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Aiming High: Foundation Support for State Advocates Brings Universal Children's Health Coverage Within Reach

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Introduction

Children's health insurance coverage has numerous benefits. For children, coverage leads to improved access to care, better health outcomes, and stronger educational achievement (Chester & Alker, 2015; Harrington, 2015). Their parents miss fewer days of work and have less trouble paying their medical bills (Robinson & Coomer, 2013; Harrington, 2015).

Despite evidence about its value, children's health insurance coverage in the United States is not a guaranteed right akin to basic education. Consequently, millions of children remain uninsured even though most are eligible for public coverage. In 2011, approximately 5.5 million children were uninsured; two-thirds of these were eligible but not enrolled in free or low-cost coverage through Medicaid or the Children's Health Insurance Program (CHIP) (Kenney, Anderson, & Lynch, 2013). Families with eligible but unenrolled children may be unaware that these coverage options exist, or fail to enroll or maintain coverage for their children due to the complexities of enrollment and renewal processes, among other reasons (Stevens, Hoag, & Wooldridge, 2010).

To help close the children's health insurance coverage gap, in 2011 the Atlantic Philanthropies created the KidsWell Campaign. KidsWell's theory of change posits that if advocates could leverage new funding and coverage opportunities created by the Patient Protection and Affordable Care Act (ACA), they could expand the number of children with coverage. Although most of those expected to gain insurance coverage for

Key Points

- To help close the children's health insurance coverage gap in the United States, in 2011 the Atlantic Philanthropies created the KidsWell Campaign. KidsWell's theory of change posits that if advocates could leverage new funding and coverage opportunities created by the Patient Protection and Affordable Care Act, they could expand the number of children with health insurance coverage.
- This article presents the major results of the KidsWell evaluation, which found substantial progress in achieving KidsWell interim policy changes and coverage outcomes. But advocates still have a full agenda, which means grantees and funders need to redouble efforts to educate the larger field about the type of advocacy that can legally be supported by funders, the gains in children's coverage achieved in part with such support, and what remains at stake for children's coverage.
- While other funders may not be able to make investments comparable to Atlantic's, advocacy networks and capacities have already been built and valuable knowledge has been gained through the KidsWell effort. Funders could target future investment to states and activities needing a short-term boost to exploit windows of political opportunity or to fight threats to children's coverage. Such support is still needed to continue momentum toward universal health insurance coverage for all children.

Enacted in 2010, the ACA held great promise for expanding insurance coverage to millions of uninsured Americans. While it provided new coverage opportunities for low-income adults who previously had no access to coverage through employers or public options, ACA provisions also benefited children.

the first time through the ACA were adults, children stood to gain as well, largely because children are more likely to have health care coverage when their parents do (DeVoe, et al., 2015).

This article presents the major results of the KidsWell evaluation, including assessments of whether and how Atlantic’s investment and engagement with grantees strengthened KidsWell groups. In addition, it explores the contribution of grantees to state policy actions on children’s coverage and discusses the potential for sustaining the advocacy work begun under the KidsWell campaign.

Background: The KidsWell Campaign

Enacted in 2010, the ACA held great promise for expanding insurance coverage to millions of uninsured Americans. While it provided new coverage opportunities for low-income adults who previously had no access to coverage through employers or public options, ACA provisions also benefited children. For example, public coverage for children with family incomes less than 138 percent of the federal poverty level would shift from separate CHIP programs to Medicaid (which provides slightly enhanced benefits compared to CHIP); some families with incomes up to 400 percent of the federal poverty

