell strengthened advocacy networks and capacities so far? and (2) which advocacy activities do grantees believe to be most effective in securing policy advances for children's health care coverage? In this introduction, we provide background on the health policy context for KidsWell, the design of the KidsWell program and organizations taking part as grantees, and the evaluation framework and methodology.

### A. Background on the KidsWell initiative

Enacted in 2010, the ACA held great promise for expanding insurance coverage to millions of uninsured Americans. Starting in 2014, it expanded Medicaid eligibility to low-income adults with family income below 138 percent of the federal poverty level. It also offered premium subsidies to people with income up to four times the poverty level so they could purchase private insurance through federal or state health insurance exchanges. While most of those expected to gain insurance coverage for the first time are adults, children stand to gain as well, since children are more likely to have health care coverage when their parents do too (DeVoe et al. 2015). In 2014, about 3.9 million children were estimated to be eligible but not enrolled in Medicaid or CHIP, representing roughly two-thirds of all uninsured children (Kaiser Family Foundation 2015).

To support effective implementation of the ACA, the Atlantic Philanthropies, along with seven other national foundations, created the ACA Implementation Fund to provide strategic support to state-based health advocates in promoting state ACA implementation policies that would benefit consumers. Atlantic also created the KidsWell Campaign to capitalize on the policy opportunities presented by the ACA and other federal laws for achieving universal children's health care coverage, as well as to support an enduring infrastructure that would remain after Atlantic's funding ended. Atlantic contracted with Manatt Health Solutions, a policy and business advisory firm, to help it develop a grant strategy that would support these goals.

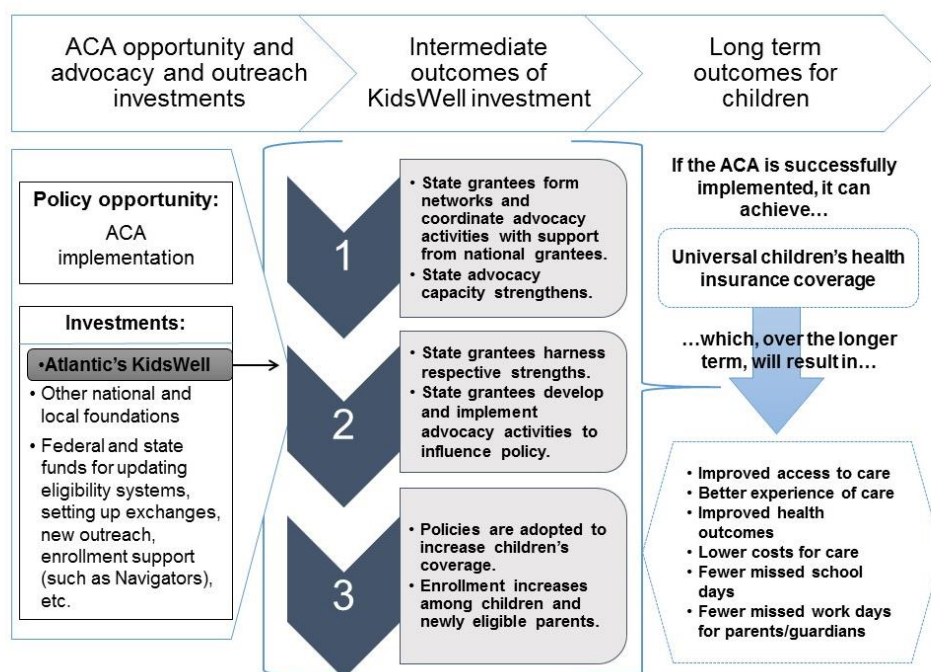
Atlantic and Manatt recognized that successful implementation of reform depended on effective action at both state and federal levels. For example, following the U.S. Supreme Court decision in *National Federation of Independent Business v. Sebelius* in 2012, states can choose whether or not to expand Medicaid eligibility. States and the federal government also play important roles in operating health insurance exchange shopping portals, conducting outreach to low-income families, helping these families apply for insurance, and creating consumer-friendly communication about families' coverage options and their costs. At the same time, the ACA extended Children's Health Insurance Program (CHIP) funding through September 2015, with

further funding requiring federal action.<sup>1</sup> As such, the KidsWell initiative was designed as a two-pronged strategy, which would invest in both state and national organizations to advance a coordinated agenda to achieve universal children's health coverage (Manatt Health Solutions 2013).

## B. Evaluation framework and research questions

Atlantic Philanthropies contracted with Mathematica Policy Research to conduct an evaluation of the KidsWell Campaign. Mathematica developed a theory of change to provide a framework for the evaluation (see Figure I.1). On the left side of this figure, we see the ACA policy opportunity as well as resources available to support ACA implementation—including resources from KidsWell, other foundations, and federal and state governments. In the center of the figure are the intermediate outcomes expected to result specifically from KidsWell support for grantees' advocacy activities, including advocacy networks and campaigns developed by KidsWell-funded partners in each state, and advances in children's health care coverage policy. In the long term, these investments are expected to achieve universal health care coverage for children and to improve the overall health and well-being of children and families.

**Figure I.1. KidsWell theory of change**



This evaluation focuses on the intermediate outcomes. To that end, Mathematica developed a set of related research questions, which focus on the activities and achievements of the KidsWell grantees operating in the seven states:

<sup>1</sup> The Medicare Access and CHIP Reauthorization Act of 2015, signed into law by the President on April 16, 2015, extends CHIP funding through September 2017.

1. How did Atlantic’s investment and engagement with the KidsWell grantees contribute to **strengthening advocacy capacities and networks**?
2. Which **advocacy activities** used by KidsWell grantees appear to be most effective in securing policy advances or preventing policy setbacks to expand or maintain access to children’s health care coverage? How did these vary by state environments? How and to what extent did children’s health care coverage rates change in the seven KidsWell states?
3. What is needed to **sustain** children’s health care coverage advocacy capacities, activities, strategies, and productive networks between national and state grantees and among state grantees, built with KidsWell support, in the future?

**What is advocacy?** In examining the key research questions, we examined seven core advocacy capacities (defined in Table I.1), which are the skills, knowledge, and resources that grantees need to be able to deploy in their advocacy campaigns. In general, these capacities do not exist within a single organization or even a single type of organization (Community Catalyst 2006), a key reason that many funders, including Atlantic, support more than one group working together on advocacy campaigns. In developing advocacy campaigns, organizations identify the issues or policies the campaign will focus on and formulate an overall strategy that consists of a mix of advocacy capacities, which we refer to as *activities* when they are put into effect.

**Table I.1. Definition of core advocacy capacities**

Capacity	Definition
Administrative advocacy	Working with state program administrators to influence procedures, rules, or regulations for how policies are carried out
Allowable lobbying	Conduct lobbying of elected officials permitted by Internal Revenue Service rules governing nonprofit organizations
Coalition building	Build and sustain strong broad-based coalitions and maintain strategic alliances with other stakeholders
Communications/media	Design and implement media and other communications strategies to build timely public education and awareness on the issue as well as to build public and political support for policies or to weaken opposition arguments
Fundraising	Generate resources from diverse sources for infrastructure and core operating functions as well as to support campaigns
Grassroots organizing and mobilizing	Build a strong grassroots base of support
Policy or legal analysis	Analyze complex legal and policy issues in order to develop winnable policy alternatives that will attract broad support

Sources: Community Catalyst 2006; Center for Effective Government 2002; BolderAdvocacy.org n.d.

## C. Methods

Our approach to this evaluation uses a mix of data sources and analytic methods (see Table I.2). The major sources of information included (1) key program documents, (2) focus groups held during the summer of 2014 with representatives from the state and national grantee organizations, (3) a survey of all grantees fielded during the summer of 2014, which asked grantees about several topics; and (4) independent sources on state health policy developments from 2011 to 2014.

**Table I.2. Key data sources and analysis methods for this report**

Data source	Description	Analytic methods
KidsWell program documents	Written materials from the grantees, including grant applications, and progress reports; activity reports produced monthly by Manatt; and background materials produced by Manatt during the selection stage	Document review; developed catalogue of all grantee activities, by month, by state, and by topical areas (Medicaid, CHIP, ACA education, ACA outreach, state budget issues, and so on), which was used to conduct a temporal analysis, analyzing the focus of and types of grantee activities over time and comparing those to independent sources on state policy developments (see fourth row below for a description of independent sources)
Focus groups	<p>Separate focus groups conducted in June 2014 with state and national grantees addressing these topics:</p> <ul style="list-style-type: none"> <li>• Whether the ACA has made it easier or more difficult to keep policy focus on children's issues</li> <li>• Lessons learned about effective advocacy strategies</li> <li>• Partnerships resulting from KidsWell</li> <li>• Use and contribution of KidsWell resources</li> <li>• Short- and long-term opportunities and threats to children's health care coverage</li> </ul>	Focus group recordings were transcribed and then analyzed for common themes
All grantee survey <sup>a</sup>	<p>An electronic, editable PDF survey emailed to representatives from all KidsWell grantees in July and August 2014 addressing these topics:</p> <ul style="list-style-type: none"> <li>• Organization and partner organization strengths and weaknesses (both self-assessed and, in the case of state grantees, as assessed by national grantees) in terms of capacity</li> <li>• Children's health coverage policy campaign targets, policy wins and losses, and activities used to influence wins and prevent losses</li> <li>• Use and value of the KidsWell grants and other KidsWell resources</li> <li>• State-national grantee interaction</li> </ul>	Produced descriptive statistics on the number of respondents in total and of each type, counts of advocacy strategies to identify which were most and least common, and number and type of other partners most frequently involved in pursuing key policy goals; advocacy capacity of state grantees was analyzed by examining whether at least one organization in each state reported having strength in each core advocacy capacity and whether there were gaps or weaknesses in the grantees within each state. Within state consistency was also assessed on key variables where commonality was of interest, such as policy wins and losses and activities used to influence wins and prevent losses.
Independent data sources on state policy developments	Publicly available sources on state and federal policy changes related to children's health care coverage or ACA issues, including health policy blogs produced by CCF and NASHP, daily health reports from American Health Line, and similar sources	Document review and analysis, in combination with other findings

<sup>a</sup>We invited two or three key respondents at each funded state KidsWell grantee to take the survey. In all, 29 individuals responded to the survey, representing 20 state grantee organizations; at least one response was received from every state grantee. One representative from each national grantee was surveyed and responded.

