

REPORT

FINAL REPORT

Securing Coverage for Children by Advocating for the ACA: Experiences from the KidsWell Grantees in New Mexico and New York

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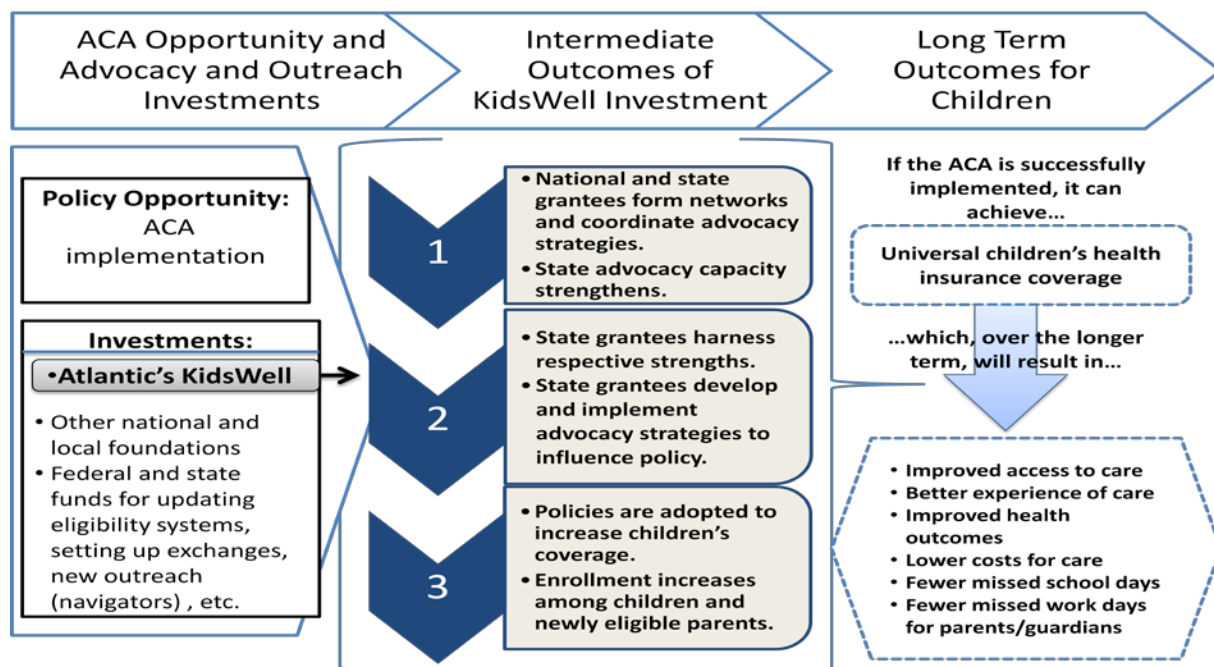
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I. INTRODUCTION

The expansion of Medicaid eligibility to low income adults and subsidies to purchase private insurance are arguably the most significant provisions of the Affordable Care Act (ACA). To the extent these measures reduce rates of uninsured parents, they could also help to close the gap in children's coverage, 7.2 million of whom were uninsured in 2012 (Finegold 2013). States are on the front-line of ACA implementation: their success in enrolling uninsured parents and their children depends on the effectiveness of state policies and systems for operating one-stop shopping portals, conducting outreach to low income families, helping them apply for insurance, and creating consumer-friendly communication about families' coverage options and their costs.

Recognizing the ACA as a crucial opportunity to close the children's coverage gap, the Atlantic Philanthropies launched its "KidsWell" campaign in 2011 to maximize the ACA's potential to ensure health insurance coverage for all children and to build a lasting child advocacy infrastructure for children's health.¹ In choosing where to invest, Atlantic selected states with diverse economic and political conditions with large numbers of uninsured children, and with strong advocacy organizations already in place. The seven KidsWell states—California, Florida, Maryland, Mississippi, New Mexico, New York, and Texas—also 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 federal health reform, while at the other end, Florida and Texas actively oppose actions that support ACA implementation. The other KidsWell states fall at different points along this continuum. Atlantic also invested nearly \$19 million in 12 national organizations to provide strategic support and advice to the state grantees. Figure 1 shows the campaign's theory of change.

Figure 1. KidsWell evaluation theory of change



This brief describes experiences of the KidsWell grantees in New Mexico and New York, including the starting points for children’s coverage in each state as well as their advocacy strategies and policy wins to date.² It is based on site and telephone interviews with the New Mexico and New York KidsWell grantees, as well as other consumer advocates, health system stakeholders, legislative representatives, and Medicaid, Children’s Health Insurance Program (CHIP), and exchange administrators, and on reviews of grant-related records and published documents. To provide context for the policy landscape in New Mexico and New York before ACA implementation, Section II provides background information, describing the political environment and status of children’s health coverage policies in each state, along with a description of the KidsWell grantees and their policy priorities. Section III describes the grantees’ advocacy strategies, campaigns, and policy wins. Finally we draw some takeaway findings for other advocates and funders based on these experiences, presented in Section IV, while Section V presents some final thoughts about expected upcoming roles for advocates.

II. CONTEXT

A. New Mexico

1. Context for ACA Implementation

Political Environment. Republican Susana Martinez, the state’s first female Latina governor, was elected in 2010, replacing Democrat Bill Richardson who was term limited after serving two full terms. A former public prosecutor, Martinez ran for office on a platform of fiscal conservatism, jobs creation, and a commitment to balancing the budget while protecting “...core priorities like classroom spending in education and healthcare for those most in need...” (Martinez 2011). Advocates speculate that her position on health care may reflect her own experience having a sister with a developmental disability.

The state has a traditional or “citizen” legislature, with relatively short sessions (30 days in even-numbered budget years and 60 days in odd numbered non-budget years) and relatively few staff, giving the Executive branch greater power to set policy. Currently, both the House and Senate are controlled by Democrats (Table 1).