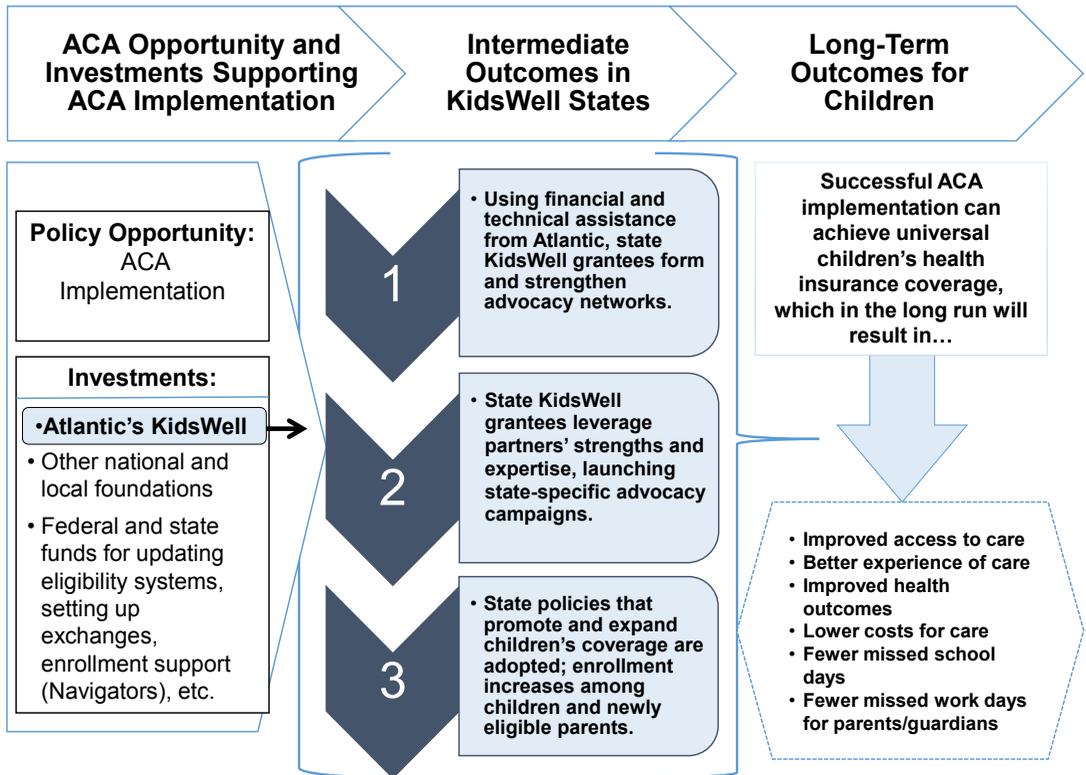
level would benefit from tax credits in the newly created marketplaces; and new coverage options for parents would likely increase children’s coverage rates through the “welcome mat” effect, whereby parents newly enrolling themselves in coverage would simultaneously enroll their eligible children (Kenney, Haley, Pan, Lynch, & Buettgens, 2016; Hoag, Lipson, & Peebles, 2015).

However, the ACA’s rapid implementation timeline, its reliance on state governments to operate major components, and political opposition to expansion of Medicaid coverage in some states gave rise to concerns that the law might not be fully or equally well implemented in all states. Although the federal government allocated some funding to develop the federal marketplace and support new information technology systems in the states, some foundations began examining further opportunities to support ACA implementation.¹

At the Atlantic Philanthropies, staff were especially keen to find ways to leverage ACA rules and funding to ensure that all children had health insurance. Due to the ACA’s complexity, Atlantic expected that implementation of its numerous provisions would require careful coordination between new coverage options and existing public insurance programs for children. Atlantic also realized that operationalizing health reform would require action by both states and the federal government, since they jointly finance and administer Medicaid and CHIP. Both also had important roles in operating health insurance exchange shopping portals, conducting outreach to low-income families, and helping families apply for insurance, among other tasks. In addition, after the U.S. Supreme Court decision in *National Federation of Independent Business v. Sebelius* in 2012, states were given a more prominent role in reform,

¹For example, shortly after the ACA passed in 2010, a group of eight national foundations (including Atlantic) created the ACA Implementation Fund, which provided strategic support to state-based health advocates to ensure effective and consumer-focused implementation of the ACA. Likewise, the Robert Wood Johnson Foundation invested in several programs to support states and consumer advocates working to implement the ACA and support enrollment into new coverage options.