ACA = Patient Protection and Affordable Care Act; CCF = Center for Children and Families; CHIP = Children's Health Insurance Program; NASHP = National Academy for State Health Policy.

To examine the relationship between KidsWell grantees' activities and policy advances, we conducted a temporal analysis which assessed the proximity in time of the advocacy campaigns with policy gains reported by grantees and independent sources by tracking grantee activities by



month, by type of activity, and by policy topic (for example, Medicaid, ACA outreach issues, state budget issues, and so on). Proximity alone does not mean that advocates had a significant influence on the policy outcomes: for example, in New York, most state policies take two years to adopt, using the first year to introduce the policy and build support and the second year to gain passage. However, temporal patterns that do emerge help to build a case, along with other supporting evidence, for the effectiveness of advocacy campaigns.

#### **D. Purpose and organization of this report**

In this report, we present descriptive, interim findings on the first two evaluation research questions: (1) to what extent has state grantees' participation in KidsWell strengthened advocacy networks and capacities so far? and (2) which advocacy activities do grantees believe to be most effective in securing policy advances for children's health care coverage? It is too soon to assess the effects on children's coverage rates post-ACA implementation since the ACA was not fully implemented until January 2014. Since the program is still operating and most grantees have at least another year or more of funding before their grants end, we will report on findings regarding post-ACA changes to children's coverage rates in the final evaluation report in 2016. In the final report, we will also examine the degree to which the grantees influenced policy outcomes in their states, based on interviews with state policymakers conducted in 2015, as well as the sustainability of the advocacy capacities and networks created or strengthened by the KidsWell Campaign.

In the remainder of this report, we will use Chapter II to summarize the design of the KidsWell initiative and Chapter III to report on the first research question of interest, describing KidsWell's contribution to strengthening advocacy capacity and networks. To address the second research question, in Chapter IV we review the policy issues that were the focus of state grantees' advocacy campaigns, which advocacy activities grantees used and identify those that appeared to be effective in advancing favorable policies. In Chapter V, we discuss the findings to date and preview future work that will assess the other key questions of interest, including how children's health care coverage rates have changed after implementation of the ACA beginning in 2014, how external stakeholders perceive KidsWell grantees' influence, and how KidsWell will be sustained.

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## II. KIDSWELL DESIGN

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The primary goal of the KidsWell Campaign was to ensure access to health insurance for all children, which in turn was expected to lead to improved health outcomes. The program sought to achieve this aim through a two-fold strategy: by protecting and expanding children's health insurance coverage and by building a lasting child advocacy infrastructure to maintain gains in children's health care coverage. Due to the complexity of the ACA, Atlantic believed that effective implementation of its numerous provisions would require careful coordination of ACA implementation efforts with existing public insurance programs for children—Medicaid and CHIP—which are jointly financed and administered by federal and state governments.

KidsWell was therefore designed as a multilevel effort to coordinate state and federal advocacy efforts by national and state children's health advocates. KidsWell grants supported two clusters of work: (1) grants to state-based advocacy organizations in seven strategically selected states; and (2) grants to 10 national organizations to provide support to strengthen advocacy campaigns in these seven states, disseminate information and resources to support campaigns in other states, and advocate for federal health policies to ensure access to insurance for children. Because ACA reforms would take many years to implement, KidsWell grants extended for at least three and as many as six years.

In this chapter, we explain how Atlantic selected the seven states for intensive state-level work with advice from Manatt Health Solutions, a private consulting firm. It then describes the state and national organizations that received KidsWell grants, the amounts awarded, and how grant funds were used. Last, we describe other KidsWell resources designed to foster state-national grantee communication and partnerships and to strengthen and coordinate advocacy efforts. This background provides important context for understanding how KidsWell funds and resources contributed to strengthening advocacy capacity and partnerships within states and between state and national organizations, which we will discuss in Chapter III.

### A. Grantee selection

**State grants.** As noted in Chapter I, Atlantic contracted with Manatt Health Solutions, a policy and business advisory firm, to help it develop a grant strategy that would support the KidsWell goals. In consultation with Atlantic staff, Manatt developed a set of criteria to select states. Primary criteria included having a large number of uninsured children in the state, but Atlantic also wanted to include states with varied economic and political conditions. To the degree that it made sense given the primary criteria, Atlantic was also interested in funding grantees in states where Atlantic was already investing resources in other programs related to school based health services.

Atlantic selected seven states for targeted investment, and identified children's health advocacy groups in each state. Atlantic very purposely chose seven lead organizations that had strong advocacy capacities, so that grantees could start on the work immediately (see Table II.1). Many grantees selected as the state leads were regarded as the leading advocacy group for children or health coverage in that state. In each state, Atlantic also funded other advocacy and grassroots organizations whose advocacy skills complemented those of the lead grantees. Four

other organizations were funded in Florida and New York, three in California and Texas, two in Mississippi, and one in Maryland and New Mexico. The organizations receiving KidsWell grants in each state were expected to form partnerships to support coordination of advocacy campaign strategies and activities. In total, Atlantic invested nearly \$10 million in these groups. Recognizing that successful implementation would take time, the grants are about six years in length.

**Table II.1. Key details on KidsWell state grantees and total funding amounts**

	CA	FL	MD	MS	NM	NY	TX
Lead grantee	Children Now	Florida CHAIN	MD Advocates for Children and Youth	MS Center for Justice	NM Center on Law and Poverty	Community Service Society of New York	Engage Texas
Other KidsWell-funded partners	1. PICO <sup>b</sup> California 2. Children's Defense Fund California 3. The Children's Partnership	1. Children's Movement of FL 2. FL Center for Fiscal and Economic Policy 3. Florida Children's Healthcare Coalition 4. Children's Trust of Miami-Dade	1. Maryland Citizen's Health Initiative Education Fund (also known as Maryland Health Care for All) <sup>c</sup>	1. Children's Defense Fund Southern Region Office 2. Mississippi Human Services Coalition	1. Comunidades en Accion y de Fe (CAFÉ) (allied with PICO <sup>b</sup> )	1. Schuyler Center for Analysis and Advocacy 2. Children's Defense Fund of NY 3. Make the Road New York 4. Raising Women's Voices	1. Center for Public Policy Priorities 2. Children's Defense Fund of Texas 3. Texans Care for Children
KidsWell funding, 2011–2016 <sup>a</sup>	\$2,153,000	\$1,600,000	\$601,000	\$800,000	\$1,600,000	\$1,550,000	\$1,500,000

Source: Mathematica analysis of grant documents supplied by Atlantic Philanthropies.

Note: In addition, New York and Texas also received separate grants of \$150,000 each specifically for communications work; these amounts are not reflected in the totals above.

<sup>a</sup> Grants in New York and Texas extend into early 2017; all other state grants end in 2016.

<sup>b</sup> PICO is a national network of faith-based community organizations working to create innovative solutions to problems facing local communities (formerly People Improving Communities through Organizing, now known as the PICO National Network).

<sup>c</sup> Maryland Health Care for All initially was the lead grantee, but subsequently Maryland Advocates for Children and Youth became the lead grantee.

CA = California; FL = Florida; MD = Maryland; MS = Mississippi; NM = New Mexico; NY = New York; TX = Texas.

**Variation in state political environments and children's coverage.** The seven KidsWell states span a continuum in their embrace of the ACA: at one end is California, the first state to pass legislation creating a health insurance marketplace after enactment of the ACA and at the other end are Florida, Mississippi, and Texas, which actively oppose actions that support ACA implementation. The other KidsWell states fall at different points along this continuum. The number of uninsured children in the states varies, as do economic and political conditions (see Table II.2).

**Table II.2. Children's health coverage rates, economic and political conditions in the seven KidsWell states and the U.S.**

	CA	FL	MD	MS	NM	NY	TX	Total US
Number of uninsured children, 2013	673,000	445,000	59,000	56,000	43,000	171,000	888,000	5,234,000
Uninsured children as a percentage of all child residents, 2013	7%	11%	4%	8%	9%	4%	13%	7%
Medicaid/CHIP participation rate, 2012	87.0%	85.5%	91.9%	90.3%	89.3%	92.4%	84.3%	88.1%
Percentage of children living in poverty, 2013	23%	24%	14%	34%	31%	30%	25%	22%
Exchange type	State	FFM	State	FFM & SHOP	FFM <sup>a</sup>	State	FFM	n/a
Medicaid expansion?	Yes	No	Yes	No	Yes	Yes	No	n/a
State political environment (2012–2014)								
Governor	D	R	D	R	R	D	R	n/a
Senate control	D	R	D	R	D	D	R	n/a
House control	D	R	D	R	D	R	R	n/a

Sources: KidsCount Data Center 2015a, 2015b; Kaiser Family Foundation 2014; Eaves 2013; U.S. Census Bureau 2013a, 2013b; U.S. Department of Health and Human Services n.d.

<sup>a</sup> New Mexico initially planned to use the FFM only until November 2014, when it expected to have its state exchange available; however, the state exchange was not ready in time and now the state expects it to be available in late 2015, for 2016 open enrollment.

CA = California; D = Democrat; CHIP = Children's Health Insurance Program; FFM = federally facilitated marketplace; FL = Florida; MD = Maryland; MS = Mississippi; NM = New Mexico; NY = New York; R = Republican; SHOP = Small business health options program; TX = Texas; US = United States; n/a = not applicable.

Given this diversity, Atlantic realized that the KidsWell state grantees would be at different starting points in their advocacy work. For example, New York had the most generous children's public health care coverage programs in the nation prior to passage of ACA, meaning that grantees there would be able to immediately target ACA-related policy advances, such as advocating for Medicaid expansion and a state exchange. In contrast, state officials in Mississippi and Texas had already expressed strong opposition to the ACA, so while the grantees did not shy away from advocating for ACA-related issues such as Medicaid expansion, they also targeted children's coverage policies that were perceived as more achievable, such as simplifying existing children's coverage enrollment and renewal policies.