Children’s Coverage and CHIP/Medicaid Policies in New Mexico. New Mexico’s support for children’s insurance coverage is somewhat mixed. The state had relatively high family income eligibility levels for children over the past decade: 235 percent of the federal poverty level (FPL) in CHIP and 185% of the FPL in Medicaid through the end of 2013; starting January 1, 2014, the income eligibility level for CHIP was increased to 300 percent of the FPL for children ages 0 to 5, and 240 percent of the FPL for children ages 6 to 18. However, administrative policies under former Governor Richardson and current Governor Martinez have hindered children’s enrollment and retention. For example, in July 2004, the Human Services Department began requiring Medicaid recertification for enrolled children every six months to retain coverage, a process that previously occurred annually (and was reinstated beginning January 1, 2006). In 2011, the New Mexico Human Services Department began requiring nonenrolled parents to present proof of citizenship or legal residency and a Social Security Number when their Medicaid-enrolled infant recertified at age one, even if the infant was enrolled at birth in the United States or parents have already verified the infant’s citizenship (Miles 2005; New Mexico Human Services Department 2006).

Table 1. Case study states: New Mexico and New York

| | New Mexico | New York |
|--|--|--|
| State context | | |
| Political environment (2014) | Governor: Susana Martinez (R) Senate: 25 D, 17 R House: 37 D, 33R | Governor: Andrew Cuomo (D) Senate: 28 D, 29 R, 4 I House: 101 D, 40 R, 1 I |
| Medicaid/CHIP upper income eligibility limit | 2010: 235% of FPL 2014: Ages 0-5: 300% of FPL Ages 6-18: 240% of FPL | 2010: 400% of FPL; children from families with income above this level can buy-in 2014: 400% of FPL; children from families with income above this level can buy-in |
| Children's Medicaid/CHIP participation rate (2011) | 90% | 92% |
| Uninsured children (2012) | 30,000 (8% of all children) | 160,000 (4% of all children) |
| Economics and demographics (2012) | Children in Poverty: 29% Population below poverty: 21% Population by Race: Hispanic 47% White 40% American Indian 10% Black 3% Asian 2% | Children in Poverty : 23% Population below poverty: 16% Population by Race: White 58% Hispanic 18% Black 18% Asian 8% |
| KidsWell grantees | | |
| Lead KidsWell grantee | New Mexico Center on Law and Poverty (CLP) | Community Service Society of New York (CSS) |
| Other funded KidsWell organization(s) | New Mexico Comunidades en Acción y de Fe (CAFé) | Schuyler Center for Analysis and Advocacy (Schuyler) Children's Defense Fund of New York (CDF-NY) Make the Road New York Raising Women's Voices |
| Funding start date | July 2011 | April 2011 |
| Total KidsWell funding, 2011-2013 | \$800,000: CLP received \$580,000 and CAFé received \$220,000 over the three-year grant. | \$750,000: CSS received \$300,000; Schuyler received \$180,000; and CDF-NY, Make the Road New York, and Raising Women's Voices each received \$90,000 over the three-year grant. Atlantic also granted an additional \$150,000 to the group to support communications (for example, to buy paid media). |

Sources: Grantee interviews; Kids Count Data Center 2013; Bishaw 2013; U.S. Census Bureau 2014; Kenney et al 2013; National Academy for State Health Policy 2010.

Notes: ACA = Affordable Care Act; CAFé = New Mexico Comunidades en Acción y de Fe; CDF-NY = Children's Defense Fund of New York; CLP = New Mexico Center on Law and Poverty; CSS = Community Service Society of New York; D= Democrat; FPL = Federal Poverty Level; I = Independent; R=Republican. Due to rounding, the population by race statistics do not total 100%.

Several of the people we interviewed characterized the current administration as favoring policies that “promote independence,” which make it more difficult to receive public benefits. Perhaps because of this, New Mexico has a relatively high eligible but not enrolled (EBNE) population: 8 percent (30,000) of children 18 and younger are uninsured, and the state ranks 37th out of 50 states in the percentage of uninsured children (State Health Access Data Assistance Center 2013). As of 2011, children’s Medicaid and CHIP participation rate in the state was 90 percent (Kenney et al. 2013).

Previous state initiatives to expand coverage to uninsured adults include the State Coverage Insurance (SCI) program and the New Mexico Health Insurance Alliance (NMHIA). Funded through a Medicaid Section 1115 waiver approved in 2002, SCI provides health coverage for low-income childless adults and parents of children eligible for Medicaid and CHIP who are not eligible for Medicaid and are between ages 19 and 64 with incomes up to 200 percent FPL. However, under the terms of the federal waiver, SCI enrollment was capped and it reached the maximum of 40,000 in 2008 (New Mexico Voices for Children and the New Mexico Center on Law and Poverty 2009). To increase access to private health insurance, the state legislature authorized the establishment of the NMHIA in 1994 to offer health plans to small businesses, self-employed, and qualified individuals who otherwise do not qualify for commercial health insurance. Because of high premiums, enrollment in NMHIA has been relatively low—about 4,300 in 2012—but NMHIA was considered to be a precursor to a state-based exchange, which would benefit from federal subsidies for plans purchased through state marketplaces.

2. KidsWell Grantees in New Mexico

As the lead KidsWell grantee in New Mexico, the New Mexico Center on Law and Poverty (CLP) focuses on improving economic and social justice through advocacy, community organizing, litigation, and training. Established in 1995 as a 501(c)(3) organization, CLP has 15 full-time staff and five focus areas including (1) health care, (2) public benefits programs and access, (3) workers’ rights, (4) civil legal services, and (5) public education. CLP received its \$800,000 multiyear grant from Atlantic for KidsWell in 2011; that amount included its subgrant to New Mexico Comunidades en Acción y de Fe (CAFé), located in Las Cruces. Also a 501(c)(3), CAFé is part of the PICO National Network, the largest faith-based community organization in the country. CAFé’s mission is to engage, recruit, train, and build the capacity of low-to-moderate income individuals and families to advocate for policies that improve New Mexican residents’ quality of life. To do so, CAFé works on five issues: (1) wages/economic security, (2) predatory lending, (3) health care, (4) access to public benefits, and (5) voting registration. Compared to CLP, CAFé is a small organization in the state, growing from one staff person in 2009 to five in 2014.