FIGURE 1 KidsWell's Theory of Change



deciding whether or not to expand Medicaid eligibility to their residents.

Atlantic's efforts culminated in the creation of the KidsWell Campaign, a nearly \$29 million, six-year initiative to promote universal children's coverage through coordinated state and federal advocacy efforts. Because ACA reforms would take many years to implement, KidsWell grants began in 2011 and finished in 2016; the evaluation of KidsWell began in 2013 and also finished in 2016.

Theory of Change

KidsWell's theory of change posits that, in the short term, the ACA policy opportunity and resources available to support ACA implementation — including the financial and technical assistance resources supported through KidsWell, as well as resources from other foundations and federal and state governments — will

lead to a series of intermediate and longer-term outcomes. (See Figure 1.) Intermediate outcomes, which were expected to occur within the life of the KidsWell grants, include:

- development of children's advocacy networks in the seven KidsWell states,
- KidsWell grantees' leveraging of the expertise of network members for advocacy activities and campaigns to expand coverage for children and their families, and
- adoption of policies and procedures that promote and expand coverage, resulting in enrollment increases for children — and likely, enrollment for their newly eligible parents.

If the KidsWell grantees achieved these results, they would yield longer-term dividends,

TABLE 1 Definition of Core Advocacy Capacities

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

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

including eventual universal health insurance coverage for children. In turn, providing all children with insurance coverage will improve the overall population health and well-being of children and families through better access to care, better health outcomes, lower health care costs, and improved health equity, leading to fewer missed days of school and work for children and their parents, respectively.

State and Grantee Selection

In choosing where to invest, Atlantic targeted states with large numbers of uninsured children. In addition, Atlantic wanted to support states where organizations with strong capacities to undertake advocacy activities were already in place, so that grantees could start on the work immediately, rather than having a ramp-up period to develop grantee capacities.² Because the full complement of essential core — advocacy capacities — which are the skills,

knowledge, and resources needed to conduct advocacy campaigns — do not typically exist within a single organization or even a single type of organization, Atlantic planned to support multiple groups in each selected state. (See Table 1.) To support the selection process, Atlantic also analyzed state political landscapes, state advocacy capacities, and investments by other foundations in similar work.

Based on these analyses, Atlantic chose to invest in children’s advocacy organizations in seven states: California, Florida, Maryland, Mississippi, New Mexico, New York, and Texas. Together, those states accounted for 45 percent of all uninsured children in the nation in 2011. They varied in political leadership and, except in Maryland, more than 20 percent of children in each of those states lived under the poverty level that year. In each state, Atlantic selected a lead grantee, with fiscal responsibility for the grant, and at least one other funded partner, although typically more than one partner was included. (See Table 2.)

²Atlantic’s grants supported specific activities the grantees proposed; they were not unrestricted, general operating-support grants.