**National grants.** Atlantic also invested nearly \$19 million in multi-year grants to 10 national advocacy organizations to support two sets of activities: (1) to provide expert advice to state grantees on federal law, health policy analysis, media and communications, outreach, litigation, and grassroots organizing; and (2) to influence national health reform and to advocate for federal health policies that ensure access to insurance for children (see Table II.3). The 10 organizations had different missions and areas of expertise that spanned the range of advocacy

capacities and expertise required to conduct effective policy advocacy.<sup>2</sup> In addition, Atlantic funded Manatt to support program operations. Manatt and Atlantic staff coordinated monthly grantee calls, facilitated information sharing so that grantees could leverage best practices, and ran [www.KidsWellCampaign.org](http://www.KidsWellCampaign.org), the project's website, to serve as a central clearinghouse of information on grantee activities and on health reform developments across the nation.

**Table II.3. Key details on KidsWell national grantees**

Grantee	Mission and expertise	Grant amount	Grant period
Children's Defense Fund	Advocates for policies and programs that promote the health and well-being of children	\$3,196,000 <sup>a</sup>	April 2013–March 2016
First Focus	Bipartisan advocacy organization that works to make children and families a priority in federal policy and budget decisions	\$2,700,000	April 2011–March 2014
Georgetown Center for Children and Families	Nonpartisan policy and research center that works to expand and improve health coverage for children and families by conducting policy analysis and research	\$3,400,000	March 2012–March 2017
Moms Rising	Advocates on issues facing women, mothers, and families through social media and grassroots organizing	\$1,700,000	October 2012–September 2015
National Academy for State Health Policy	Nonpartisan network of state health policymakers sharing information on state health policy solutions and best practices	\$1,600,000	October 2010–June 2015
National Council of La Raza	Largest national Hispanic civil rights and advocacy organization in the U.S.; works to improve opportunities, including health care coverage, for Hispanic Americans through affiliated community-based organizations	\$600,000	July 2011–June 2014
National Health Law Program	Protects and advances the health rights of low-income and underserved individuals and families through litigation and policy analysis	\$2,450,000 <sup>b</sup>	October 2013–September 2017
Pacific News Services/New America Media	National network of ethnic news organizations that develops multimedia content to inform communities and influence social policy, including health care coverage	\$850,000	October 2012–September 2015
PICO National Network	National network of faith-based community organizations working to create innovative solutions to problems facing urban, suburban, and rural communities	\$1,000,000	December 2010–December 2014
Young Invincibles	Nonpartisan organization that mobilizes young adults, ages 18 to 34, to expand youth access to health insurance and care through outreach and advocacy campaigns at the national and state levels	\$1,125,000	March 2012–March 2016

Source: Mathematica analysis of grant documents supplied by Atlantic Philanthropies.

<sup>a</sup> This grant was partially shared with the American Association of School Administrators, in a project designed to increase children's access to health insurance coverage and accelerate adoption of better school disciplinary practices by engaging school district leaders in reform.

<sup>b</sup> This grant also supported other populations besides children (for example, when National Health Law Program works on Medicaid policy issues, it may also benefit older adults).

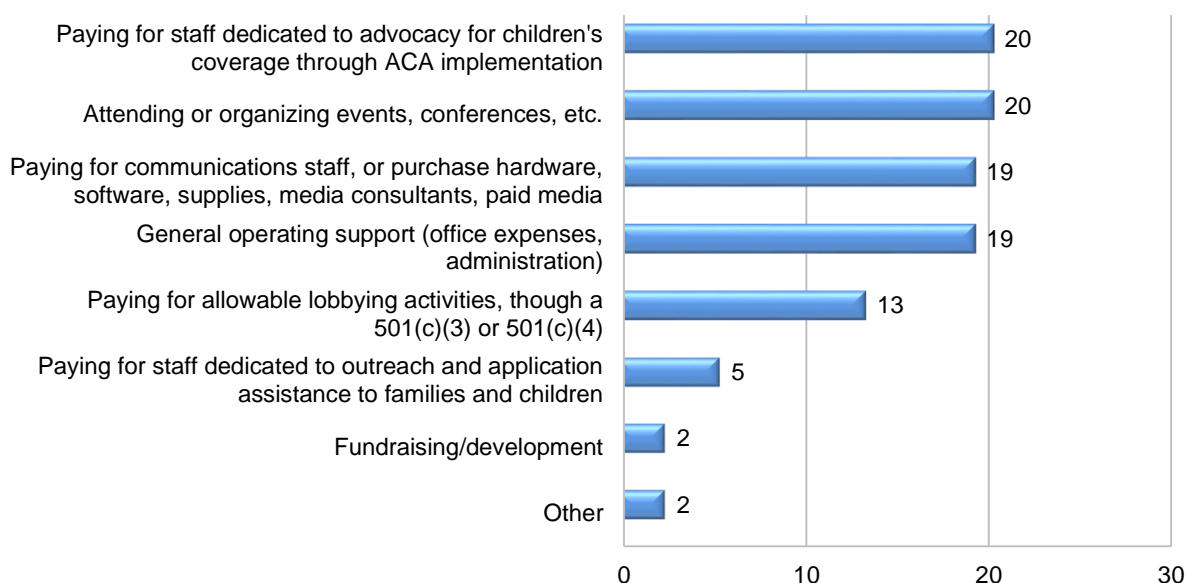
<sup>2</sup> Atlantic also funded some other groups to support children's coverage, but because they were not funded to directly support the KidsWell state grantees or to advocate for federal policy, they are not listed in the table. These groups include Grantmakers in Health and Grantmakers for Children, Youth, and Families, which were funded to convene national and local foundations interested in children's health coverage issues, and the National League of Cities, which was funded to offer a re-grant program to increase outreach and enrollment in eight cities.

## B. Grant amounts, period, and uses

Grants ranged from \$601,000 to \$2.1 million per state and \$600,000 to \$3.4 million for the national organizations. In most cases, KidsWell funding represented less than 10 percent of grantees' annual budgets. Of the 29 state grantee respondents to the 2014 KidsWell Grantee Survey, 18 reported that KidsWell represents less than 10 percent of their organization's annual budget in 2014. Of the 10 national grantees, half reported that KidsWell comprised less than 10 percent of their annual budget.

KidsWell grants were made for an initial three year period, and later extended over a five- to six-year period depending on the grantee. Foundation grants of this length are unusual, but Atlantic structured them this way because it recognized that ACA implementation, and advocacy to build support and make advances in public policy, would take many years. The ACA implementation timeline began in 2011, but many of its provisions were not scheduled to take effect until 2014 and many implementation issues were expected to take several more years to work out. Atlantic also gave grantees flexibility to use grant funds to best meet each organization's needs. In the 2014 KidsWell grantee survey, state grantees reported using KidsWell funding for a number of activities, including paying for staff dedicated to advocacy for children's coverage through ACA implementation (20 respondents); attending or organizing events, conferences, and so on (20 respondents); paying for communications staff (19 respondents); and general operating support (office expenses and administration) (19 respondents) (see Figure II.1).

**Figure II.1. State KidsWell grantee use of funds**



Source: Survey of 20 KidsWell state grantees (N = 29).

Note: Other responses included local organizing and indirect costs.

### **C. Other KidsWell resources**

Atlantic funded or carried out several other activities to support state advocates, including those that received KidsWell grants as well as those in other states. For state grantees, Atlantic and Manatt held monthly check-in calls with state grantees, attended by staff from national grantees, to offer advice on advocacy strategies and collaboration opportunities; facilitate information sharing on best practices; and coordinate policy, communications, and organizing strategies across grantees.

For advocates around the country, Manatt created and maintained the KidsWell website, [www.KidsWellCampaign.org](http://www.KidsWellCampaign.org), which provided extensive resources on federal and state ACA implementation developments across all 50 states and the District of Columbia. The website also served as a hub for KidsWell grantee activities; analytics provided by Manatt show that between March and September 2014, the site had nearly 7,000 unique visitors who visited the site nearly 10,600 times, viewing 2 pages per visit on average. Manatt kept track of all grantees' advocacy activities and from February 2012 to September 2014, produced weekly email updates on federal and state policy developments with a peak subscription of 4,700, monthly round-up reviews of KidsWell grantee activities, and occasional in-depth reports, such as an analysis of state Medicaid expansion decisions in December 2013. In addition, KidsWell grantees and other children's health coverage advocates were invited to participate in annual conferences, organized by the Georgetown University Center for Children and Families, where they had multiple opportunities to network with and learn from their peers and Atlantic staff about advocacy strategies and hear from experts on ACA policy and implementation issues.



### III. HOW DID THE KIDSWELL RESOURCES CONTRIBUTE TO STRENGTHENING ADVOCACY CAPACITY AND NETWORKS?

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While KidsWell state grantees had reputations for effective advocacy on children's coverage, they had varying levels of skills and knowledge in core advocacy capacities: coalition-building, policy analysis, good relationships with elected and executive officials, grassroots organizing, and media and communications campaigns. Although KidsWell was not intended as a capacity-building grant—grantees were selected because of their existing capabilities—KidsWell was expected to strengthen the advocacy capacity of state grantees through coordination among grantees within each state that could leverage the strengths of each organization and through support and advice from national grantees.

In this chapter, we examine how KidsWell resources, including grant funds and technical assistance resources provided by national grantees, strengthened state-level advocacy capacities. First, we describe the strengths and weaknesses of state grantee advocacy capacities and the degree to which the support and participation in KidsWell contributed to improvement. Second, we explore the degree to which KidsWell strengthened networks and collaboration among advocates within each state and across state and national grantees.

