



State-Based Advocacy as a Tool for Expanding Children's Coverage: Lessons from Site Visits to Six IAC Grantee States

EVALUATION BRIEF

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Insuring America's Children: States Leading the Way (IAC) is a grant program funded by the David and Lucile Packard Foundation. Begun in 2007, IAC includes support (funding, training, policy analysis, and technical assistance with communications and strategy) for state-based advocates working to expand children's health insurance coverage. A separate evaluation component of IAC aims to inform decision makers in states and at the national level about promising coverage strategies and programs. The evaluation component is led by Mathematica Policy Research in collaboration with its subcontractors, the Urban Institute and the Center for Studying Health System Change.

For more information on the IAC project, see www.packard.org/finishlineproject. For more information on the evaluation component, including additional research findings, see www.mathematica-mpr.com/health/iac.asp.

References to legislation and legislative activities are provided for context. No Packard Foundation grant funds were used in any legislative activities.

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This brief presents research findings from the evaluation component of the Insuring America's Children: States Leading the Way (IAC) grant program. Funded by the David and Lucile Packard Foundation, the IAC program supports state-based advocates working to expand children's health insurance coverage in 16 states. The brief summarizes key findings from site visits made to six (of eight) states where IAC has made its most substantial investment in advocacy through multiyear "Finish Line" grants. Findings from these site visits affirm the critical importance of persistence, flexibility, and commitment to conducting effective state-based advocacy; the added value of building meaningful coalitions that encompass both grassroots and state-level stakeholders; and the importance of maintaining a unified voice among a sometimes crowded community of advocates working to improve children's well-being. Although work remains to attain health coverage for all children, a number of important gains in children's coverage have been achieved despite a severe and ongoing economic downturn.

State-Based Advocacy Targets Coverage for All Children

Nationally, more than nine million children are uninsured and many are eligible for but not enrolled in Medicaid or the Children's Health Insurance Program (CHIP). Recognizing that effective advocacy in states is essential for expanding coverage to more children, the David and Lucile Packard Foundation funded an initiative—Insuring America's Children: States Leading the Way (IAC)—to provide financial and technical support to state-based advocacy organizations, with the ultimate goal of attaining health coverage for all children. In February 2008, advocacy organizations in eight states received multiyear Finish Line grants. The aim of the Finish Line grants is twofold: to foster state-based efforts to make significant advances in children's health coverage by supporting policy advocacy efforts in select states, and to seed and support a broader movement to cover all children by building on increased interest in moving coverage efforts forward and applying lessons generated from state-based coverage initiatives. The Georgetown University Center for Children and Families (CCF) provides technical assistance and guidance to each of the eight Finish Line grantees, in partnership with Spitfire Strategies.

As part of an evaluation of the IAC initiative led by Mathematica Policy Research, a pair of study teams (one at the Urban Institute and one at the Center for Studying Health System Change, or HSC) conducted site visits between March 2008 and April 2009 to six of the eight Finish Line grantee states—Arkansas, Colorado,

Iowa, Ohio, Texas, and Washington. During their three-day visits, the teams conducted a series of semistructured, in-person interviews in order to gather insights and perspectives on the issue of children's health coverage and the environment for expansion in each state. The first team (from the Urban Institute) focused on policy and program issues, conducting interviews with key legislators, gubernatorial staff, state Medicaid and CHIP program officials, and other key program staff responsible for children's health coverage issues. Meanwhile, the second team (from HSC) concentrated on the work of advocates and stakeholders, conducting interviews with staff of children's advocacy groups and a variety of stakeholder organizations involved in or knowledgeable of children's coverage issues (including safety net providers, academic institutions, foundations, and members of the news media).

By the time of the site visits, all six Finish Line grantee states had made tangible advances in covering children: Arkansas and Colorado had expanded eligibility in their public coverage programs to children in families with incomes up to 250 percent of the federal poverty level (FPL); Iowa and Washington had expanded program eligibility to children in families with incomes up to 300 percent of the FPL; Colorado had adopted a buy-in program; Iowa had expanded coverage to immigrant children, with Arkansas making plans to do the same; and all six states had adopted simplified enrollment and renewal policies and procedures. As highlighted later, a number of strategies were useful to the Finish Line grantees in advocating for these gains. Among these strategies are building broad-based, grassroots coalitions of support; cultivating respected champions to advocate coverage expansion; developing consistent and powerful message strategies; positioning grantees as the "go-to" organizations for information on children's coverage issues; and capitalizing on opportunities created by the recent reauthorization of CHIP.

IAC Finish Line Grantees in the Six Study States

- **Arkansas:** Arkansas Advocates for Children and Families
- **Colorado:** Colorado Coalition for the Medically Underserved (in partnership with Colorado Children's Campaign, Covering Kids and Families, and Metro Organizations of People)
- **Iowa:** Child and Family Policy Center
- **Ohio:** Voices for Ohio's Children
- **Texas:** Children's Defense Fund of Texas (in partnership with Center for Public Policy Priorities and Texans Care for Children)
- **Washington:** Children's Alliance

States Tackle Coverage for All Children from Different Starting Points

The six states visited varied significantly in the starting point from which efforts to expand children’s coverage began. For example, the proportion of uninsured children ranged from 6 percent in Iowa to 22 percent in Texas (Table 1). This variation is in part a reflection of the states’ histories of children’s coverage expansions. Federally, Medicaid and CHIP statutes permit states considerable flexibility in setting income limits, designing enrollment and renewal policies and procedures, determining covered benefits, and setting cost-sharing requirements. Some states have a history of adopting programs that better facilitate outreach and enrollment, while others have had less supportive children’s health coverage programs.