TABLE 2 State and National KidsWell Grantees

State	KidsWell State Grantees ^a
California	ChildrenNow, PICO California, Children's Defense Fund-California, the Children's Partnership
Florida	Florida CHAIN, Children's Movement of Florida, Florida Center for Fiscal and Economic Policy, Florida Children's Health Care Coalition, Children's Trust of Miami-Dade County
Maryland	Advocates for Children and Youth, Maryland Citizens' Health Initiative Education Fund (aka Maryland Health Care for All)
Mississippi	Mississippi Center for Justice, Children's Defense Fund-Southern Regional Office, Mississippi Human Services Coalition
New Mexico	New Mexico Center on Law and Poverty, Comunidades en Acción y de Fé (CAFé)
New York	Community Service Society of New York, Schuyler Center for Analysis and Advocacy, Children's Defense Fund-New York, Make the Road New York, Raising Women's Voices
Texas	Engage Texas, Center for Public Policy Priorities, Children's Defense Fund-Texas, Texans Care for Children
National Grantee Organization	National Groups' Mission and Expertise
Children's Defense Fund	Advocates for policies and programs that promote the health and well-being of children
First Focus	Bipartisan advocacy organization that works to make children and families a priority in federal policy and budget decisions
Georgetown Center for Children and Families	Nonpartisan policy and research center that works to expand and improve health coverage for children and families by conducting policy analysis and research
MomsRising	Advocates on issues facing women, mothers, and families through social media and grassroots organizing
National Academy for State Health Policy	Nonpartisan network of state health-policy leaders sharing information on state health-policy solutions and best practices
National Council of La Raza	Largest national Hispanic civil rights and advocacy organization in the U.S.; works to improve opportunities, including health care coverage, for Hispanic Americans through affiliated community-based organizations
National Health Law Program	Protects and advances the health rights of low-income and underserved individuals and families through litigation and policy analysis
New America Media	National network of ethnic news organizations that develops multimedia content to inform communities and influence social policy, including health care coverage
PICO National Network	National network of faith-based community organizations working to create innovative solutions to problems facing urban, suburban, and rural communities
Young Invincibles	Nonpartisan organization that mobilizes young adults, ages 18 to 34, to expand youth access to health insurance and care through outreach and advocacy campaigns at the national and state levels

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

^aThe lead grantee in each state is listed first.

National Grantees

As part of KidsWell, Atlantic also invested in multiyear grants to 10 national advocacy organizations to support two sets of activities: (1) to provide expert advice to the state grantees on federal law, health-policy analysis, media and communications, outreach, litigation, and grassroots organizing; and (2) to influence national health reform and to advocate for federal health policies that ensure access to insurance for children. (See Table 2.) For example, while state KidsWell groups focused on pressing policy issues in their states, the national groups focused on issues that might affect children in all states, such as advocating for states to cover all immigrant children regardless of immigration status, or publishing research showing continued coverage disparities for Hispanic children in the U.S.

Evaluation Goals, Data Sources, and Methods

The KidsWell evaluation focused on understanding whether the intermediate outcomes from the theory of change have been achieved. To that end, we developed a set of research questions about the activities and achievements of the state KidsWell grantees:

1. How did Atlantic's investment and engagement with the KidsWell grantees contribute to strengthening advocacy capacities and networks?
2. Which advocacy activities used by KidsWell grantees appear to be most effective in securing policy advances or preventing policy setbacks to expand or maintain access to children's health care coverage?
3. To what extent did policymakers and leaders in the KidsWell states perceive grantees to have shaped or influenced policies that advanced children's coverage?
4. How and to what extent did children's health insurance coverage rates change in the seven KidsWell states?

5. Will children's health care coverage advocacy capacities, activities, strategies, and productive networks built with KidsWell support be sustained?

The data sources used in the evaluation include an all-grantee survey, program documents, key informant interviews, and focus groups. (See Table 3.) We used analytic software to code interview notes and identify common themes, produced descriptive statistics from survey and interview results to highlight patterns, analyzed within-state consistency in reporting among grantees, and compared grantees' responses to those of state policy leaders.

To examine the relationship between KidsWell grantees' activities and the policy advances they targeted, we conducted a temporal analysis to compare the proximity in time of the advocacy campaigns against policy wins reported by grantees and independent sources by tracking grantee activities by state, month, type of activity, and policy topic (e.g., Medicaid, ACA outreach issues, state budget issues).³ Proximity of a policy advance to advocacy-campaign activities alone does not mean that advocates had a significant influence on the policy outcomes; for example, advocates in one state told us that most policies there take two years to adopt, using the first year to introduce the policy and build support and the second year to gain passage. However, temporal patterns that do emerge help to build a case, along with other supporting evidence, for the effectiveness of advocacy campaigns. This temporal analysis was also informed by the interviews with policy leaders in each state, who were asked for their views about KidsWell grantees' campaigns and the degree to which those campaigns, as well as other factors, influenced policy outcomes.