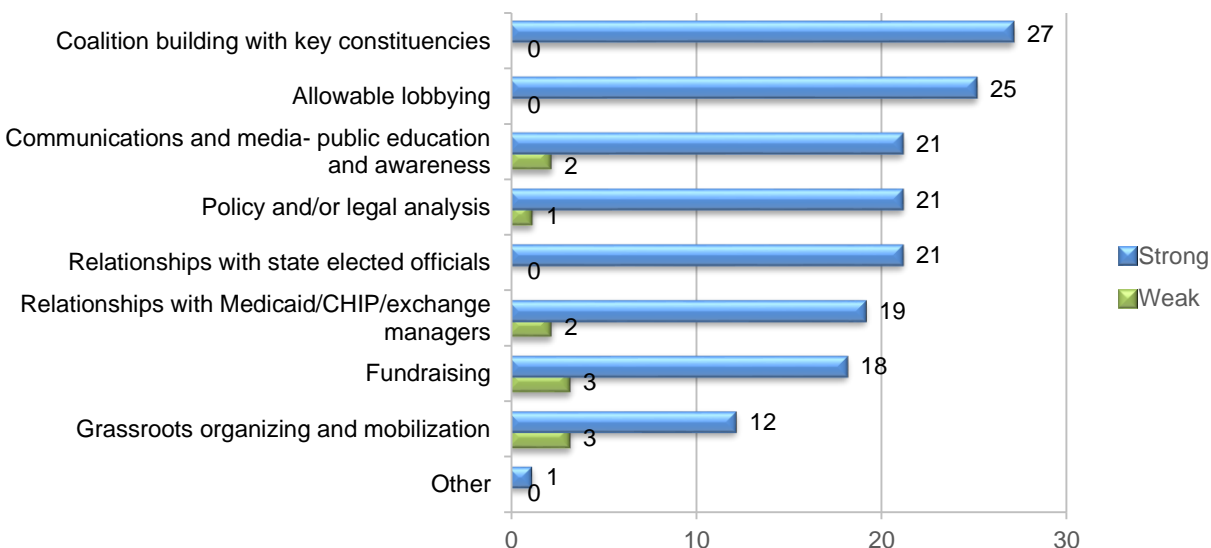
#### A. State grantee advocacy capacities

**State grantees generally believe their advocacy skills and capacity are strong across the board; national grantees mostly agreed but see room for improvement in grassroots organizing.** Overall, state grantees identified their strongest advocacy skills as coalition building (27 of 29 state grantee respondents); allowable lobbying (25 respondents); and, policy analysis or legal analysis, communications, and relationships with elected officials (21 respondents each) (see Figure III.1). National grantees who work with state advocates around the country and have a better vantage point for comparing state grantee strengths and weaknesses largely concurred with state grantees' self-ratings. National grantees cited coalition building, using data and research for policy or legal analysis, relationships with state officials, and communications as state grantee strengths (data not shown).

State grantees' self-ratings closely align with what grantees report as their major advocacy activities, with one notable exception: 21 respondents said they do grassroots organizing, but only 12 said it was a strength and 3 acknowledged it as a weakness. National grantees also rated five state grantee coalitions as weak in grassroots organizing. If an advocacy campaign depends on mobilizing constituencies to voice support or opposition to policy changes, grassroots organizing capacity needs to improve, either through building coalitions with grassroots organizations or strengthening this capacity in lead organizations.

At least one organization in each state cited having strength in each of the core advocacy capacities, with one exception. Neither of the two organizations funded in New Mexico reported having a strong relationship with the state Medicaid agency, which may have put them at a disadvantage in advocating for administrative rules and procedures to help low-income families enroll their children in Medicaid and fulfill renewal requirements.

**Figure III.1. Advocacy skills rated “strong” or “weak” by state grantee respondents (self-rating)**



Source: Survey of 20 KidsWell state grantees (N = 29 respondents).

CHIP = Children’s Health Insurance Program.

**Nearly all state grantee respondents believed that KidsWell funding enhanced their organizations’ advocacy skills.** In the 2014 survey of grantees, all but one of the 29 respondents believed that KidsWell resources enhanced their organizations’ advocacy capacities. Those that were most enhanced included communications and media (19 respondents), policy and/or legal analysis (17 respondents), grassroots organizing and mobilization (17 respondents), and coalition building (16 respondents).

## **B. State grantee networks**

**State grantees sought to influence policy advances primarily by creating networks with other organizations to develop coordinated advocacy campaigns.** Atlantic did not require state grantees to establish formal coalitions with unique identities for the KidsWell campaign, so the structure and formality of KidsWell networks varied in each state. Four lead grantees—those in Florida, Maryland, Mississippi, and Texas—created new, special-purpose coalitions. For example, in Texas, the lead grantee, Engage Texas (the 501c4 arm of Texas Civic Engagement Table, which organizes nonprofit organizations to increase civic engagement), created the Texas Well and Healthy Coalition to promote access to health coverage. This coalition brought together partners in Cover Texas Now, an existing coalition of consumer and faith-based organizations, with other partners and funding from KidsWell (Atlantic) and Getting to the Finish Line (Packard Foundation).

Similarly, Florida CHAIN, the lead KidsWell grantee in Florida, used KidsWell funds to establish a united coalition among children’s advocates in the state, which one respondent described as “rife with territorial disputes” in the past. Florida CHAIN used its KidsWell grant to

create a leadership team, shared KidsWell funding with three other leading child health advocacy groups, and reached out to many other groups in the state to develop shared policy priorities.

The other three state lead grantees built their KidsWell campaigns on existing coalitions. In New York, the KidsWell grantees formed a coordinating group of advocacy organizations to work together to achieve KidsWell goals. Rather than form a new coalition, they created a Children, Youth, and Families (CYF) task force within an existing coalition, Health Care for All New York (HCFANY), which has more than 160 member organizations and is managed by the lead KidsWell grantee, Community Service Society of New York. New York grantees decided that KidsWell funds would be better spent using the infrastructure and momentum of an existing coalition rather than launching a new, separate coalition or trying to rebrand the existing group. Some CYF task force members come from health advocacy groups in the HCFANY coalition, and new members were added because of their focus on children and families, such as childcare providers and preschool groups. Additionally, one important capability that the three New York KidsWell-funded groups did not initially have but believed they needed was grassroots capabilities—the ability to enlist, mobilize, and activate local supporters at critical points in policymaking. To support this capacity, the lead New York grantee regranted funds to two grassroots groups.

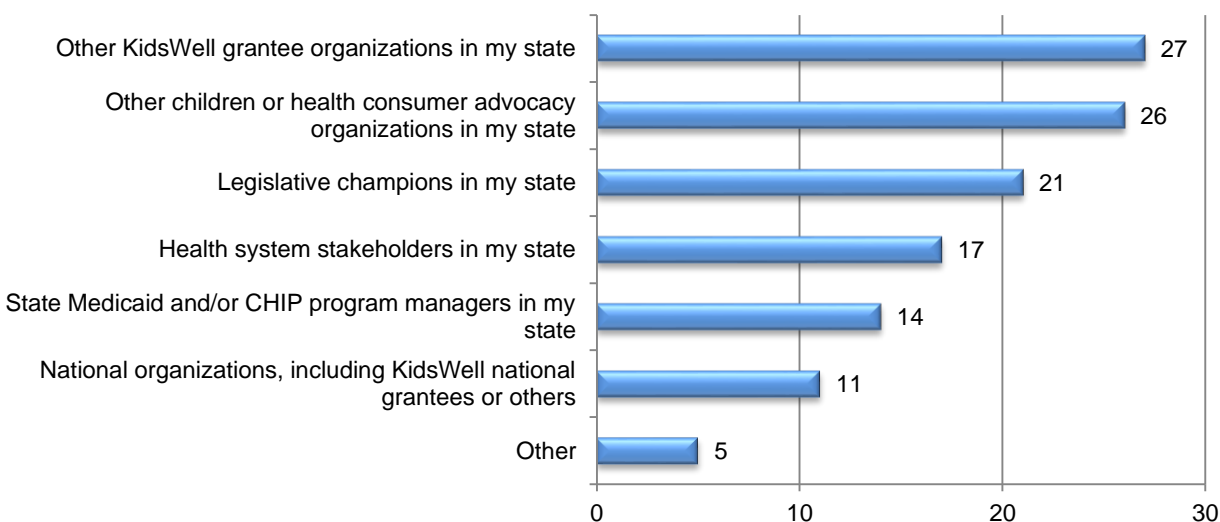
Likewise in New Mexico and California, the lead KidsWell grantees built on existing coalitions to coordinate health advocacy strategies. In New Mexico, the NM Center on Law and Poverty (the lead grantee) worked closely with New Mexico Voices for Children, which champions public policies to improve the status and well-being of children and families, and with members of the preexisting Health Care for All Coalition, which advocates for ACA implementation with a focus on adults (Hoag et al. 2014). In California, the KidsWell-funded groups had been working together for over a decade before this project began. Their existing coalition, called the Children’s Movement of California, focused on universal children’s coverage. KidsWell funding helped support various advocacy activities, including policy development and organizing, engaging, and mobilizing consumers so that their voices are included in state policy decisions. The lead KidsWell grantee, Children Now, created and leads this coalition, working in partnership with three other leading children’s advocates in the state: the Children’s Defense Fund-California, The Children’s Partnership, and PICO California.

It was common for state KidsWell grantees to collaborate with numerous types of organizations in planning or conducting advocacy campaigns. For example, 26 of 29 KidsWell state grantee survey respondents reported working with other children or health consumer advocacy groups in their states on ACA implementation campaigns, and most reported collaborating with key stakeholders, including legislative champions (21), health care organizations (17), and state Medicaid or CHIP officials (14) (see Figure III.2).

**State networks helped grantees to leverage each other’s strengths.** The majority of state grantee respondents (25 of 29 responding, or 86 percent) reported utilizing each partner’s strengths in their advocacy campaigns (data not shown). For example, one grantee reported, “[One partner] used lobbying and policy skills; [another partner] used grassroots efforts to collect stories; [a third partner] kept all of the advocates on the same page in terms of who to contact and what Medicaid enrollment numbers were.” In focus groups, one grantee representative explained that the groups in their state sought to divide the activities based on their respective strengths: “We’ve worked together a long time, so we know the unique strengths

of various partners and how best to maximize their impact.” Another state grantee reported in the focus groups that after it identified each partner’s strengths, the coalition worked to utilize them: “It [required] finding out what everyone does best and piecing that together to achieve policy.” Finally, one state grantee talked about the benefits of working with other stakeholders to try to achieve change: “We have found that working with partners—both in coalitions and work groups—to produce concise, timely comments that are signed onto by multiple stakeholder groups is a particularly effective strategy for getting policymakers to pay attention to our issues. Collaboration is key!”

**Figure III.2. Major advocacy partners reported by state grantees**



Source: Survey of 20 KidsWell state grantees (N=29).

Note: Other responses include the media, state foundations, a public university, business- and faith-based community.

CHIP = Children’s Health Insurance Program.