Table 1. Demographic and Health Coverage Characteristics

	Total Population	Population 18 and Under	Children Below 100% FPL (%)	Children Below 200% FPL (%)	Children Below 300% FPL (%)	Uninsured Children (%)	Children Covered by Private Insurance (%)	Children Covered by Public Insurance (%)
Arkansas	2,834,797	742,180	28	56	70	8	47	44
Colorado	4,861,515	1,260,310	16	35	51	14	68	18
Iowa	2,988,046	749,660	18	36	55	6	68	26
Ohio	11,466,917	2,947,690	23	41	60	8	64	28
Texas	23,904,380	6,988,520	29	51	67	22	49	29
Washington	6,468,424	1,622,730	16	34	50	7	65	28
National	301,621,157	78,645,220	23	43	59	11	60	29

Sources: U.S. Census Bureau, Population Estimates (2007); Kaiser State Health Facts, states (2006-2007), U.S. (2007); Personal Communication with Kaiser State Health Facts, June 23, 2009.

Medicaid and CHIP policies also varied in the Finish Line states at the beginning of the grant period in 2007. For example, upper-income eligibility limits in CHIP ranged from a high of 250 percent of the FPL in Washington to a low of 200 percent in Arkansas, Iowa, Ohio, and Texas (Table 2). Only two of the six states visited— Washington and Texas—covered legally resident immigrant children within the five-year waiting period (using state-only money).¹ On several program features, including elimination of the face-to-face interview requirement and a joint application for Medicaid and CHIP, most states had already instituted policies to help facilitate enrollment. However, Colorado was the only state with presumptive eligibility. There was some variation in the extent to which states had streamlined or simplified their renewal policies. Of states with separate CHIP programs, Colorado and Washington had joint renewal forms, while Iowa and Texas did not. Of the six states visited, only Washington had 12-month continuous eligibility in its Medicaid programs. As a consequence of these different starting points and variations in program policies and procedures, states also differed in the actions needed to reach the finish line—coverage for all children.

¹ Starting in 1996, noncitizen and legal permanent resident immigrant children who have lived in the United States were subject to a five-year waiting period before becoming eligible for federally funded Medicaid/CHIP coverage. With the February 2009 passage of the Children’s Health Insurance Program Reauthorization Act (CHIPRA), however, states were given a new option to remove the five-year waiting period and extend health coverage to these legal permanent resident children who otherwise meet Medicaid/CHIP eligibility requirements.

Table 2. State Program Characteristics as of 2007

	CHIP Program Type	Upper Income Limit	Coverage of Legally Resident Immigrant Children (within the five-year waiting period)	State-Only Funded Program for Undocumented Children	Presumptive Eligibility ^a	12-Month Continuous Eligibility ^b
Arkansas	Medicaid Expansion	200%	No	No	No	CHIP: Yes Medicaid: No
Colorado	Separate	CHIP: 205% Medicaid: Ages 0-5: 133% Ages 6-19: 100%	No	No	Yes	CHIP: Yes Medicaid: No
Iowa	Combina- tion	CHIP: 200% Medicaid: Ages 0-1: 200% Ages 1-19: 133%	No	No	No	CHIP: Yes Medicaid: No
Ohio	Medicaid Expansion	200%	No	No	No	No
Texas	Separate	CHIP: 200% Medicaid: Ages 0-1: 185% Ages 1-5: 133% Ages 6-19: 100%	Yes	No	No	CHIP: Yes Medicaid: No
Washington	Separate	CHIP: 250% Medicaid: 200%	Yes	Yes	No	Yes

^a Presumptive eligibility allows states to provide immediate, but temporary, enrollment in Medicaid or CHIP to children who appear to meet program eligibility standards.

^b Continuous eligibility allows states to provide coverage to children for up to one full year, even if families experience a change in income or status.

Grantees' Agendas for Expanding Children's Coverage

Despite different starting points, Finish Line grantees set out to accomplish similar goals. This similarity was due largely to the guidance provided by the Packard Foundation in its *Finish Line Grant Proposal Guidelines*, which stated:

“While the Foundation does not have a position on a specific policy agenda to cover all children, such policies may typically include: (1) expansion of eligibility for public programs . . . to uninsured children with incomes up to 300% of FPL or higher; (2) a buy-in program for uninsured children in families with income above the state's eligibility level for subsidized coverage; (3) a focus on enrollment and retention policies . . . ; and (4) a focus on expanding coverage for immigrant children . . . ” (Packard, September 21, 2007).