CLP coordinates its health advocacy strategies with other consumer advocacy groups in the state. It works closely with New Mexico Voices for Children (Voices), a nonpartisan, nonprofit 501(c)(3) organization founded in 1987 that champions public policies to improve the status and well-being of children, families, and communities in health, education, and economic security. Until recently, Voices focused on children’s health issues through its participation in the Packard Foundation’s Finish Line project. Since that grant ended, Voices has been unable to devote as much time or resources to health care, but it still convenes the Medicaid Coalition, an informal coalition composed of nine organizations that share information and coordinate strategies to

support the Medicaid program. CLP also participates in the Health Care for All Coalition, which advocates for ACA implementation with a focus on adults. This coalition includes many of the same groups as those in the Medicaid Coalition and a few others representing seniors and disability-oriented groups.

Grantee Strengths. CLP’s primary strengths relevant to ACA implementation and children’s health insurance advocacy include its (1) technical expertise, (2) strategic planning, and (3) partnerships. CLP approaches problems from a legal perspective, includes experts in the legislative process, and can litigate when it deems such action necessary. As lawyers, staff members bring a specialized skill set to the table when analyzing issues and strategizing responses. CLP staff believed that their in-depth knowledge of 2,000 pages of ACA statutory provisions and dozens of regulations, as well as the mandates and options available to states, enabled them to develop advocacy goals and strategies tailored to New Mexico. As a faith-based non-profit, CAFé’s main strengths are community-based organizing, leadership development, and civic engagement in some of the most underserved and high-need communities in New Mexico, including Doña Ana and surrounding southern counties. Through CAFé, CLP is able to broaden its reach in southern New Mexico. CAFé is also located in Governor Martinez’s hometown of Las Cruces.

CLP conducts annual, coordinated planning to align its efforts with other stakeholder organizations. As part of this process, it identifies who is best positioned to carry its message to policymakers. If CLP does not have close ties with key decision makers, it identifies potential allies who are better placed to reach them. They also have learned from previous experience “what works” in the state, which taught them to blend personal stories with their traditional legislative, legal, and administrative advocacy. For example, to address provisions in a proposed Medicaid redesign that attempted to increase copays and end retroactive coverage, CLP pursued a two-pronged approach, using the regulatory comment opportunity and filming youth discussing how the Medicaid changes would impact their lives. It used a similar approach to advocate for Medicaid expansion (explained in detail in Section III).

CLP also places emphasis on developing relationships with providers, advocacy organizations, and professional organizations at the state level. These relationships provide timely information that helps CLP to respond quickly to new policy changes or proposals. For example, in addition to its coalitions with other consumer advocates, CLP was in regular contact with the New Mexico Hospital Association, New Mexico Medical Society, and New Mexico Pediatric Society to coordinate efforts to try to influence the governor’s decision regarding Medicaid expansion (discussed in Section III).

Use of KidsWell Funds. Anticipating that ACA implementation would face political hurdles in a state with a Republican governor, CLP viewed Atlantic funding as a way to enhance its advocacy and organizing infrastructure and to conduct outreach to help New Mexican children and families access health care and coverage. CLP has primarily used Atlantic funding to (1) increase its health care staffing to support Medicaid advocacy and ramped-up ACA implementation work and (2) develop ACA resource materials such as “Understanding Healthcare Reform: A Resource Guide for New Mexico,” which has been widely distributed in print and online, as well as materials specific to Native American and immigrant children on Medicaid. Given that CAFé is the only community-based organization involved in health care

work in the southern part of the state, its KidsWell funds have largely been directed at building capacity of the organization to address its five priority areas. For example, CAFé has used the grant to connect CLP to organizations in southern New Mexico, develop a user-friendly ACA training for community advocates, support advocacy training in Doña Ana County and health enrollment fairs, and develop relationships with two schools to pursue a school-based strategy to enroll EBNE children in Medicaid.

KidsWell Campaign Objectives. CLP emphasized six objectives for its campaign to support KidsWell goals: (1) build a diverse and sustainable network of New Mexico residents for children's health care advocacy, (2) remove barriers to EBNE children and families enrolling in Medicaid and retaining their enrollment, (3) protect the state budget allocation for Medicaid and its benefits package, (4) ensure that the state-based exchange is responsive to affordability issues and implements a streamlined enrollment system with Medicaid during ACA implementation, (5) create communications capacity to advocate for children's coverage, and (6) promote Medicaid expansion in New Mexico (New Mexico Center on Law and Poverty 2012).

Key ACA Implementation Policy Decisions. Following the passage of ACA in 2010, then Governor Bill Richardson (D) initiated plans to create a state-run insurance exchange. However, the election of a new Republican governor who took office in January 2011 flung the ACA decision making process into doubt. In this context, advocates had to make the case for ACA implementation more strongly than they might have if a Democratic candidate won the election. Clashes between the Democratic-led legislature and the new Republican governor delayed decisions on the exchange and Medicaid expansion during 2011 and into 2012. After the United States Supreme Court ACA ruling in June 2012 that made it optional for states to expand Medicaid eligibility to low-income people, advocates were concerned that Governor Martinez would face greater pressure from conservatives not to adopt Medicaid expansion. Thus, the KidsWell grantees maintained their level of advocacy on the Exchange, but redirected resources from other efforts to work on Medicaid expansion.⁴

B. New York

1. Context for ACA Implementation

Political Environment. Democrat Andrew Cuomo was elected governor in 2010, replacing incumbent Democratic governor David Paterson, who announced he would not seek re-election. Like New Mexico's governor, Cuomo had been a public prosecutor; since 2006, he had been the state's Attorney General. Governor Cuomo selected a group of knowledgeable and hard-working health care administrators to serve on his health care team, although informants say health care is not a topic he speaks widely about in public, typically preferring to speak about the state economy, job creation, infrastructure, and education, among other topics. His major policy document as a candidate, *The New NY Agenda: A Plan for Action*, contained little discussion of health issues, and his pre-election policy documents had minimal focus on children, youth, and families.

The state has a bicameral legislature; historically (and currently), the legislature has split party control, with the Assembly led by Democrats and the Senate led by Republicans. Unlike New Mexico, the New York legislature regular session runs annually from January to mid-June; if needed, the governor can call extraordinary sessions outside this period. In the past few years,

New York's policy priorities often have been initiated in the governor's annual budget, with the legislature debating and approving the budget and in turn, deciding which policy priorities will move forward. The budget process concludes by April 1st each year; additional policy priorities that have no fiscal impact are occasionally proposed and enacted in the remainder of the regular session.