### C. State-national coordination

**Most state grantees found it helpful to work with national KidsWell grantees and said the support received from national organizations enhanced their advocacy capacity by increasing their knowledge of policy issues and skill in planning campaign strategy.**

Collaboration between state and national organizations was common, with one of the national organizations—the Georgetown Center on Children and Families (CCF)—cited by 16 of the 29 state grantee respondents as the national organization they most frequently worked with. As one grantee said, “CCF’s policy knowledge and newsletter provided great information and [kept] our group abreast of what other grantee states were doing and how we could obtain best practices.” Most state grantees also said that the support they received from national organizations was valuable, and seven groups were cited for adding high or medium value: CCF (25 of 29 state grantee respondents); New America Media (20 respondents); Moms Rising (19 respondents); First Focus (15 respondents); Children’s Defense Fund and National Health Law Program (14 respondents each); and PICO (12 respondents).

For example, two grantees specifically cited the work of New America Media on engaging ethnic media as highly valuable. One grantee said these efforts generated a number of media hits and gave the group new ideas about how to engage ethnic media; according to the other, the grantees learned how to organize ethnic media roundtables and subsequently held four of them to garner attention to policy issues. State grantees also appreciated hearing from national organizations about advocacy strategies that were successful in other states. For example, one grantee learned how to conduct a power analysis to identify which stakeholders it needed to reach to achieve policy advancement. Several state grantees also noted that collaboration worked both ways, with state grantees getting advice on issues they were working on, and the national grantees using information gained from the state grantees, often about policy implementation, to inform their national work.

**While KidsWell created opportunities for national-state collaboration, the most effective partnerships were those among organizations that had previously worked together.** KidsWell created the conditions for collaboration by setting up communication avenues, but other factors influenced the extent to which that communication has occurred. Some state grantees clearly valued the national support; as one state grantee said in the focus group, “The support from national organizations has truly been valuable....The national KidsWell grantees share with us what is going on in other parts of the country, letting us know new ways of doing things, which we can then pull down to our coalition to work on.”

Despite the availability of all national grantee organizations’ resources to state grantees, survey findings indicate that the strongest state-national collaborations were between those grantees who had worked together before KidsWell. For example, California and Texas had the most extensive prior history with the national partners and appeared to have the strongest partnerships with national grantees during this grant. As one national grantee put it, “It helps to have a history” with partners.

In explaining why collaboration did not occur, two state grantees said it was difficult to work with national organizations if they did not have sufficient appreciation for the state perspective or did not have enough time or capacity to help state advocates. A few national grantees also reported challenges partnering with certain state grantees due to the lack of state grantees’ capacity or leadership or difficulties finding the right opportunity to work on an issue. For example, state grantees like those in Maryland and New York, which focused on the design of state-based exchanges, reported less need to work with national organizations focused on social media and community organizing. As one national grantee noted, collaboration cannot be forced. However, state grantees’ exposure to national organizations during the KidsWell grant period sets the stage for future collaboration.

#### **D. Value of other KidsWell resources**

**Most grantees reported that KidsWell information sharing among state and national grantees helped them to spread their reach or be more effective advocates.** The majority of state grantees reported that the technical assistance provided through KidsWell helped them to spread their reach in advocacy efforts and be more effective. Sharing information across states, through monthly check-in calls and at the national conferences, was viewed as particularly useful to enhancing state grantees’ skills. Six of 10 national grantees reported that monthly calls with

Atlantic, Manatt, and other national grantees were helpful to them as well. One national grantee explained: “The monthly calls motivated us to focus on organizing in-depth, state-based trainings for child advocates, because they revealed the need for intensive, on-the-ground assistance with strategies.”

Other technical assistance resources, such as the KidsWell website and Manatt’s KidsWell reports, did not have as much influence on national grantees’ approaches to advocacy.<sup>3</sup> Only one of 10 national grantees reported that the KidsWell website influenced their advocacy strategy, and only 2 reported the same for the KidsWell reports. However, Manatt’s analytics indicate that the KidsWell website was regularly accessed by a wide variety of users, and that more than 500 federal and state officials subscribed to the KidsWell newsletter, suggesting these resources had some value beyond influencing the KidsWell grantees’ advocacy strategies.<sup>4</sup> State grantees also found “high-touch” technical assistance, such as monthly calls with the foundation, Manatt, and national grantees, to be more valuable than the website or reports. Participation in meetings and calls allowed state grantees to absorb more expertise and ask questions specific to their own state’s environment, more useful than the general information available through other avenues. Twenty-two out of 29 state grantee respondents reported that the monthly calls were valuable to their advocacy efforts, and 13 of those 22 rated the monthly calls as highly valuable. As one grantee representative said, “We find the monthly discussions and annual meeting to be most useful for exchanging information with other grantees. In addition, our calls with our Atlantic program officer are very useful, since she provides technical assistance and strategic input.”

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<sup>3</sup> Outside of the KidsWell grants, Atlantic contracted with SPIN Academy and Spitfire Strategies to provide strategic communications training and support to Atlantic grantees. Six KidsWell state grantees and one national grantee took advantage of these opportunities.

<sup>4</sup> In a fall 2012 online survey of 46 newsletters subscribers, 84 percent indicated they were satisfied or very satisfied with the newsletter.

#### **IV. WHICH ADVOCACY ACTIVITIES DID STATE GRANTEES USE, AND WHICH APPEARED TO BE EFFECTIVE IN ADVANCING POLICIES FAVORABLE TO CHILDREN'S HEALTH CARE COVERAGE?**

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##### **A. Introduction**

When KidsWell began in 2011, the policy landscape for children's coverage was unclear on both national and state levels. On the one hand, passage of the Children's Health Insurance Program Reauthorization Act (CHIPRA) in 2009 infused new funds into the CHIP program, and the percentage of uninsured children had steadily declined both nationally and in each of the seven KidsWell states, due to an increase in Medicaid and CHIP coverage (Harrington et al. 2014). On the other hand, there was substantial uncertainty about the future of children's health care coverage: the ACA had extended CHIP funding only through September 2015; state budgets were under stress, with many states still in or just beginning to exit a recession; and the broader question of the ACA's constitutionality was being challenged in a lawsuit (*National Federation of Independent Business v. Sebelius*) that was winding its way through the U.S. court system.

Given these circumstances, the seven state KidsWell coalitions began mapping out their own plans for advancing children's health care coverage in their states. Each set state-specific policy priorities, some directly related to ACA implementation and others related to state policies governing children's health care coverage. Common priorities included defending Medicaid and CHIP from state budget cuts; Medicaid and CHIP enrollment and renewal policies; and, after the ACA Supreme Court decision in 2012, advocating for the adoption of the ACA-authorized expansion of Medicaid eligibility to low-income adults. In three states, advocates supported development of state exchanges, rather than letting the federal government manage the exchange for their states' residents, based on the expectation that state exchanges would give advocates a stronger voice in influencing exchange policies and benefits affecting children's health care coverage.

Since 2011, KidsWell state grantees reported important policy advances (wins) as well as setbacks (losses) for children's health care coverage in their states. **This evaluation defines a state policy win as legislation or an administrative rule, budget decision, court case, or other state policy action that will increase or accelerate gains in children's health care coverage; a state policy loss is defined as legislation or an administrative rule, funding decision, court case, or other state policy action that reverses, prevents, or hinders gains in children's health care coverage.** Major policy wins reported by the state KidsWell grantees included the establishment of state-based exchanges in California, Maryland, and New York; Medicaid expansion in California, Maryland, New Mexico and New York; and sustaining coverage for children amidst state budget cuts in Texas. KidsWell grantees in Florida and Mississippi saw no state-level policy wins for children, although they reported expanding advocacy capacity and public support for issues that they hope will translate into positive change in the future.

In this chapter, we review progress in achieving ACA implementation policies at the end of 2014 related to children's health care coverage and the advocacy activities that appeared to be most effective, by state. We start by looking at the five states that adopted important coverage

policy advances for children and then examine the two states without major policy wins for children to date.

## **B. State level findings**

### **1. KidsWell states with policy wins**

#### **a. California**

**The most pressing policy issue in California for children’s health care coverage when KidsWell began was trying to prevent elimination of the state’s separate CHIP program, Healthy Families, which covered about 1 million children in 2011.** The program had been under threat since 2009, when the then governor proposed eliminating it to address budget shortfalls, and transfer all enrolled children to Medicaid. Although Medicaid offers protections and benefits that CHIP does not—for example, children in Medicaid can obtain services without cost sharing, and early periodic screening diagnosis and treatment (EPSDT) benefits are mandated—advocates were concerned that lower provider reimbursement rates in Medicaid would jeopardize children’s access to care, that continuity of care would be disrupted if Medicaid provider networks did not include the doctors who had participated in CHIP, and Medicaid might not make as much information about the program publicly available as CHIP had (CHIP and Medicaid were separately administered in California) (Hill, Benatar, and Macri 2013). The debate over terminating the program lasted into Governor Jerry Brown’s first term, when, during a budget impasse in June 2012, the decision was made to end Healthy Families, transitioning all of the CHIP enrollees to Medicaid over the course of 2013.

The KidsWell grantees did not focus exclusively on the proposed elimination of the separate CHIP program. As discussed below, they also worked on supporting the implementation of other ACA provisions in the state. But fighting the elimination of Healthy Families was the biggest focus throughout the KidsWell grant period, and the KidsWell grantees agreed it was their greatest policy loss. Our analysis of activities shows that from October 2011 through December 2014, the California KidsWell coalition undertook 70 distinct activities focused on trying to maintain Healthy Families and ensure a smooth transition of these children to Medicaid after the decision to cut it was made. They also reported an additional 29 activities focused specifically on the state budget for children’s health care coverage (see Table IV.1). Grantees reported using all of the major advocacy activities except litigation in trying to defeat the elimination of Healthy Families.

**California KidsWell grantees also focused on a number of areas to implement ACA provisions, such as securing the Medicaid expansion for low-income adults and adopting a state-based exchange, both of which the state achieved.** These wins likely were never in serious doubt: California was the first state to pass legislation in 2010 authorizing the creation of a state exchange, and given that Democrats led the state house and senate and held the governor’s office, Medicaid expansion was widely expected. While acknowledging the importance of state leaders and other child health advocates on these issues, the KidsWell grantees advocated for these issues in large part to keep children’s issues at the forefront of ACA implementation. For example, among the 13 activities focused on essential health benefits (EHBs), which the qualified health plans participating in the state exchange would be required to cover (see Table IV.1), they recommended inclusion of EPSDT services for children in EHBs,



developed talking points for other advocates about the best way to define EHBs for children, submitted comments on the state’s proposed EHBs for children, and produced an issue brief on the subject, among others.