³Policy wins or advances are broadly defined by this evaluation as legislation or an administrative rule, budget decision, court case, or other state policy action that will increase or accelerate gains in children's health care coverage. Policy losses are defined as legislation or an administrative rule, budget decision, court case, or other state policy action that reverses, prevents, or hinders gains in children's health care coverage.

TABLE 3 Evaluation Data Sources

Data Sources	Description
KidsWell program documents, 2011–2015	Written materials from the grantees included grant applications and progress reports throughout the grant period, activity reports produced monthly through 2014, and background materials produced during grantee selection.
Site visit data, 2014	Site visits to grantees in New Mexico and New York in 2014 developed in-depth case studies; on-site interviews were conducted with grantees and other key stakeholders, including policymakers, in each state.
In-person focus groups, 2014	Separate focus groups were conducted with representatives from state and national grantees in June 2014 addressing KidsWell partnerships, ACA issues related to children's coverage, resources, and upcoming opportunities and challenges for children's coverage policies. Representatives from eight national grantees, and at least one representative from each state, participated.
All-grantee survey, 2014	An electronic, editable PDF survey was emailed to representatives from all KidsWell grantees in July and August 2014 addressing organization and partner strengths and weaknesses in terms of capacity; children's health-policy campaign targets, policy wins and losses, and activities used to influence wins and prevent losses; use and value of KidsWell grants and resources; and state-national grantee interaction. At each organization, the staff person with the most knowledge of the grant project was asked to complete the survey. 29 respondents from the state grantee groups and 10 respondents from the national grantee groups responded to the survey.
Telephone interviews with policy leaders in the seven KidsWell states, 2015–2016	Interviews were conducted between November 2015 and April 2016 with children's health-policy leaders (state legislators, Medicaid or insurance agency heads, advisors to governors) in seven states to inquire about their familiarity with the KidsWell grantees, their assessment of the contributions of KidsWell grantees to particular state policies and how effective the grantees were at various advocacy activities, and their views on future health coverage issues and issues that might affect coverage (such as the state budget or political landscape). They targeted six respondents per state and interviewed six respondents from California, Maryland, Mississippi, New Mexico, and New York, but only five respondents from Florida and Texas, due to refusals to participate (40 respondents in total from the seven states).
Telephone interviews with grantees, 2016	Interviews were conducted between February and April 2016 with 22 state grantees to inquire about their main policy focus since the evaluation's 2014 survey; any policy changes in the state; sustainability of grantee networks and whether they had sought and/or identified replacement funding to sustain this work; lessons learned from participating in KidsWell; and their views on future health coverage issues and issues that might affect coverage, such as the state budget or political landscape. Five national grantees were asked about issues they expected to focus on in the near term and any upcoming challenges or opportunities related to coverage policies, whether policies promoted by the grantees influenced changes in non-KidsWell states or at the federal level, sustainability of grantee networks and whether they had sought and/or identified replacement funding to sustain this work, and lessons learned from participating in KidsWell.
Independent data sources on state policy developments and insurance coverage statistics, 2009–2014	Publicly available sources on state and federal policy changes related to children's health care coverage or ACA issues, including health policy blogs produced by the Georgetown Center for Children and Families and the National Academy for State Health Policy, daily health reports from American Health Line and similar sources; analyses of annual American Community Survey data, and data on Medicaid/CHIP participation over time to examine coverage and uninsurance rates among children.

[A]ll but one of the 29 state grantee respondents reported that KidsWell resources enhanced their organizations' advocacy capacities. Skills that were most enhanced included communications and media, policy and/or legal analysis, grassroots organizing and mobilization, and coalition building. Technical assistance from national groups was an important mechanism for expanding these capacities.

Although the evaluation examines changes in children's coverage rates during the grant period, it does not assess the direct effect of KidsWell on coverage rates. Given the many federal and state policy, budgetary, and political factors influencing ACA implementation, which in turn affect enrollment into coverage, it is not possible to draw a causal relationship between KidsWell advocacy activities and coverage gains in the states in which KidsWell advocates were active.