Children's Coverage and CHIP/Medicaid Policies in New York. Insuring children in New York has always been a policy priority, enjoying political support from both parties since the 1980s. The Child Health Plus (CHPlus) program is the state's Separate CHIP program and is rooted in a state-funded initiative that began in 1990 (Hill and Benatar 2012). In the ensuing years, the age of eligibility (now age 19) and the benefit package were expanded. In 2009, CHPlus financial eligibility for state-subsidized coverage was expanded to 400 percent of the federal poverty level—the highest level in the nation. Children in families above that level can buy in to the program; together these two policies created a coverage option for every child in the state. State-only funding is provided to cover undocumented children through the program. As a result of these policies, national estimates show that about 4 percent of children in the state are uninsured, compared to 8 percent in New Mexico; but because of the much larger state population in New York, this equates to about 160,000 children, over five times the number of uninsured in New Mexico (State Health Access Data Assistance Center 2013). As of 2011, children's Medicaid and CHIP participation rate in the state was 92 percent (Kenney et al 2013).

Before the passage of the ACA, New York had several programs to cover adults and small businesses. Family Health Plus, a program offered through a Medicaid Section 1115 waiver since 1999, covered childless adults with incomes up to 100 percent of FPL, and parents up to 150 percent of poverty. Small businesses in the New York City region had access to plans through the HealthPass program and the Healthy New York program, which offered coverage to individuals, sole proprietors, and small businesses.

2. KidsWell Grantees in New York

The Atlantic Philanthropies funded the Community Service Society of New York (CSS), Schuyler Center for Analysis and Advocacy (Schuyler), and the Children's Defense Fund-New York (CDF-NY) to work in partnership on the KidsWell grant (see Table 1 for grant details). The lead grantee, CSS, is a 501(c)(3) nonprofit agency headquartered in New York City with 170 years' history focusing not only on health but on multiple issues affecting low-income families in New York, including housing, economic security, imprisonment and reentry, volunteer mobilization, workforce, and poverty. Schuyler, also a 501(c)(3) nonprofit organization, is a policy analysis and advocacy organization focused on health, welfare, and human services issues for New York residents. Schuyler is located in Albany, and as such allows the KidsWell grantees to have a daily voice at the capital, keeping the group in close contact with the governor's office, legislators, and exchange and other health department staff. CDF-NY is the New York affiliate of the national CDF organization; it integrates research, public education, policy development, community organizing, and advocacy activities and focuses on children in the state. According to key informants, CDF is viewed as a trusted source of policy information on children because it does not accept government funding. Staff members also have on the ground experience doing in-person enrollment assistance and facilitated enrollment in the state; like CSS, CDF-NY is located in New York City.

Rather than form a new coalition to address KidsWell goals, the three grantees formed a Children, Youth, and Families (CYF) task force as part of a larger existing coalition that they all belong to and that CSS administers called Health Care for all New York (HCFANY). This statewide coalition comprises more than 160 organizations focused on bringing affordable, comprehensive, and high-quality health care coverage to all residents in New York.³ The grantees decided that the KidsWell funds would be better spent building from the momentum of this existing coalition rather than launching a new, separate coalition or trying to rebrand the existing group. Stakeholders in the CYF task force represent diverse groups focused on children; some CYF task force members come from health-focused groups that are part of the larger HCFANY coalition, whereas other members were newly attracted to the CYF task force because they focus on children and families but not health, such as childcare providers and preschool groups.

Grantee Strengths. As in New Mexico, the New York KidsWell grantees are all experienced advocates, with particular strength in (1) policy analysis, (2) cultivating partnerships, and (3) strategic planning. All three of the grantees were described as “savvy” and “sophisticated” with “tremendous expertise in policy details” related to coverage and the ACA by a variety of key informants in the state. In addition to their analytic skills, lead staff at CSS and Schuyler have worked in this field for more than two decades, so they have longstanding working relationships with legislators and key state administrators. Given this experience, they also know how to lobby within the limits of 501(c)(3) rules to advocate for policies they support. Observers say the grantees know when and how to engage these relationships, both in the legislature and in the governor’s administration: that is, they know both how to play the “inside” advocacy strategy—working closely with administrators to simplify enrollment rules or with legislators to craft legislation or provide them with information needed for hearings, for example—and the “outside” advocacy strategy—undertaking activities designed to put the public spotlight and pressure on decision makers, ranging from earned media to rallies. CDF-NY brings credibility to children’s issues as the local division of the leading children’s advocacy group in the nation.

Use of KidsWell Funds. Atlantic funds were utilized by the three KidsWell grantees in New York to (1) support a portion of the salaries of existing staff doing the work, (2) create and lead the CYF task force, (3) contract for grassroots capacities, and (4) deploy communications strategies. Although the KidsWell grant makes up only a small proportion of each of the three grantees’ total annual budgets, the funds supplemented the work of existing staff, enabling them to carry out advocacy work through the CYF task force, with the majority of Atlantic funding going to CSS (see Table 1), which leads and convenes the task force. Additionally, one important capability that these three groups did not have, but believed they needed to support the KidsWell goals, was grassroots capabilities—the ability to enlist, mobilize, and activate local supporters at critical points in policymaking. To support this capacity, CSS set aside some of its KidsWell grant to regrant to two grassroots groups: Make the Road New York and Raising Women’s Voices, two nonprofits that CSS had partnered with in the past who focus on grassroots organizing, and each received a portion of the grant funds. Atlantic also gave the New York grantees additional funds for communications work, which they used for paid media posts; grantees reported that paid media was “highly effective,” garnering much attention from both politicians and their constituents. For example, the grantees identified an issue with “surprise” out-of-network charges (for example, when a consumer receives services at an in-network

hospital but is unknowingly treated by an out of network provider within that setting, such as for lab or anesthesiology services) and used its communications funds to draft an advertisement that caught the attention of legislators, focusing them on the issue even before the ad ran in local media outlets. The New York grantees noted that consumer coalitions typically do not have the resources for this type of outreach.