Finish Line grantees embraced these guidelines and often built upon them in important and creative ways:

- Grantees in all six states included significant eligibility expansion under CHIP as a key agenda item. Five advocated for expansion to 300 percent of the FPL and one worked for expansion to 250 percent of the FPL.
- Grantees in four states—Arkansas, Ohio, Texas, and Washington—included a buy-in program on their agendas, each designed to allow parents who earned income above CHIP's upper limit to purchase coverage for their children on a sliding scale.
- Grantees in four states—Arkansas, Colorado, Iowa, and Texas—aimed to improve and simplify enrollment or renewal procedures for children already eligible by advocating for such policies as 12-month continuous eligibility, administrative renewal, presumptive eligibility, increased outreach, help with applications, and modernizing computerized eligibility and data systems.

While recognizing the value of including advocacy for coverage of immigrant children on their agendas, most grantees reported that this issue was too politically controversial to pursue. The grantees in Iowa and Ohio, however, explicitly identified advancing the policy dialogue surrounding immigrant children as part of their agendas. In the short term, they aimed to clarify the differing issues surrounding legally resident immigrants versus undocumented immigrants; over the longer term, they planned to focus on expanded coverage for undocumented children.

Other priorities of the grantees included working to improve the reach and operations of Early Periodic Screening, Diagnosis, and Treatment (EPSDT) programs (Ohio); expanding coverage of uninsured children who are blind and disabled (Colorado); and expanding coverage of pregnant women and transitional youth (Ohio).

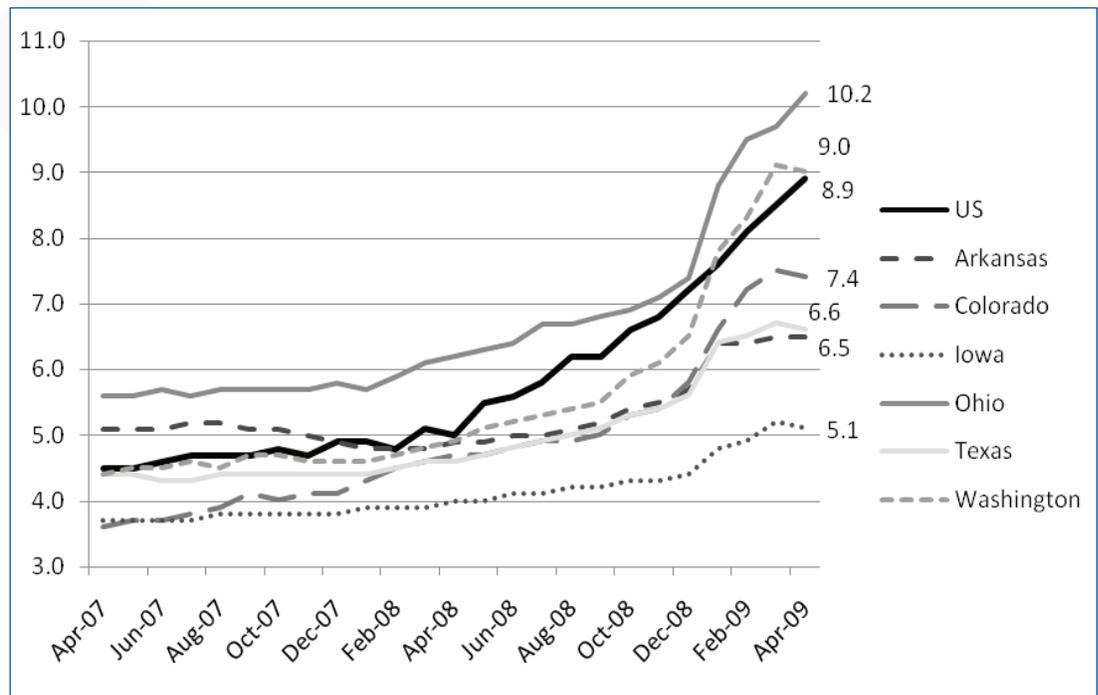
Grantees Faced Challenges Working Toward Coverage for All Children

In pursuing their agendas, Finish Line grantees in all six states faced significant challenges, including securing and maintaining political support, responding to counter-productive federal policies, combating long-standing state procedural obstacles,

and overcoming data limitations. But perhaps the most formidable challenge has been the unprecedented economic decline at national and state levels. States' fiscal conditions have significantly worsened since the Packard Foundation awarded the Finish Line grants in 2008.

Worsening Fiscal Climate. States' fiscal woes have been driven in part by unemployment rates that have risen to levels not seen in many years (Figure 1). In Washington, for example, the unemployment rate of 9.0 percent in April 2009 was higher than the national rate (8.9 percent) and reflects a significant increase from 4.4 percent two years previously. Other signs of economic distress, such as increased home foreclosures, also have been readily apparent in all six states. In April 2009, according to RealtyTrac, Colorado ranked 9th nationally in the rate of home foreclosures; Ohio ranked 10th; Arkansas, 21st; Washington, 26th; Texas, 27th; and Iowa, 40th.

Figure 1. Seasonally Adjusted State Unemployment Rates, April 2007 to April 2009



Sources: United States Department of Labor, Bureau of Labor Statistics, Labor Force Statistics from the Current Population Survey, Seasonally Adjusted Unemployment Rate, April 2007-April 2009 (data extracted July 7, 2009); United States Department of Labor, Bureau of Labor Statistics, Local Area Unemployment Statistics, Seasonally Adjusted, April 2007-April 2009 (data extracted July 7, 2009). Note: State data from April 2007-December 2008 reflects revised population controls, model re-estimation, and new seasonal factors.