**Table IV.1. California findings**

Survey report: highest policy priorities 2011–2014	Protecting Medicaid and CHIP budgets, Medicaid eligibility issues, exchange design, Medicaid expansion	
Temporal activities analysis: Main focus of activities 2011–2014	Medicaid/CHIP eligibility (including Medicaid expansion)	70 activities
	State budget related to children’s coverage	29 activities
	Public outreach and education related to the ACA	23 activities
	Defining EHBs to include important children’s benefits	13 activities
	Exchange/marketplace implementation	9 activities
Biggest policy win reported by grantees?	Medicaid expansion; creation of state exchange	
Biggest policy loss reported by grantees?	Loss of separate CHIP and transfer of children to Medicaid	
California grantee respondents’ assessment of most and least effective advocacy activities used to support policy wins/oppose policy losses	<p>Most effective: administrative advocacy, coalition building, direct contact with elected officials, policy analysis</p> <p>Least effective: administrative advocacy, public education/mass media, grassroots organizing/social media, coalition building</p>	

ACA = Patient Protection and Affordable Care Act; CHIP = Children’s Health Insurance Program; EHB = essential health benefits.

**California grantees said that administrative advocacy was one of their most effective activities in advocating for Medicaid expansion and the state exchange but one of the least effective activities in trying to prevent the elimination of the separate CHIP.** Coalition-building and policy analysis were also cited as effective activities to secure these wins, but by fewer respondents (one respondent each cited these as most effective, compared to three respondents citing administrative advocacy as most effective). The fact that administrative advocacy was effective for two issues but not another suggests the importance of matching advocacy activities to each policy goal based on careful analysis, such as which branch of government has the ultimate power to make the decision, something we will explore further in future analyses.

**California KidsWell considered their most effective activities in their fight to prevent the elimination of Healthy Families to be direct contact with elected officials and coalition building; grantees also reported these two capacities to be among the groups’ strongest advocacy capacities.** The four KidsWell grantees partnered with each other as well as other children’s advocacy groups, legislative champions, and health system stakeholders like providers and large hospital systems. As the representative of one grantee said, “Ultimately, despite both houses of the legislature rejecting the governor’s proposal to eliminate Healthy Families during their budget subcommittee process, the governor insisted on the elimination during the final negotiations and prevailed over widespread opposition from a broad coalition that we had assembled.” Even after this defeat, the KidsWell grantees remained focused on this issue, shifting in 2013 and 2014 to efforts to ensure that children would be smoothly transitioned from CHIP to Medicaid and to ensuring coverage of former foster care youth through Medicaid. Four

survey respondents thought there was probably nothing more they could have done to offset this defeat, although one thought more personal stories might have helped: “Governor Brown was moved on immigration issues due to the strength of the Latino vote and personal testimonies.... Throwing more personal stories at the governor ... getting him face to face with kids and families that are not being adequately served by the current health system might have helped.”

## **b. Maryland**

**The Maryland KidsWell grantees sought to convince policymakers to implement ACA in a way that would maximize its potential to provide comprehensive coverage options for children and families.** Maryland’s governor came out early in support of ACA implementation: the day after the ACA’s passage in 2010, he announced formation of a “health reform council” that subsequently held 35 public meetings to obtain consumer input on how the state should implement the ACA. Thus, Maryland grantees did not need to convince policymakers to embrace the ACA. Instead, they focused on promoting ACA-related policies that would take full advantage of its potential to provide comprehensive and continuous health care coverage for children and families. They conducted 20 activities specifically focused on outreach and education, 10 on a variety of rules affecting Medicaid or CHIP eligibility, and 7 on exchange implementation (see Table IV.2). The biggest win reported by the Maryland grantees was securing a set of consumer protections in the state exchange legislation that would benefit children and parents, including provisions to establish a strong consumer assistance program to support enrollment, consumer protections for standalone dental programs, and automatic enrollment for former foster youth in Medicaid when they leave the foster care system at age 18.

As for policy losses, the KidsWell grantees had pushed for the mandatory offer of dental coverage for children in exchange plans, but the state permitted exchange plans to exclude these dental benefits, and consumers were not required to separately purchase pediatric dental coverage. (In contrast, health plans outside of exchanges are not permitted to exclude pediatric dental benefits.) Survey respondents said this proposal failed because state leaders were unwilling to go beyond federal requirements and because there were so many reforms being debated and decided simultaneously that the issue did not emerge as a high priority. However, one respondent said, “It may be possible to change the state’s position on this moving forward.” In fact, since this survey was completed, Maryland changed this rule to require exchange carriers, as well as those outside the exchange, to embed pediatric dental benefits beginning in 2015 (Maryland Health Benefit Exchange 2014).

**Grantees identified coalition building as one key to their policy wins.** Advocates cited a major factor in achieving these wins was their work with other stakeholders, including state Medicaid and insurance program administrators, legislative champions, other child advocates, and health system stakeholders, while acknowledging that strong state leadership on the issues they supported was of vital importance. Policy analysis was also cited as important; for example, to support the consumer protections in the exchange legislation that they ultimately won, they prepared analyses showing the benefits of the various child-friendly policies and submitted proposed amendments to the legislature for consideration. The Maryland grantees reported that their least effective advocacy activities for achieving this policy win were grassroots organizing and public education efforts, likely because the strong support from state leaders carried the day on these issues.

**Table IV.2. Maryland findings**

Survey report: highest policy priorities 2011–2014	Exchange benefit design, Medicaid expansion, avoiding a coverage gap for youth aging out of foster care, open enrollment	
Temporal activities analysis: Main focus of activities 2011–2014	Public outreach and education related to the ACA	20 activities
	Medicaid/CHIP eligibility (including Medicaid expansion)	10 activities
	Exchange/marketplace implementation	7 activities
	Defining EHBs in the state insurance exchange to include important children's benefits	5 activities
Biggest policy win reported by grantees?	Exchange benefit provisions, including rules related to Navigator program, automatic enrollment of foster children who turn age 18, and stakeholder advisory committee	
Biggest policy loss reported by grantees?	Mandatory offer of pediatric dental coverage and offer of stand-alone pediatric dental plans in exchange	
Maryland grantee respondents' assessment of most and least effective advocacy activities used to support policy wins/oppose policy losses	Most effective: coalition building, direct contact with elected officials, policy analysis	
	Least effective: public education/mass media, grassroots organizing/social media, direct contact with elected officials	

ACA = Patient Protection and Affordable Care Act; CHIP = Children's Health Insurance Program; EHB = essential health benefits.

### c. New Mexico

**The New Mexico KidsWell grantees focused their initial efforts on securing Medicaid eligibility expansion in the state.** One of the poorest states in the country—in 2013, New Mexico ranked second to last both in the percentage of people with income below the poverty line and percentage of children under 18 in families with income below the poverty line (U.S. Census Bureau 2013a, 2014b)—the state nevertheless had relatively high family income eligibility levels in Medicaid and CHIP for children over the past decade. However, administrative policies such as requiring beneficiaries to submit recertification documents every six months hampered enrollment and retention efforts. To pursue the Medicaid expansion, the KidsWell grantees conducted 26 specific activities focused on that issue, with another 10 activities focused on exchange implementation and 9 on ACA education and outreach (see Table IV.3). Grantees report two policy losses: first, an inability to secure express lane eligibility, which they believed would help to enroll 30,000 eligible but unenrolled children; and second, early childhood education policies (as part of a larger child welfare agenda).

**The New Mexico grantees believe policy analysis, coalition building, and direct contact with elected officials were among the most effective advocacy activities, which, along with favorable public opinion, helped secure the Medicaid expansion.** The New Mexico grantees conducted careful policy analysis to show the economic benefits of coverage expansion. They also used administrative advocacy for both policy wins and losses, but they viewed this activity as the least effective of those they tried. It is worth noting that neither of the funded grantees in New Mexico reported having a strong relationship with the state Medicaid agency, which made administrative advocacy more difficult for them and possibly put them at a disadvantage in advocating for changes to administrative rules and procedures. Interestingly, while they viewed coalition building as an important factor in achieving the Medicaid expansion, they reported not doing well in building coalitions to support early childhood education; as one respondent said:

“Coordinating with other advocates on similar issues to have one coherent message on child welfare might have prevented this loss. We were all battling our own fires.” On their inability to get express lane eligibility implemented, one grantee suggested that future policy analysis and policymaker education might work: “I think we could do more in educating policymakers about the inequity that has occurred in children's coverage—over 90 percent of unenrolled children are from Native American or Latino families in New Mexico. There are particular barriers in these communities that must be addressed, and this level of racial inequity is something that several key legislators may respond to and champion.”

**Table IV.3. New Mexico findings**

Survey report: highest policy priorities 2011–2014	Medicaid eligibility expansion, Medicaid/CHIP enrollment and renewal procedures, outreach and application assistance, state budget decisions	
Temporal activities analysis: Focus of activities 2011–2014	Medicaid eligibility (including Medicaid expansion)	26 activities
	Exchange/marketplace implementation	10 activities
	Public outreach and education related to the ACA	9 activities
	Basic Health Program	8 activities
Biggest policy win reported by grantees?	Medicaid expansion	
Biggest policy loss reported by grantees?	Express lane eligibility and early childhood education	
New Mexico grantee respondents' assessment of most and least effective advocacy activities used to support policy wins/oppose policy losses	Most effective: policy analysis, coalition building, direct contact with elected officials	
	Least effective: administrative advocacy, coalition building	

ACA = Patient Protection and Affordable Care Act; CHIP = Children's Health Insurance Program.