KidsWell Campaign Objectives. Despite the generous eligibility of its CHIP program, New York had been unsuccessful in making gains toward closing the gap in children’s coverage; as noted above, about 160,000 children in the state were uninsured at the time the KidsWell grant began in 2011. In their proposal for KidsWell funding, the grantees wrote, “Exactly who these children are, and why they are persistently not enrolled in coverage, remains unknown, but research provides some answers. Children of insured parents are almost twice as likely to have coverage than children of uninsured parents.” Given this, the CYF task force decided to focus broadly on coverage issues affecting families, not just children, recognizing that New York already offered generous coverage to children and that the key to expanding their coverage was likely tied to getting their parents into coverage through the ACA. As a result, the CYF task force began with three broad coverage objectives: (1) Build the foundation for a lasting infrastructure for health care advocacy for children and families in New York, (2) ensure that child and family-friendly policies are adopted by the state as it plans for and implements key milestones of the ACA, and (3) make certain New York children are enrolled in health care coverage in 2014.

Key ACA Implementation Policy Decisions. To accomplish its stated goals, the New York KidsWell groups focused on a number of legislative and administrative policies, but two priorities emerged that they viewed as critical to helping New York families: (1) securing a state-based exchange, and (2) enacting a Basic Health Plan (BHP) in New York.⁵ Grantees saw the state-based exchange as an important way for New Yorkers to shape how coverage policies would be implemented; grantees were concerned that if the state defaulted to the federal or a partnership exchange, it would be difficult for the state to have a voice at the table to ensure that child and family friendly policies were adopted. BHP, a policy permitted by Section 1331 of the ACA, permits states to help bridge the coverage affordability gap for families between 139 and 200 percent of the FPL. With a BHP, a state can cover families ineligible for Medicaid up to 200 percent of the FPL; and states are eligible for substantial federal financial subsidies to cover BHP costs (Benjamin and Slagle 2011). The KidsWell grantees targeted this policy as it aligned with their goal of helping families—parents and children—get coverage: a BHP makes coverage much more affordable for families under 200 percent of the FPL compared to exchange coverage, attracting more uninsured parents to coverage and in turn, those parents are likely also to enroll their uninsured children. The lead grantee, CSS, had already invested substantial resources into researching BHP at the time the KidsWell grant was issued in 2011, and had identified BHP as a potential key to enrolling eligible but uninsured children and their parents into affordable coverage.

III. CAMPAIGNS, STRATEGIES, AND POLICY WINS

A. Campaigns and Strategies

New Mexico. In New Mexico, advocates decided that an economic argument for expansion was the most effective way to appeal to Governor Martinez. Given the state's high rate of poverty—one in five New Mexicans live in poverty, the second highest rate in the United States—that more than a quarter of its population is already enrolled in Medicaid, and its slow economic growth, expansion proponents built their case around three key messages: (1) the benefits of Medicaid expansion to the state's health care system, (2) the savings to the state budget, and (3) the jobs and indirect economic benefits that it would generate. To support these messages, CLP mounted an informational campaign to convey these messages to decision makers and to counter misinformation about the impact of expansion on the state budget. CLP produced an analysis demonstrating the economic impact of expansion, testified before the state Legislative Finance Committee, and then worked with Committee staff to produce their own analysis, which corroborated CLP's findings. To ensure acceptance of the findings, CLP commissioned a study by the University of New Mexico on the economic impacts of Medicaid expansion (Reynis 2012). The paper concluded that expansion "is estimated to result in net gains for the state between \$478 million to \$523 million over fiscal years 2014 to 2020." Another advocacy organization, Voices, also commissioned a report on the economic benefits of Medicaid expansion that estimated it could generate as much as \$18 billion in direct and indirect economic activity in the state (New Mexico Voices for Children 2012). CLP provided input into this report as well.

The potential economic benefit of Medicaid expansion was evident to most of the business community, health care providers, and insurance companies, who all understood the ripple effect of billions of dollars in federal Medicaid expansion money on health care infrastructure and job recovery in the state. Although these groups were not publicly unified in favor of expansion, advocates communicated informally with hospital systems and insurers, so CLP knew that both groups had conveyed their support for Medicaid expansion to the governor. CLP also presented data on the impact of Medicaid expansion to the state and children in an October 2012 in-person meeting with the governor. One advocate noted that, overall, "The economic arguments got a lot of traction."

The KidsWell grantees also coordinated support from other stakeholders. For example, the faith communities, such as the Catholic and Lutheran Churches, play a large role in New Mexico and have significant political clout. Both the Catholic and Lutheran Church lent their support to Medicaid expansion in the form of letters to the governor. The advocates also worked with tribal leadership to coordinate a letter to the governor in support of expansion as a means of being able to use Medicaid as another method of payment at tribal clinics, which would improve the financial stability of the clinics. For legislators, CLP took a slightly different tack: they hired a geographic information systems specialist to prepare a county-by-county breakdown on EBNEs and how each legislator's constituents would benefit from expansion.

Other tactics to push for the expansion included grassroots organizing to showcase New Mexican residents' support for Medicaid expansion. As part of the Medicaid coalition work, CLP organized a call-in campaign to the governor's office called "Adopt a Day for Medicaid," in

which organization staff, clientele, and board members would call the governor's office in support of expansion. CLP was able to recruit enough organizations to cover 88 days during the 100-day campaign. Each organization committed to making at least 10 calls a day. CAFé also participated by representing the southern part of the state and put CLP in contact with other organizations in southern New Mexico. Grantees also created a flash mob dance video of children and New Mexico residents dancing for Medicaid expansion that was well received by the governor. The third prong of the campaign was communications work with state and local newspapers to editorialize the benefits of Medicaid expansion.