For fiscal year (FY) 2010, all six states expect budget shortfalls, ranging from approximately 3 percent of the general fund in Arkansas to nearly 23 percent in Washington (Table 3). This outlook reflects a worsening situation from FY 2009 and is in sharp contrast to FY 2007, when the National Conference of State Legislatures reported that no state ended the year with a budget deficit. Until recently, the economic outlook in Texas had been relatively promising because of increased oil and gas revenues, but that outlook has quickly darkened: the state now expects a \$3.5 billion budget gap for FY 2010.

Table 3. State Budget Gaps, FY2009 and FY2010 (As of May 2009)

	FY2009		FY2010	
	Gap (\$billions)	% General Fund	Gap (\$billions)	% General Fund
Arkansas	\$0.107	2.4	\$0.146	3.2
Colorado	\$0.859	11.1	\$1.000	13.0
Iowa	\$0.484	7.6	\$0.779	12.2
Ohio	\$1.900	6.8	\$2.000	7.1
Texas	\$0.000	0.0	\$3.500	7.6
Washington	\$1.300	8.5	\$3.400	22.6

Source: Lav, Iris, and Elizabeth McNichol. "State Budget Troubles Worsen." Washington, DC: Center on Budget and Policy Priorities, 2009. Retrieved from <http://www.cbpp.org/cms/?fa=view&id=711> on June 11, 2009.

These economic woes have put pressure on Finish Line grantees to preserve existing children's coverage levels and significantly added to the challenge of expanding coverage. As a Texas respondent aptly said, "[The] budget defines what policy can be." Competing funding priorities have also added to the challenges, which have become even more intense as the economic decline further reduces available funds. For example, Arkansas had until recently been under a State Supreme Court ruling that required it to put significant funding into its education system. As the state's budget was squeezed, cuts to areas other than education were more likely because, as respondents in that state mentioned, state policymakers do not want to go back to court over education. Some states have given priority to tax cuts in recent years, which has implications for current and future budgets. In Colorado, for example, the 1992 Tax Payer Bill of Rights (TABOR) created a difficult budget situation because it stipulates voter approval of tax increases, revenue limits, spending limits, and limits on revenue options. During times of falling state revenues, these constitutional limits leave little room for Colorado advocates and policymakers to expand programs or invest in systems change.² In Ohio, a respondent described the state's tax base as being "like a sieve—leaky" as a result of the steady progression of tax cuts over the past 10 to 15 years.

Rising levels of unemployment also mean that people are losing their employer-sponsored insurance coverage, which increases demand for public programs such as Medicaid and CHIP. For those who still have access to employer-sponsored coverage, affordability is a growing problem as premiums, deductibles, and copayments

² In 2005, Colorado voters passed via statewide ballot the Colorado State Spending Act Referendum C, which suspended TABOR spending limits for five years to enable policymakers to address the state budget deficit.

are rising. Growing numbers of people joining the ranks of the uninsured add to the challenges Finish Line grantees face as they work toward coverage for all children.

Securing and Maintaining Political Support. Political support is essential for grantees to move their agendas forward. Although some states, such as Washington, have a long history of political support for children's coverage, garnering such support in other states, such as Texas, has been considerably more difficult. According to a Texas respondent, "One of the basics for successful expansions is having state leadership on the issue . . . like a governor or lieutenant governor, who gets out front and says 'This is the right thing to do.' Without that, you're fighting the inertia of the system." In Arkansas, Colorado, and Iowa, the presence of Democratic governors and majorities in both houses of the state legislature created a favorable political environment for expanding children's coverage, with many politicians running on campaign platforms that publicly supported these efforts. Over time, however, Finish Line grantees in all six states have been challenged to keep political support from wavering and losing focus, particularly during this period of economic turmoil.

In some of the states, Finish Line grantees found that both policymakers and other stakeholders were growing weary of the constant focus on expanding children's coverage and were eager to move on to other issues, such as universal coverage for all state residents or education reform. According to a Texas respondent, "CHIP boomed, then busted, then boomed again. People are fatigued and tired of hearing about CHIP." An Arkansas respondent noted, "Most people see kids' coverage as being under control." In a few Finish Line states, some organizations expressed concern about the focus being only on children and believe that adult coverage also needs to be addressed. Respondents often stated that pushing the children's coverage agenda too hard or at an inopportune time may anger people and diminish both the support for the agenda and the credibility of those advocating it.

Even in states where coverage expansion legislation had passed, maintaining political support remained a critical challenge because implementation was sometimes incremental and funding to support the expansion may not have been secured. In 2007, for example, Washington passed legislation that aimed to cover all children by 2010. The legislation provided for a phased-in approach, with a first step of expanding coverage to children in households whose income was up to 250 percent of the FPL and a second step, targeted for 2009, of expanding coverage up to 300 percent of the FPL, and creating a buy-in program for children in households whose income was more than 300 percent of the FPL. In Iowa, 2008 legislation provided a framework for expansion, but with an ambiguous timetable and limited funding. According to an Iowa respondent, "It was impressive legislation in terms of scope, but there is a long way to go in terms of implementation."