#### d. New York

As in California and Maryland, the New York KidsWell grantees sought to ensure that state implementation of ACA provisions would maximize children's health care coverage, focusing its efforts primarily on design of the state exchange and convincing the state to implement a Basic Health Program option. As Table IV.4 indicates, the majority of KidsWell grantees' activities focused on outreach and education about new ACA coverage options (31 activities), followed closely by exchange design and implementation (29 activities). The establishment of a single-portal exchange, which works as a one-stop shopping site where families can apply for coverage through Medicaid, CHIP, or the exchange, was viewed by grantees as their biggest policy win to date. As one grantee said, “Building a one-stop shop exchange is a credit to advocates and state officials working together to make sure function and form met.” The New York grantees also helped secure the adoption of the Basic Health Program option,<sup>5</sup> passed by the legislature in 2014. New York grantees reported they have not had any significant losses to date, although they have not been able to secure guaranteed long-term funding for application assistance programs for consumers. And even though New York covers

<sup>5</sup> The Basic Health Program, authorized by Section 1331 of the ACA, gives states the ability to provide more affordable coverage for low-income residents who do not qualify for Medicaid, CHIP, or other minimum essential coverage and have income between 133 percent and 200 percent of the federal poverty level and to improve continuity of care for people whose income fluctuates above and below Medicaid and CHIP levels.

legally residing immigrant children, grantees believe there are still educational barriers for these families to seek coverage that need to be overcome.

**Table IV.4. New York findings**

Survey report: highest policy priorities 2011–2014	State exchange design, Basic Health Program	
Temporal activities analysis: Focus of activities 2011–2014	Public outreach and education related to the ACA	31 activities
	Exchange/marketplace implementation	29 activities
	Other (overall well-being for children and families and dental health)	16 activities
	State budget actions	12 activities
	Medicaid/CHIP eligibility (including Medicaid expansion)	11 activities
	Basic Health Program	9 activities
Biggest policy win reported by grantees?	Establishing a single-portal state exchange	
Biggest policy loss reported by grantees?	Long-term funding for the consumer assistance program	
New York grantee respondents' assessment of most and least effective advocacy activities used to support policy wins/oppose policy losses	Most effective: administrative advocacy, coalition building, direct contact with elected officials	
	Least effective: grassroots organizing/social media	

ACA = Patient Protection and Affordable Care Act; CHIP = Children's Health Insurance Program.

**The New York grantees found administrative advocacy, coalition building, and direct contact with elected officials to be the most effective advocacy activities, which provide support to strong state leaders who act as legislative champions on key children's coverage issues.** Insuring children in New York has always been a policy priority, enjoying political support from both parties since the 1980s. As one grantee said, “We are fortunate in New York that our policymakers understand the importance of covering children. What is most helpful to keep advancing the issue is making sure we can show the cost-effectiveness of preventive services, illustrate barriers families face in accessing or renewing coverage and quality services, [and the] importance of language-accessible information about coverage.” Grantees all agreed their use of grassroots organizing and social media were the least effective activities they used in pushing for policy gains, perhaps because key stakeholders did not need large public show of support to be convinced on these issues.

#### e. Texas

**Texas KidsWell grantees faced an uphill battle, with state elected leaders strongly opposed to the ACA.** As Table IV.5 shows, Texas grantees' activities zeroed in on Medicaid eligibility expansion and informing the public about ACA coverage options (42 activities each) and cited the failure to expand Medicaid as their biggest policy loss. Grantees believe there was little they could do to change the outcome and they have little optimism for future change on the issue, given the political context in the state: “I don't think that we could have done more. This was dead in the water. Moving forward, our returning legislators don't want to touch health coverage with a ten-foot pole due to smear campaigns in the primaries that painted them as pro-Obama due to their willingness to have this bill heard on the floor.”

Despite a large state budget deficit in 2011, the KidsWell grantees were successful in fighting off proposed budget cuts that would have impaired the eligibility processing system and imposition of an across-the-board 10 percent cut to provider reimbursement rates, both wins for children's coverage. The grantees noted that consumers helped support this win by flooding legislators' offices with constituent calls. However, the advocates acknowledged that this victory had unintended costs for Texas children, as these budgets were saved at the expense of cuts in state education funding (which was not the intention of the KidsWell grantees).

**Table IV.5. Texas findings**

Survey report: highest policy priorities 2011–2014	Medicaid eligibility expansion, outreach, application assistance	
Temporal activities analysis: Focus of activities 2011–2014	Medicaid eligibility (including Medicaid expansion)	42 activities
	Public outreach/education related to ACA coverage options	42 activities
	Other (budget, overall well-being of children and families, legislative agenda)	23 activities
	Exchange/marketplace implementation	12 activities
Biggest policy win reported by grantees?	Sustaining coverage amid budget cuts	
Biggest policy loss reported by grantees?	Failure to expand Medicaid	
Texas grantee respondents' assessment of most and least effective advocacy activities used to support policy wins/oppose policy losses	Most effective: coalition building, public education/mass media, direct contact with elected officials	
	Least effective: administrative advocacy, grassroots organizing/social media, public education/mass media, direct contact with elected officials	

ACA = Patient Protection and Affordable Care Act.

**Coalition building, public education/mass media, and direct contact with elected officials were cited as most effective advocacy activities used by the Texas grantees.** Texas was the only state in which grantees named public education/mass media as a most effective activity. For example, one public education activity that gained a lot of traction in this period was grantees' decision to create a bilingual site (accessed via internet or an 800 number) called Texas Left Me Out to help collect family stories of those without any access to affordable coverage options. Grantees viewed this as an effective way to collect stories and to engage other groups to collaborate on coverage issues. Administrative advocacy, grassroots organizing, public education, and direct contact with elected officials each were named by at least one Texas respondent as least effective to their efforts. Despite setbacks, the grantees remained focused on trying to provide support to children's coverage while the legislature is out of session, such as preparing to make the most of the open enrollment period for 2015 and continuing Medicaid and CHIP outreach efforts.

## 2. KidsWell states without policy wins so far

### a. Florida

**With an estimated 300,000 uninsured children eligible but not enrolled in Medicaid and CHIP, the Florida KidsWell grantees focused on trying to make it easier for families to enroll children into these programs.** When KidsWell began in 2011, prospects for either

Medicaid expansion or a state exchange looked dim: Florida was the lead plaintiff in the lawsuit seeking to declare parts of the ACA unconstitutional, and the state had rejected an exchange planning grant worth \$1 million. Thus, the KidsWell coalition advocated for policies that would support enrollment of the many children in the state who were already eligible but not enrolled in public coverage, which was more politically feasible to pursue given the state environment. They also sought to persuade the state to expand coverage to children of lawfully residing immigrant children, an option permitted by CHIPRA. As Table IV.6 shows, there were 74 distinct activities related to Medicaid and CHIP eligibility issues, such as press releases and blog posts supporting both expansion of coverage to legal immigrant children and adoption of a presumptive eligibility policy, hosting a family health expo to provide application assistance directly to families, and others. Beginning in 2012, the grantees also began trying to rally support for the Medicaid expansion to adults as well, which, if passed, could help to cover more children, since they are more likely to have insurance when their parents have it too. Among the 48 activities focused on ACA implementation were a rally at the state capital, a webinar reviewing the effects of not expanding Medicaid on uninsured Floridians, and disseminating information on coverage options and health plans available to Floridians through the ACA.

**Table IV.6. Florida findings**

Survey report: highest policy priority/priorities 2011–2014	Medicaid and CHIP enrollment and renewal, in particular covering children of lawfully residing immigrant residents	
Temporal activities analysis: Main focus of activities 2011–2014	Medicaid/CHIP eligibility (including Medicaid expansion)	74 activities
	Public outreach and education related to the ACA coverage options	48 activities
	Exchange/marketplace implementation	19 activities
Biggest policy win reported by grantees?	No policy wins at the state level; ACA policies that apply to all states seen as “wins” for Florida’s children, such as requiring private plans to allow children to be covered through a parent’s plan through age 26	
Biggest policy loss reported by grantees?	Failure to pass bills that would have extended Medicaid and CHIP coverage to legally residing immigrant children	
Florida grantee respondents’ assessment of most and least effective advocacy activities used to support policy wins/oppose policy losses	Most effective: coalition building, direct contact with elected officials, administrative advocacy	
	Least effective: public outreach/education efforts	

ACA = Patient Protection and Affordable Care Act; CHIP = Children’s Health Insurance Program.

**Despite advocacy efforts of the KidsWell grantees, Florida did not adopt any policies that would help to expand children’s coverage.** The biggest defeat came in 2014 when, according to grantees, “despite significant progress” in the 2013 and 2014 legislative sessions and bipartisan support that the KidsWell grantees helped secure, a bill that would have expanded coverage to legally residing immigrant children failed to pass because of opposition in the Florida senate; the grantees plan to pursue the issue again in 2015. The only progress on children’s coverage came through ACA provisions that are required in all states; grantees cited the importance of new federal rules, such as extending private coverage to children on their parents’ policies up to age 26 and covering former foster care youth through Medicaid up to age 26.

**All four Florida respondents reported in the survey that collectively, their advocacy strengths were coalition building, relationships with state officials, allowable lobbying, and communications, and these were the main activities used to push for policy changes in the state.** Despite losses, grantees reported coalition building, direct contact with elected officials, and administrative advocacy as the most effective activities in securing political and public support. In contrast, public outreach and education efforts were viewed as least effective. One grantee thought they could have done a better job with the use of personal stories, to put a face on the issue. They intend to renew efforts at collecting and publicizing individual stories in the coming year, according to two respondents. But the political environment in the state remains challenging, with a Republican-led house and senate and a Republican governor all focused on fiscal restraint and, according to grantees, a strong anti-immigrant sentiment in many areas of the state.

#### **b. Mississippi**

**When KidsWell began, the grantees were optimistic about prospects for the state to take advantage of ACA options for expanding coverage.** When KidsWell began in 2011, Mississippi's Insurance department was devoting significant resources to planning for a state-based exchange, believing it would give the state more control over the insurance marketplace (Steenhuysen 2013). The KidsWell grantees advocated for state adoption of the Medicaid eligibility expansion for low-income parents and adults, along with other ACA-related provisions that were subject to state discretion (see Table IV.7). For example, the grantees developed an issue brief to educate policymakers about the importance of reform for Mississippi, and met with the Insurance Commissioner, Medicaid director, and allies in the state legislature. However, in January 2012, a new Governor, Republican Phil Bryant, took office; Bryant made it clear he would not implement any aspects of the law (Varney 2014). Although the Insurance Commissioner persisted in trying to implement the state exchange, HHS did not want to wade into the middle of an argument between two state officials, and it denied the state's application to run a state exchange—making Mississippi the only state HHS turned down (Steenhuysen 2013; Varney 2014).