New York. The New York grantees pursued BHP with economic and fiscal arguments; as in New Mexico, the grantees used multiple strategies in their pursuit. The chief one was policy analysis, followed by lobbying; community organizing; regional meetings; developing strategic partnerships; and media, including social media. The lead KidsWell grantee published an analysis (supported by funding from the New York State Health Foundation) in June 2011 that highlighted the economic gains BHP could generate for the state—estimated at more than \$900 million—as well as the significant contribution of BHP to low-income New Yorkers, helping 466,700 New Yorkers access coverage more affordable than what they could obtain through the exchange (Benjamin and Slagle 2011).⁶ Throughout 2011, 2012, and into 2013, the advocates used various tactics to push the BHP agenda, including conducting a listening tour of roundtables and surveys with consumers and organizations to explore issues related to the exchange, including BHP;⁷ producing and disseminating a report summarizing results of the listening tour; hosting a webinar on the issue; getting earned media opportunities to speak about the issue; and summarizing the findings of the BHP report in a short policy brief issued in early 2013.⁸

The New York grantees worked closely with the legislature in 2013 to enact BHP authorizing legislation. Instead, legislative authority was enacted to establish a BHP workgroup as part of the 2013–2014 budget legislation. This group began meeting in July 2013; it was chaired by the state's CHIP director and included two of the lead KidsWell grantee staff from CSS and Schuyler. Its charge was "...to evaluate federal guidance related to basic health programs; discuss fiscal, consumer, and health care impacts of a basic health program; and consider benefit package, premium, and cost-sharing options for a basic health program." This committee helped to formalize a plan for how BHP could work in the state, and the presence of the KidsWell grantees on the committee helped it shape those plans. In 2014, the grantees worked to make the enactment of BHP the top HCFANY legislative priority, used communications funding from Atlantic to strategically place ads supporting its enactment, and organized many lobby days and sign-on letters to the governor and legislative leaders.

To pursue passage of the state exchange, the New York grantees focused on a broader message of the many benefits of a state exchange to New Yorkers, including access to affordable health care for the uninsured, lower health care costs, and letting the state determine its own needs and preferences by designing the exchange itself. Like the New Mexico grantees, the New York KidsWell advocates used a number of strategies to influence passage of the state exchange, including community organizing, regional meetings, lobbying, developing strategic partnerships, policy analysis, outreach, and the use of stories and media campaigns. They also cited their longstanding relationships in the capital as being a central factor in their easy access to the decision makers.

Advocates began pursuing the state exchange in spring 2011, when they met with the governor's staff to provide insight and negotiate details of S5849, a bill that would have established a state-based exchange as a nonprofit corporation in the state of New York. In addition, they worked with Assembly members on consensus language to try to help the bill pass. Using their KidsWell communication funding from Atlantic, they coordinated with AARP to robocall AARP members, who in turn would call their local legislators to ask for passage of the bill; they also used these funds to create web banners on political blogs. The grantees did not anticipate a last-minute Republican backlash over the bill, and the bill did not pass as expected in June 2011. Grantees reengaged the issue in fall 2011 in a media campaign targeting the governor, writing on their blog in October 2011 that the state should explore options for establishing and implementing a state-based exchange, including the possibility that the governor might consider doing so by Executive Order as Rhode Island had done in September 2011. In addition to meeting with Assembly and Senate members to discuss language in a new proposed state exchange bill, they also lobbied the governor's advisors and crafted policy language. They issued a press release publicly applauding the governor for including a state-based exchange in his state of the state address that year; continued to work with legislators on the new bill that was working its way through the legislature; and issued a report in early 2012 on how the ACA was already benefitting New Yorkers, but how more would benefit by enacting a state exchange.

B. Policy Wins

New Mexico. In New Mexico, the governor announced in January 2013 that New Mexico would adopt Medicaid expansion, expanding Medicaid eligibility to approximately 170,000 New Mexicans between the ages of 19 and 64 with incomes below 138 percent FPL on January 1, 2014. The New Mexico Human Services Department estimated that as many as 130,000 people would become new Medicaid enrollees in 2014—a combination of newly eligible adults, current State Coverage Initiative enrollees, and those currently enrolled in limited benefit programs who transition to full-benefit status—with total Medicaid enrollment at 660,000 by the end of fiscal year 2014 (Earnest 2013). In addition to expanding Medicaid, Governor Martinez submitted a letter of intent to the U.S. Department of Health and Human Services (HHS) to establish a state-based exchange, the New Mexico Health Insurance Exchange (NMHIX), in November 2012. Currently using a hybrid model, New Mexico operates a state-based exchange for small businesses and individuals purchase their insurance through the federally-facilitated marketplace. The state anticipates shifting individuals to the state-based exchange in fall 2014.

The argument for Medicaid expansion was a compelling economic case: expansion would generate jobs, increase state revenues, and strengthen the state's health care system. As the governor of a poor state with high rate of uninsured, Governor Martinez likely found it economically difficult to turn down the expansion opportunity. Several informants believed that most legislators, including many conservative Republicans, understood the economic value of the Medicaid program, since one in four New Mexicans were already enrolled and few sectors other than health care have potential for economic growth in New Mexico. Although the extent to which adoption of Medicaid expansion can be attributed to KidsWell grantee efforts is subject to debate, advocates actively participated in the policy debate, worked closely with other key stakeholders to carry the message to specific targets, and put a human face on the economic impact research.

New York. In New York, a chance event prevented the expected legislative win on the state exchange. On the same day the 2011 exchange bill came up for a vote, the state legislature passed same-sex marriage in the state; given the passage of that policy, key informants interviewed for this study said, the Republicans felt they could not show support for what they labeled “ObamaCare” on the same day. Outside observers, and the KidsWell grantees themselves, say there was no way the grantees could have anticipated the chain of events on a single day in June that would lead to the bill’s defeat. The governor later issued the exchange under Executive Order in 2012; his initial press release announcing the exchange included the KidsWell lead grantee’s commending the governor for his decision (Cuomo 2012). Observers interviewed for this study suggested that while the KidsWell grantees’ advocacy on behalf of the state exchange was important and influential, New York always intended to pass a state-based exchange.

BHP is a more recent win, having passed on March 31, 2014. At the time of our site visit in early March, key informants were optimistic that BHP-enabling legislation might be enacted because it was included in the governor’s proposed 2014–2015 budget. Legislators interviewed for this study in early April after BHP’s passage credited the KidsWell lead grantee, CSS, with this win, saying if it were not for its economic analysis showing significant financial gains to the state, BHP would never have been included in the governor’s budget, let alone passed by the legislature. One informant called the analysis “vital” to the win, and another said, “The data and analysis they put together really made everyone pay attention.”