Respondents across the six states agreed that political champions are essential to move children's coverage agendas forward, but they also acknowledged the difficulty in identifying and nurturing them. In some states, factors such as term limits and the part-time status of legislators added to the difficulty. Term limits in Arkansas, for example, restrict legislators to three two-year terms in the House and two four-year terms in the Senate. As an Arkansas respondent said, "The problem with term limits

is that as soon as we get a key champion, they're gone. It used to be you had the champions who really stood out, and now, it's getting harder and harder to identify those people quickly enough." Texas respondents, like those in other states, also noted challenges in getting legislators focused when the state legislature meets for only six months every two years.

Overt opposition among state political leaders to expanding coverage for children was rare in the six states. Even strong conservatives who opposed expansion stated that it was politically risky to come out directly against public programs targeting children. As a result, political opposition to coverage expansions would most often manifest as opposition to big government, the high costs associated with public programs, and the belief that individuals are better served by relying on the private sector.

Responding to Counterproductive Federal Policies. Many respondents noted that the federal government has posed significant obstacles to expanding children's coverage in recent years—a situation that has required significant effort on the part of Finish Line grantees to overcome. For example, although the Ohio legislature passed legislation to expand coverage for children in households whose income was up to 300 percent of the FPL in 2007, the Centers for Medicare & Medicaid Services (CMS) denied the state's plan amendment based on a directive that required states to enroll at least 95 percent of eligible children in households whose income was up to 250 percent of the FPL before expanding eligibility to higher-income families. As an Ohio respondent stated, "It is very frustrating because we should be celebrating, but we cannot. . . . We are very hopeful and committed. But there are changes needed at the federal level." New citizenship documentation requirements under the Deficit Reduction Act of 2006 also caused problems and reportedly resulted in children being dropped from Medicaid and CHIP rolls because families were unable to provide documentation to prove citizenship. Reportedly, this issue was worse in some states because of varying interpretations of the citizenship requirements. Delayed CHIP reauthorization further impeded progress because states were reluctant to expand coverage before the federal policy picture was clear.

The lack of federal funding for undocumented immigrants and, until recently—under the Children's Health Insurance Program Reauthorization Act, or CHIPRA—for legally resident immigrant children within the five-year waiting period, added another challenge for Finish Line grantees. Although one study state, Washington, uses state funds to provide coverage for undocumented immigrant children, support for such policies in most states is lacking. Moreover, within each of the six states, there is prevalent and often hostile opposition from both the public and policymakers to providing any type of public coverage expansion for immigrants. Finish Line grantees have struggled to find effective messages to combat this opposition. Grantees also faced obstacles in securing reliable data on the size and characteristics of this population, although their sense in each of the states was that it was rapidly growing.

Combating Long-Standing State Procedural Obstacles. Respondents noted a number of key historical challenges facing Finish Line grantees. One was the existence of policies and procedures that perpetuate a stigma with respect to public coverage of children. In two states, Colorado and Ohio, individual counties are responsible for



determining Medicaid and CHIP eligibility, which typically is conducted in the same county offices that handle eligibility for cash assistance programs. As an Ohio respondent stated, “People have to sign up for coverage through the county departments of human services. If someone is higher income and is only eligible for CHIP benefits (and not food stamps), the notion of going to a government office is not ideal.”

Another challenge cited frequently was problems with states’ enrollment and renewal processes. For example, implementation of new computerized systems to assist with eligibility in Colorado (the Colorado Benefits Management System, or CBMS) and Texas (the Texas Integrated Eligibility Redesign System, or TIERS) was not only expensive, but essentially failed to enroll large numbers of eligible children in a timely way—or at all. Moreover, delays in processing applications have become increasingly common as some states have reduced their workforces in response to the economic downturn. This might cause even more enrollment delays because information provided by families might change between the time they file an application and when it is processed.

Overcoming Data Limitations. Data limitations have created a number of difficulties for Finish Line grantees in some of the six states. Credible and relevant data about the population targeted for expansion efforts have reportedly been difficult to obtain. In some cases, the data do not exist, but in others the grantees face problems getting the state (or others) to provide the information they need. In Ohio, for example, the proprietary nature of the state’s Medicaid managed care records precludes advocacy organizations from obtaining performance data that would help inform planning and implementation of their outreach efforts.

Without good data, it is difficult for grantees to develop and pursue strategies likely to have the most impact. Further, the lack of data precludes grantees’ ability to monitor and track progress, which is important to determine whether any midcourse strategic changes are needed and what those changes might entail. As many respondents noted, good data are extremely powerful—it is hard for anyone to argue against the facts.

Addressing Challenges and Accomplishing Results

Even in the face of sometimes daunting challenges, grantees in many of the Finish Line states were successful in moving their agendas forward (Table 4). Highlights of recent improvements in coverage policies for children include these achievements:

- In *Arkansas*, eligibility for ARKids was expanded to 250 percent of the FPL after Governor Mike Beebe gave his support to a \$0.56 tobacco tax. In addition, spurred by advocates after the passage of CHIPRA, he issued a recommendation for the state Department of Human Services to do away with the five-year waiting period for Medicaid coverage of legally resident immigrant children; state officials hope to implement this new coverage after successful completion of a legislative review process. Eligibility systems for families also improved, as the state Department of Human Services implemented online enrollment this year (and plans to implement online renewal as part of eligibility system changes).