**The Mississippi KidsWell grantees therefore focused on trying to eliminate bureaucratic and administrative barriers to enrollment and renewal in Medicaid and CHIP.** Faced with these losses, the grantees focused on what they considered to be more winnable issues. With Mississippi among the poorest states in the nation on a number of economic metrics, its Medicaid and CHIP policies created a number of barriers to enrollment and renewal that left many eligible children uncovered (estimated at 43,000 children in 2011 [Kenney et al. 2013]). For example, Mississippi was the last state to still require a face-to-face interview to enroll in Medicaid or to renew coverage (a requirement eliminated by the ACA effective January 2014), and it did not have an online application available as of 2013 (Heberlein et al. 2014). Although it was not a state policy win, the ACA rule requiring all states to eliminate face-to-face interview requirements was considered a huge improvement for Mississippians.



**Table IV.7. Mississippi findings**

Survey report: highest policy priority/priorities 2011–2014	Medicaid and CHIP enrollment and renewal, Medicaid eligibility expansion, Medicaid or CHIP outreach and application assistance	
Temporal activities analysis: Focus of activities 2011–2014	Medicaid eligibility (including Medicaid expansion)	8 activities
	Public outreach and education related to the ACA coverage options	5 activities
	Application assistance/ Navigators	2 activities
Biggest policy win reported by grantees?	None but ACA policies required in all states were seen as “wins” for Mississippi’s children, particularly removal of face-to-face enrollment rules	
Biggest policy loss reported by grantees?	Failure to expand Medicaid and the implementation of managed care in Medicaid and CHIP	
Grantees’ assessment of most and least effective advocacy activities used to support policy wins/oppose policy losses	Most effective: coalition building, grassroots organizing/social media	
	Least effective: administrative advocacy, policy analysis, direct outreach to elected officials	

ACA = Patient Protection and Affordable Care Act; CHIP = Children’s Health Insurance Program.

**The grantees reported that coalition building and policy analysis were among their greatest strengths, but when it came to trying to secure state ACA implementation, coalition building was viewed as one of their most effective activities, and policy analysis among the least effective.** The KidsWell grant helped grantees expand their coalition into some of the poorest areas of the state in the Mississippi Delta region, in particular by allowing them to use social media and grassroots activities to educate residents. Despite losses—including not being able to secure Medicaid expansion for low-income parents and the implementation of managed care in Medicaid and CHIP, which grantees believe adversely affected access and continuity of care in rural areas, where managed care networks included few physicians—they view this outreach, particularly to youth and young adults, as having the potential to sway policy in the future by empowering residents to have a powerful and influential voice in the media and policy arenas as well as through a better informed electorate. Grantees reported that administrative advocacy, policy analysis, and outreach to elected officials were their least effective activities, with one grantee reporting “we’d have to elect different legislators” to have changed the outcomes. Two grantees suggested that the use of more personal stories about the loss of long-time personal physicians might have changed legislators’ minds about implementing managed care in Medicaid, although others suggested nothing would have changed the outcome since legislators considered managed care to be an important way to achieve savings in the program. The governor’s staunch opposition to the ACA was a barrier that the grantees could not overcome, although the KidsWell grantees remain optimistic that continued advocacy work could change the policy landscape for children’s coverage in the next few years.

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## V. DISCUSSION AND NEXT STEPS

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When KidsWell began in 2011, there was uncertainty about how federal and state governments would execute all ACA provisions and coordinate those implementation efforts with Medicaid and CHIP. As of early 2015, there has been enormous progress in reducing the number of people without health insurance: states and the federal government have set up exchanges, and despite a rough start with operations of the federal exchange and some state exchanges, over 11 million people have signed up for new coverage or renewed existing coverage for plans purchased in those exchanges (with subsidies for those who qualify) and another 9 million have gained coverage through expanded Medicaid eligibility in 28 states and the District of Columbia (Rattner 2015). More children have gained coverage in this period as well, with the rate of uninsured children dropping from 7.5 percent in 2011 to 7.1 percent in 2013 (Alker and Chester 2014).

While gains in children's health insurance coverage throughout the last decade are important, the complexity and variability of public insurance programs across states, as well as the future of national policy regarding children's coverage, place these advances at risk. First, the legality of premium subsidies for those who enroll through the federal exchange is in question, as the U.S. Supreme Court prepares to decide *King v. Burwell* in 2015, and the Department of Health and Human Services has announced it has no backup plan if the ACA premium subsidies are struck down. Second, the ACA authorized funding for CHIP only through September 2015, and Congress has yet to decide whether to continue CHIP funding past this date. Moreover, there is no transition plan for ensuring that CHIP-enrolled children will be covered after that date should funding not be reauthorized.

With the policy environment in continued flux, advocacy at both national and state level is needed to ensure that gains in children's coverage are not lost and that progress continues toward insuring all children. Atlantic Philanthropies provided generous funding and technical resources for this advocacy effort over an extended period to try to strengthen grantees' capacities and networks in the hopes of achieving lasting systems change so that universal children's coverage can become a reality. As Atlantic prepares to exit philanthropy, this is an important juncture to examine KidsWell grantees' progress towards these goals. Here, we summarize and discuss the key findings to date about this initiative regarding the contribution of Atlantic's investment strategy and engagement with KidsWell grantees to strengthening advocacy capacities and networks, and which advocacy activities appear to have been most effective in securing policy advances for children's health coverage so far.

**Careful vetting of grantee organizations helped ensure that the organizations given grants were capable of undertaking strong advocacy campaigns and combining their knowledge and skills.** Atlantic sought to maximize its investment by intentionally funding capable children's advocacy organizations with different strengths who could partner to advance ACA implementation within the target states. According to grantee representatives, at least one organization in each state reported having strength in each of the core advocacy strategies with one exception (in one state, neither grantee had a strong relationship with the state Medicaid agency). In a few states, the desire to fund organizations that in combination had all advocacy skills led to "arranged marriages" of partners that had not worked together previously, creating

challenges for groups with different approaches to advocacy. Tensions were apparent in a few states at the outset, but over time these strains seem to have abated as groups learned to collaborate and leverage each other's strengths, sometimes with the help of project-provided technical assistance. At the time of the survey in mid-2014, grantees in all states reported consistent policy goals, strategies, wins, losses, and assessment of partner strengths within state coalitions, indicating strong alignment.

**KidsWell funding and resources helped grantees develop effective advocacy campaigns by strengthening both partnerships within states and specific advocacy capacities.** Grantees cited the most important contribution of KidsWell support as building strategic partnerships within their states. The KidsWell grants permitted grantees to hire new staff to enhance their own organizations' skills to carry out advocacy; facilitated internal collaborations to help groups leverage and capitalize on members' strengths; and supported information sharing between national and state grantees and across states. Besides expanding strategic partnerships, grantees reported that they were able to enhance several capacities, including communications and media, policy or legal analysis, grassroots organizing and mobilization, and coalition building. Atlantic's support was also helpful in securing additional support for children's advocacy efforts; 9 of 10 national grantees and 10 of 20 state grantees reported that the KidsWell grants helped them leverage additional funding for work on children's health care coverage. This issue will be examined in more detail in the final evaluation report, where we assess the sustainability of these advocacy efforts when KidsWell funding ends; the fact that KidsWell helped grantees garner additional support for children's coverage, especially at a time when the media, state legislatures, and other funders were focused on adult coverage, appears to be an important legacy of the KidsWell initiative.

**KidsWell created opportunities for national-state collaboration, although the strongest national-state partnerships predated KidsWell.** State grantees reported that when they worked with national grantees, the technical assistance they received expanded their skills or knowledge, helping them to become more effective in their work. However, a few state grantees did not need or want help or expertise from the national partners, and Atlantic supported this evolution; neither Atlantic nor the national partners have been prescriptive about the strategies and campaigns that the state grantees undertake. There was more collaboration between state and national partners who had worked together prior to KidsWell, and when circumstances made sense (for example, as noted earlier, two grantees cited the work New America Media did with them on engaging ethnic media as highly valuable, expanding their capacity to do this work in their states). Nonetheless, state grantees' exposure to national organizations during the KidsWell grant period may enhance future collaboration.

**In all seven states, grantees reported coalition building and direct contact with elected officials to be their most effective activities, while administrative advocacy, mass media, and grassroots organizing were viewed as least effective in four states each.** More than 70 percent of state grantees believed that coalition building, lobbying, policy analysis, and relationships with elected officials were most effective in securing policy advances to date. However, which advocacy activities work best in any given situation appears to depend on state context and the specific policy goal. For example, where key policymakers were seriously considering Medicaid eligibility expansion and state exchange sponsorship, as in California, Maryland, New Mexico, and New York, policy analysis was more likely to be cited as an

important input to the debate. In Florida, Mississippi, and Texas, where state policymakers were overwhelmingly opposed to these policies, advocates focused on trying to make it easier for eligible children to enroll in and renew coverage under existing Medicaid and CHIP programs. Along with coalition building and contact with elected officials, grantees in these states viewed administrative advocacy (in Florida and Mississippi), grassroots organizing (Mississippi) and public media campaigns (Texas) as the most effective strategies to achieving these goals. We will examine this issue in more detail in future work through interviews with state policy stakeholders to understand their perceptions of the grantees' contribution to policy change and of the relationship between grantees' advocacy activities and effectiveness.

**Looking ahead.** This interim report has focused on what grantees believe they have been able to achieve with KidsWell support received so far. The KidsWell grantees have nearly two years of funding remaining to continue advocating for policies that guarantee health coverage for all children, and they still face a long slate of issues that will determine whether the potential of the ACA to provide universal coverage and access to care for children is realized. In the final report to be issued in 2016, we will compare grantee perceptions with those of key policymakers and other stakeholders in the seven target states regarding the role of consumer advocacy groups in shaping policies for children's health coverage, the effectiveness of the grantees' advocacy activities, and which issues and advocacy activities they expect to be important in the future. The final report will present overall conclusions about and lessons drawn from the contribution of the KidsWell initiative to policies that expand and maintain children's health care coverage. It will also draw conclusions about what can help to sustain these gains and networks after the end of KidsWell funding.

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