IV. BUILDING ON SUCCESS AND MAINTAINING MOMENTUM: KEY TAKEAWAYS

The case studies conducted in New Mexico and New York assessed the role advocates in these two states played and the strategies they used to try to keep policymakers’ attention on policies that would support children and families during state ACA implementation debates. Their experiences may be instructive for other groups advocating for adoption of child- and family-friendly ACA policies and suggest effective approaches that advocates and funders might consider for upcoming policy battles, such as how Medicaid managed care reforms affect children’s access to care and the reauthorization of CHIP in 2015. Key takeaways from the case studies include the following:

- 1. Advocates need to determine the most effective messages that will resonate in their state and support those key messages with careful policy analysis. In New Mexico and New York, the economic benefits of coverage, demonstrated by thorough policy analysis, made a convincing case to policymakers.**

The KidsWell grantees in New Mexico and New York both were able to use the economic benefits argument for coverage to their advantage. In New Mexico, with few prospects for economic growth aside from the health sector, it made sense to promote the economic benefits of Medicaid expansion. According to observers, the eventual adoption of Medicaid expansion in New Mexico cannot be attributed to the KidsWell grantees alone because many actors contributed to the decision, but the economic analysis did influence the debate on Medicaid expansion in the state. In New York, several key informants interviewed for this study said the lead KidsWell grantee’s report on the economic and fiscal impact of BHP, along with the

ongoing lobbying and media campaign around it conducted by the KidsWell grantees, was essential in getting the governor's and legislature's attention on BHP. The informants said that without the analysis, BHP most likely would not have been included in the governor's budget and later passed in March 2014.

Although the economic benefits argument worked in these two states, realistically it may not always win, given the strength of the political opposition to Medicaid expansion in many states. For example, reports in Texas show that advocates have used this message, but to no effect with the governor (Viebeck 2013), whereas in Florida, the governor initially said he would not support expansion, changing course and announcing his support for expansion in 2013, but the legislature remained strongly opposed to any arguments—economic or otherwise—in support of policies promoting health reform in the state. This suggests advocates need to determine the most effective messages that will resonate in their state and support those key messages with careful policy analysis.

2. Public engagement remains a crucial tool to draw policymakers' attention to issues.

Public engagement—sometimes called playing the “outside” advocacy game, in which advocates use tactics like earned media, personal stories, and public rallies to put a spotlight on an issue and, in turn, pressure on decision makers—remains a critical advocacy strategy. Although not a new or innovative strategy, public engagement cannot be overlooked when advocates are deploying issue campaigns.

KidsWell grantees in both states recognized that policy analysis and targeted messaging were important first steps, but by themselves were insufficient to mobilize support for the issues. In New Mexico, the KidsWell grantees used grassroots efforts to engage partner organizations and the public—and to put pressure on the governor—organizing a flash mob dance and producing a video that was shown to the governor and released on social media (YouTube). Grantees in New Mexico also targeted the legislature, developing a county-by-county breakdown of where eligible but not enrolled children resided and how each legislator's constituents could benefit from the expansion.

In New York, the KidsWell grantees used a multipronged public engagement strategy, including paid media buys in newspapers and online news websites and political blogs, as well as radio interviews, rallies, and public education events about the need for a state exchange and BHP. The New York grantees also received a supplementary KidsWell communications grant from Atlantic, which allowed them to do paid media activities; according to the New York grantees, paid media is a tool advocates rarely have the money to employ, but one they perceive as particularly effective. For example, to mobilize support for the state exchange legislation, they partnered with AARP; AARP paid for and deployed a robocall strategy to motivate citizens to voice complaint to the legislature about delays in acting on the exchange bill, while the KidsWell grantees used their resources to extend the campaign to other media (print, radio, etc.). Likewise, money for paid media allowed them to run ads in local papers—or threaten to do so—if needed to stimulate action in a particular legislative district.

3. Given limited resources, funders can maximize their investment by supporting advocates who can forge coalitions with a broad range of stakeholders.

Advocates have long known the importance of creating strategic alliances to broaden support for public policy change and expand the advocacy resources and tools that can be deployed. Several key informants reinforced the point by noting that decision makers are strongly influenced by “strength in numbers,” when multiple constituencies and advocates speak in unison on an issue.

In both case study states, KidsWell grantees were strategic with their selection of allies. Both groups recognized the need to bring multiple voices to the table through proactive collaboration with other consumer advocacy groups and either informal or formal coordination with hospitals and insurers. For example, in New York, grantees teamed with the hospital trade association and the public health plans’ lobbyist on the push for Medicaid expansion, the state exchange, and BHP; these groups also supported ACA implementation and thus brought additional resources to the table. Although these groups sometimes disagree on other health policy issues, they realize the advantages of working together when they can find common ground. In turn, stakeholders in New York reported that this teaming arrangement was important in how these policies were viewed because decision makers were hearing a consistent message from these diverse groups on the many benefits of reform for New York. In New Mexico, the arrangement was more informal, but no less effective, as the KidsWell grantees worked behind the scenes to assure that hospitals and insurers had the same information and analyses available to support their pro-reform agendas.

4. Policymakers and administrators view advocates who offer constructive solutions as more effective partners.

Several key informants reported that in their view, effective advocates were ones who did not just come to the table with complaints but who offered constructive solutions to problems. As one informant stated, “Advocacy groups have to find a way to yes, and some groups can’t. Advocates must be willing to compromise...not that they don’t need to advocate strongly, but [successful groups] have a good sense when they need to fight and when they need to compromise.”

Although this finding is hardly new and may seem obvious, some policymakers in New Mexico viewed certain advocates more as adversaries than as partners in solving problems, which suggests that advocates must keep in mind that true or not, how they are perceived affects what they can achieve. The lead KidsWell grantee in New Mexico, CLP, is a legal services organization, so policymakers’ perception of CLP may be colored by its history of using litigation as a strategy when required. This speaks to the limits of the New Mexico grantee to play an “inside” advocacy game with Medicaid officials, a role that requires a greater level of trust between advocates and Medicaid administrators. However, the New Mexico grantees have had success developing constructive relationships with legislators by providing them with policy research and drafting legislation they might not have access to otherwise, suggesting another avenue where they have been able to build their credibility.

We heard that New York grantees are perceived as effective, solutions-focused partners. New York grantees noted that they have learned that litigation is a less constructive strategy in the state compared to either working closely with legislators to craft legislation or providing information Medicaid and CHIP administrators need to develop administrative policies and procedures.