- In **Colorado**, Governor Bill Ritter signed the Colorado Health Care Affordability Act in April, establishing a new hospital fee that, coupled with federal matching funds, is expected to secure approximately \$1.2 billion in new funding. With this money, Colorado will expand coverage for children (and pregnant women) to 250 percent of the FPL and for parents to 100 percent of the FPL. The state will also create a new coverage group for childless adults with incomes up to the poverty level. Furthermore, the law creates a buy-in program for children with special health care needs in families with income up to 400 percent of the FPL and extends Medicaid continuous eligibility to 12 months, bringing it in line with CHIP policy. After federal passage of CHIPRA, Colorado also moved to drop the five-year waiting period for Medicaid coverage of legally resident immigrant children (though implementation of this provision is pending while officials look for a funding source). Additionally, Colorado passed a bill to allow telephone and online reenrollment.
- **Iowa** is expected to begin covering children in families with incomes up to 300 percent of the FPL starting July 2009, as the result of passage of a comprehensive health care reform bill earlier in the year. Coverage expansions also were enacted for pregnant women (to 300 percent of the FPL) and for legally resident immigrant children (under Medicaid and hawk-i, the state's CHIP program). The state also adopted a host of new enrollment-simplification strategies, including reduced income verification requirements, as well as five of the eight strategies required under CHIPRA for states to receive Medicaid matching funds from the federal government: premium assistance, presumptive eligibility, express lane eligibility, paperless renewal, and a joint application and renewal process for both Medicaid and hawk-i. In addition, a new soft mandate will take effect with the state's 2010 state income tax form, in which all families will be asked if they have uninsured children and require those that do to submit an application for Medicaid or hawk-i within 90 days of receiving an application from the state. (This mandate is considered a soft one because, at this time, the state does not plan to monitor or enforce it.)
- In **Ohio**, the grantees' primary focus has been to protect the gains made in 2007 against cuts that have loomed since the economy faltered. Thus far, that effort has been successful. At the time of this writing, the state budget was still under review, but it included funding to increase children's eligibility to 300 percent of the FPL and to adopt a number of enrollment simplifications as part of the grantee's Cut the Red Tape agenda, including express lane eligibility, 12-month continuous eligibility, and telephone renewals.
- In **Texas**, the most notable recent improvement occurred in 2007 when CHIP policy was revised to reinstate 12-month continuous eligibility for children. (CHIP continuous eligibility had been reduced to six months in 2003, a change that was largely to blame for approximately 200,000 children losing coverage in the following year.) Other improvements accomplished in 2007 included removing a 90-day waiting period for coverage of newly enrolled children (instituted in 2003 as a cost-cutting strategy), restoring some income disregards to the eligibility

determination process, and making the assets test less stringent. In the past year, although no direct expansion of coverage was enacted, the grantee was successful in building strong bipartisan support, as well as endorsement from business leaders, for its proposal to expand coverage to all children in households whose income is below 300 percent of the FPL. The grantee is optimistic about this effort moving forward soon. In addition, a budget request for increased eligibility staffing was approved, which will allow the hiring of nearly 1,600 more employees to address long-standing problems of untimely processing of applications and errors in processed applications.

- **Washington** implemented a children’s coverage expansion to 300 percent of the FPL in 2009. The provision, passed in 2007, had faced delays as the state

Table 4. Recent Children’s Coverage Gains in Six Finish Line States

	Eligibility Expansion	Buy-In Program	Simplify Enrollment/Renewal	Other
Arkansas	200 -> 250% of the FPL*		<ul style="list-style-type: none"> • Online enrollment • Online renewal* 	<ul style="list-style-type: none"> • Legally resident immigrant children*
Colorado	205 -> 250% of the FPL	CSHCN < 400%	<ul style="list-style-type: none"> • 12 months continuous eligibility • Telephone and online renewal 	<ul style="list-style-type: none"> • Pregnant women (250% of the FPL) • Parents (100% of the FPL) • Childless adults (100% of the FPL) • Legally resident immigrant children*
Iowa	200 -> 300% of the FPL		<ul style="list-style-type: none"> • 12 months continuous eligibility • Presumptive eligibility • Joint application and renewal • Express lane eligibility • Paperless renewal • Premium assistance • Reduced income verification 	<ul style="list-style-type: none"> • Pregnant women (300% of the FPL) • CSHCN (300% of the FPL) • Legally resident immigrant children • Dental coverage • Translation services
Ohio	200 -> 300% of the FPL*		<ul style="list-style-type: none"> • 12 months continuous eligibility* • Telephone renewal* • Express lane eligibility* 	
Texas			<ul style="list-style-type: none"> • 12 months continuous eligibility • Restored income disregards • Reduced assets test stringency • Removed 90-day wait • Increased eligibility staffing 	
Washington	250 -> 300% of the FPL		<ul style="list-style-type: none"> • Express lane eligibility 	<ul style="list-style-type: none"> • Apple Health for Children (rebranding of public coverage for children)

*Pending

struggled against mounting budget deficits. However, passage of CHIPRA and the promise of federal matching funds opened the doors for final approval. In advance of the expansion, the state moved ahead with a rebranding of public coverage for children, renaming the program Apple Health for Children. At this time, state officials are designing new enrollment procedures, including express lane eligibility, that are expected to streamline children's access to coverage.

Gaining Ground Through Effective Advocacy

When asked to identify the most important advocacy strategies, those that contributed to these gains, respondents in the six states named the following approaches:

Building and Involving a Broad-Based Coalition of Stakeholders. Coalitions have been a centerpiece in each of the Finish Line grantees' strategies. By identifying, recruiting, and collaborating with a broad base of stakeholders, the grantees have worked to build diverse, widespread support for children's coverage in their states. In Texas, for example, grantees including the Children's Defense Fund, the Center for Public Policy Priorities, and Texans Care for Children have collaborated to develop and promote an agenda for children's coverage and worked to include organizations representing hospitals, health plans, providers, and a plethora of community-based and grassroots organizations among their coalition members. Most recently, the Texas grantee succeeded in adding the business community to its coalition ranks, working with a prominent business owner to convene a symposium of 200 leading CEOs to discuss children's health coverage and present the economic argument for CHIP expansion.

Colorado's grantee—a partnership of the Colorado Coalition for the Medically Underserved, the Colorado Children's Campaign, Covering Kids, and Families and Metro Organizations for People—harnessed the diverse interests of each group's membership and convened a one-day summit, Colorado Can Cover All Kids, in early 2009 to gather stakeholders to discuss new opportunities contained in CHIPRA and brainstorm strategies for promoting expanded coverage. In Washington, the Children's Alliance, which staffs that state's long-standing Health Coalition for Children and Youth, accessed the power of its more than 40 organizational members, representing labor, providers, community health centers, and faith-based entities. Together, they pressed firmly and continually for implementation of expansions to children's coverage that were threatened by the state's economic downturn.

Identifying and Cultivating Diverse, Respected Champions for Children's Coverage. In all six states, Finish Line grantees worked hard to identify and build strong relationships with various champions who could help expand children's coverage. In some states, the governor was seen as the primary champion. For example, Arkansas's governor is a key supporter who took steps to drop the five-year waiting period for coverage of legally resident immigrant children when Arkansas Advocates for Children and Families informed his staff of the provision's inclusion in the CHIP reauthorization. In other states, such as Iowa, state legislators adopted the champion role; State senator Jack Hatch has been the Child and Family Policy Center's key champion, leading health reform legislation and incorporating many of the grantee's

recommendations into bills he introduced or sponsored. Colorado's All Kids Covered coalition saw an opportunity to recruit a key ally from the state program responsible for administering CHIP and Medicaid. The grantee has worked closely with the new director of the Health Care Policy and Finance (HCPF) bureau to identify problems in Colorado's eligibility systems, to find ways to address those problems, and to collaborate on the design and implementation of a summit on modernizing eligibility to plan system reforms.

Using Effective and Impactful Message Strategies and Using Strategies in Flexible Ways.

With help from Spitfire Strategies, each Finish Line grantee has worked to identify and use effective message strategies to promote and build public support for children's coverage. Importantly, as state circumstances have changed, the grantees were often able to adjust their core messages to better fit the situation. For instance, in light of the economic downturn and mounting state budget deficits, Iowa advocates changed their message to "Now, more than ever, we cannot desert children and families" and to emphasize that "the state budget is a reflection of families' budgets." In Ohio, as the fate of the state's passed expansions languished, Voices for Ohio's Children argued that CHIP expansions could represent "a key win" for children that the governor and legislature could achieve. In Washington, where expansions previously approved were also on hold, the grantee seized on the passage of CHIPRA as a means for giving the governor an opportunity to rise above the budget impasse; specifically, the grantee suggested that the new message should be that the state was "grateful for the significant federal investment in children's health, which makes it possible for Washington to implement its expansions at a net savings for the state."

Working to Encourage a Cultural Shift Among Health Program Administrators. In the years since the passage of CHIP, states across the nation have worked to make enrollment and renewal systems simpler and more user-friendly. As part of this effort, advocates have worked to change the culture of state and local agencies responsible for eligibility determination, changing them from bureaus that see themselves as guarding the state's till by keeping undeserving families off of public programs, to groups that are more customer-oriented and willing to facilitate access to coverage for eligible families. The challenge of this cultural shift has been especially difficult in states such as Colorado and Ohio, where county-based departments autonomously administer social services programs and have, at times, interpreted and implemented federal and state policies in different ways. In response, Finish Line grantees in these two states have focused direct attention on local agencies and administrators (and their state counterparts), working to include them in their coalitions, priority setting, and decision making.

Establishing Themselves as Respected Go-To Organizations for Credible Information and Data. Each of the Finish Line grantees has placed high priority on building its capacity to collect, analyze, and present high quality data and information on children, coverage options, and the consequences of inaction. Indeed, in each of the six states, stakeholders consistently praised the grantees as the go-to organizations for such information. These children's advocates were viewed as credible, presenting information in a careful and balanced way to make a strong case for expanded

coverage. Not surprisingly, therefore, this capacity was identified as one of the key reasons grantees were successful in moving their agendas forward.