5. Funders should avoid the temptation to require grantees to adopt a new label for each new initiative.

Smart grantmaking can work behind the scenes, which can mean that funders will not be publicly recognized for their contribution. Grantees in both case study states capitalized on existing coalitions for their KidsWell work rather than either re-branding these existing groups or starting a new group for the work. Neither wanted to divert KidsWell resources on a branding campaign; it was more important to focus on getting the work done. Funders supporting advocacy should explicitly consider whether labeling is important—and whether the level of resources available can support both a branding campaign and an advocacy campaign.

6. Advocates 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. As a result, they will need ongoing financial support to provide the stability needed to maintain momentum and to garner ongoing attention by policymakers to the issues.

Policy change doesn't happen overnight; national health reform has been debated since the early part of the 20th century. The same is true at the state level: the New York grantees noted that policy change in New York typically takes a two year cycle, with the first year spent introducing the issue and why it is important and the second year spent ratcheting up the pressure to make a decision on the issue. Similarly the New Mexico grantees noted that “you can't do this work in a year,” and their ability to advocate for the Medicaid expansion would have been severely diminished were it not for the KidsWell grant. Both grantees noted the three-year grants from Atlantic for this work (recently renewed, extending another three years' support) provided stability, giving the grantees time to develop resources such as policy analyses and messages in support of the key issues facing families. Both grantees noted that Atlantic funding has also helped to secure other foundation funding, particularly in support of ACA issues.

When asked what policy issues would be at the forefront in states in 2014 and beyond, key informants interviewed for this study had a long list. The initial enrollment period to sign up for the marketplace plans may be over, but states are far from being in a steady state of operations. The next set of challenges includes educating consumers new to insurance about how premiums, copays, and prior authorization work; helping consumers navigate their first renewal period in 2015; and making sure people enrolled in Medicaid managed care plans understand their options and how to access care.

Although not the focus of these studies, Medicaid reform also will move to the forefront in both states. New Mexico is already in the midst of implementing a Medicaid managed care reform aimed at integrating and coordinating services across the continuum of care, including medical, behavioral, and long-term services and supports, and is requiring newly eligible Medicaid beneficiaries and most of those who were previously exempt from managed care to

enroll in one of four managed care plans. In New York, the governor announced in February 2014 that the state had come to an agreement with HHS over its proposed Medicaid redesign. The redesign focuses primarily on using managed care for all Medicaid enrollees—including populations historically excluded, such as people with disabilities—along with a concerted effort to reduce avoidable hospitalizations and emergency department use in the state’s public hospitals. It also includes having safety net providers (including hospitals, nursing homes, clinics, and home care agencies, among others) better coordinate care to garner savings. Other issues related to the redesign that the New York KidsWell grantees are likely to address are whether school-based health clinics also will be incorporated into the state’s Medicaid managed care program and how Medicaid managed care will affect children with special health care needs. Such reforms, concurrent with ongoing ACA implementation, underscore the need for ongoing advocacy for children and families, although advocacy efforts may shift from macro-level state policy to micro-level administrative policies that make systems work better.

V. FINAL THOUGHTS

In the coming years, advocates can play a critical role in identifying problems with how health reform is working for consumers; those with strong links to low-income families—and with those who set administrative and procedural policies in the states—will be key to this “bottom up” strategy, using the information they gain through one on one contact with consumers as Navigators (as in New York) or legal services aides (as in New Mexico).

At the same time, broader policy issues loom. For example, the push to renew federal funding for CHIP, slated to expire in 2015, is already underway. National advocacy groups will need the help of state advocates to raise awareness among federal policymakers about CHIP’s role in the health care safety net by bringing stories of children and families who rely on CHIP to the national debate. Advocates at the state level will be challenged to maintain focus on state ACA implementation issues while keeping an eye on issues at the national level that could change the playing field for children’s coverage. Future work on this project will examine the interaction among national and state grantees in support of KidsWell goals and whether and how they support state and federal policy momentum for children’s coverage.

ENDNOTES

¹ KidsWell was just one way Atlantic supported ACA implementation. For example, shortly after the ACA passed in 2010, a group of eight national foundations created the ACA Implementation Fund, to provide strategic support to state-based health advocates to ensure effective and consumer-focused implementation of the ACA, initially targeting 16 states. Besides Atlantic, other foundations included The California Endowment, The Nathan Cummings Foundation, Ford Foundation, The Jacob and Valeria Langeloth Foundation, two anonymous funders, and a corporate funder (Community Catalyst 2014).

² After assessing the seven state grantees along a number of policy, political, and economic dimensions, New Mexico and New York were selected both for their history of policies supporting children's coverage, grantee reports of policy wins, and differing political climates.

³ HCFANY began under the Robert Wood Johnson Foundation's Consumer Voices for Coverage program in 2007.

⁴ Because the Medicaid expansion was the highest priority, that issue received more attention from the KidsWell grantees. However, as in New York, the New Mexico KidsWell grantees have also advocated for the adoption of a Basic Health Plan. To date, the New Mexico grantees have not made progress on the issue.

⁵ Medicaid expansion was also a policy priority for the KidsWell grantees, but the governor announced that New York would expand Medicaid to 138 percent of the FPL on the same day the Supreme Court upheld the ACA constitutional, in June 2012. This effectively retired New York's Family Health Plus program, with most of the adults who were in it now eligible for Medicaid coverage. However, in the 2013 legislative session, the KidsWell grantees worked closely with the Executive branch and Legislative leaders to assure that parents formerly eligible for Family Health Plus between 138 and 150 percent of the FPL were provided with a state-funded premium assistance to support their share of monthly premiums, letting them enroll in the qualified health plan of their choice in the state marketplace.

⁶ An analysis by the Urban Institute generated findings that were consistent with this work (Blavin et al. 2012).

⁷ The listening tour was supported by funding from the ACA Implementation Fund (see endnote 1 for more detail on this fund).

⁸ Part of the delay in getting attention to the BHP issue was that the Centers for Medicare & Medicaid Services (CMS) delayed issuing guidance on BHP until September 2013. Earlier in 2013, CMS announced that no state could implement a BHP until 2015 (it was originally planned to begin in 2014), which also delayed movement on the issue.

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