Taking Advantage of Recent Federal Changes. As illustrated in many of the examples cited earlier, Finish Line grantees were well positioned to take advantage of the change in the federal administration and seize opportunities presented by CHIP reauthorization. Working closely with those at the Georgetown University Center for Children and Families who provided technical assistance, policy analysts within each grantee organization tracked evolving legislation at the federal level and quickly grasped provisions that allowed the states greater flexibility in expanding coverage and simplifying enrollment and renewal. As described earlier, several of the grantee states added coverage of legally resident immigrant children into expansion legislation; many also pushed for greater enrollment simplification, justified by the promise of enhanced federal matching funds or additional funding. Finish Line grantees, with support from the Packard Foundation, were ideally positioned to maximize the opportunity of CHIPRA.

Lessons Learned and Implications Going Forward

When asked what lessons they had learned through the process of advocating for children's coverage expansions, grantees shared the following points:

Achieving Reform Is a Long-Term Process that Requires Persistence and Commitment. In light of the many challenges they faced, especially those related to the economic downturn, Finish Line grantees spoke of the importance of being persistent in their work, adapting their strategies to changing conditions, and continually keeping the pressure on as they work for change.

Coalitions Must Involve Grassroots and State-Level Partners. Community and local grassroots organizations brought to the grantees stories and experiences from the front lines, where families with uninsured children were struggling to obtain health care services. Such stories lent real-world credibility to the advocates' positions, bringing to life their messages about the hardships families face when they cannot meet their children's health care needs because of a lack of insurance. Local partners were valuable strategists when it came to identifying effective outreach approaches, while community-based organizations that worked directly with families were able to contribute specific examples of the enrollment barriers parents faced when attempting to sign up their children for insurance, or the difficulties they encountered trying to renew coverage.

Advocates Must Have a Unified Voice. One difficulty of working with diverse and broad-based coalitions is that coalition members sometimes struggle to speak with a consistent and unified voice. Naturally, different organizations bring different views, experiences, and priorities to the table. But for the decision makers that grantees were targeting, mixed or inconsistent messages can lead to confusion over the advocates' goals and priorities. According to the grantees, Spitfire Strategies was extremely helpful in identifying shared priorities and common messages that coalition members could adopt, that met the diverse partners' needs, and that kept their voices unified.

Creativity and Flexibility Are Required in a Changing Environment. Given the economic downturn, grantees were forced to be flexible and creative in pursuing their coverage agendas. Some efforts to expand children’s coverage had to be scaled back simply to defend the prior year’s gains. Other times, grantees settled for smaller incremental improvements rather than large expansions. Messages were altered to reflect the reality of diminished resources. On the other hand, after CHIP was reauthorized, creating new opportunities for coverage and eligibility simplification, grantees expanded their agendas. The fact that none of the grantee states experienced a significant setback during the downturn and that the majority were poised to seize the opportunities presented by CHIPRA are testament to the grantees’ adaptive skills.

Strong Data Are Critical for Supporting Objectives. Being perceived as level-headed, objective, and rational analysts armed with strong data was reportedly critical to grantees’ ability to argue effectively for reform. By documenting the extent of the problem regarding the growing number of uninsured people, identifying the various negative consequences of lack of insurance, and outlining the potential benefits of policy reforms, grantees could forcefully argue for and defend their positions for expanded coverage. Often, cultivating stronger relationships with state program staff helped grantees by giving them access to important data.

Legislation Is Just the First Step. Much of the grantees’ work has focused on making a strong case for expanding income eligibility under CHIP or Medicaid or adding new groups of children to the covered ranks. Yet grantees have arguably focused at least as much time and effort on the actual implementation of new coverage policies or programs. Advocates repeatedly stressed that simply having a new law on the books does not translate into coverage, nor does coverage necessarily translate into access to care. Sometimes this gap occurs because legislation was passed but not funded. But even with expansions that receive funding, grantees were compelled to immerse themselves in the details of eligibility and renewal processes, working hand in hand with state CHIP and Medicaid program officials to identify operational barriers and solutions to those barriers. Through these efforts, grantees felt more confident that broader coverage was actually being achieved.

Advancing the Dialogue on Immigrant Children Matters. Grantees were mostly frustrated in their desire to extend coverage to undocumented immigrant children, acknowledging that the issue was simply too politically contentious for most decision makers. In addition, policymakers and the public often lacked accurate information about the size, characteristics, and needs of this population. However, grantees stressed that one should not underestimate the importance of advancing the dialogue surrounding these children. By promoting the idea that “all children means all children” (including immigrants), and that “children should not be punished as a result of the actions of their parents,” grantees felt they succeeded in spurring some thoughtful discussions that had not previously occurred. Such dialogue, it was hoped, might lay the groundwork for discussion of coverage for these vulnerable children in future expansion efforts.

In conclusion, although reaching the finish line of health care coverage for all children remains a work in progress, effective state-based advocacy has contributed to significant gains in the expansion of coverage to children even during the worst economic decline since the Great Depression. Each of the six Finish Line states examined in this report succeeded in either significantly broadening public program eligibility for children (often to as high as 300 percent of the FPL) or adopting important policies to simplify enrollment and renewal of eligibility. Several of the grantees' strategies were cited as contributing to these gains: building broad-based, grassroots coalitions of support; cultivating respected champions to advocate coverage expansions; developing consistent and powerful message strategies; encouraging a cultural shift in public programs to focus on covering all children; positioning themselves as the go-to organizations for information on children's coverage issues; and seizing opportunities resulting from the 2009 reauthorization of CHIP.