Findings

1. *How did Atlantic's investment and engagement with the KidsWell grantees contribute to strengthening advocacy capacities and networks?*

Atlantic sought to maximize its investment by intentionally funding capable children's-advocacy organizations, with different strengths, that could partner to advance ACA implementation within the target states. In a few states, the desire to fund organizations that in combination had all advocacy skills led to "arranged marriages" of partners that had not worked together previously,

creating challenges for groups with different approaches to advocacy. Tensions were apparent in a few states at the outset, but these strains seemed to abate quickly, as groups learned to collaborate, share accountability, and leverage each other's strengths, sometimes with the help of technical assistance provided by KidsWell.

Grantees' and policy leaders' views suggest that Atlantic's approach to grantee selection was effective. In the mid-2014 grantee survey, grantees in all states reported consistent policy goals, strategies, wins, losses, and assessment of partner strengths within state coalitions, indicating strong alignment. According to grantee representatives, at least one organization in each state except New Mexico reported having strength in each of the core advocacy capacities; in New Mexico, neither grantee had a strong relationship with the state Medicaid agency. Policy leaders validated these self-perceptions: when asked to rate the grantees' effectiveness at undertaking six different advocacy activities, at least one grantee within each state except New Mexico was ranked as moderately or very effective in each category across states.⁴ Grantees also reported that KidsWell funding and resources strengthened partnerships within states, with KidsWell-funded partners and with other interest groups, which in turn allowed them to develop effective advocacy campaigns.

As noted, KidsWell was not intended primarily as a capacity-building grant — grantees were selected to advance policy changes because of their existing capabilities. Indeed, the state grantees had varying levels of skills and knowledge in each of the core advocacy capacities, and KidsWell was expected to strengthen their advocacy capacity by leveraging the strengths of each organization and through support and advice from national grantees. Still, in the 2014 grantee survey, all but one of the 29 state grantee respondents reported that KidsWell resources enhanced their organizations' advocacy capacities. Skills that were most enhanced included communications and media, policy and/or legal

⁴In New Mexico, respondents did not identify grantees as weak at grassroots organizing; rather, all respondents said they did not know if either grantee was effective at grassroots organizing activities.

analysis, grassroots organizing and mobilization, and coalition building. Technical assistance from national groups was an important mechanism for expanding these capacities, with nearly all state grantees — 28 of 29 responding — reporting that the technical assistance provided through KidsWell helped them to spread their reach in advocacy efforts and be more effective. National grantees benefited as well: six of 10 national survey respondents noted that their interactions with the state grantees helped them identify where assistance was needed most and kept them abreast of state policy developments that enhanced their national advocacy work.

Grantees attributed their successes in KidsWell to two key features of Atlantic's grantmaking approach. First, grantees said that multiyear funding provided more security compared to a single year of funding, giving them the ability to hire new staff and alleviating the burden of annual grant writing. As one state grantee commented, "multiyear funding is a gift. It means we can spend time on real policy work." Several also mentioned that policy progress requires a sustained focus and "doesn't just happen in a year or 18 months," another reason grantees appreciated multiyear support.

Second, a majority of grantees cited Atlantic's flexible approach, in which grantees could decide which policies to target and campaign strategies to use, as long as they aligned with KidsWell's overall goal of improving children's coverage. That meant that grantees in each state had leeway to identify the policy priorities that they believed would improve children's coverage and could be achieved in their state. Common priorities across the seven states included defending Medicaid and CHIP from state budget cuts, Medicaid and CHIP enrollment and renewal policies, and, after the ACA Supreme Court decision in 2012, advocating for the adoption of the ACA-authorized expansion of Medicaid eligibility to low-income adults. In California, Maryland, and New York, advocates also supported development of state exchanges, based on the expectation that state exchanges would give advocates a stronger voice in influencing exchange policies and benefits affecting children's health care

coverage. One national grantee noted how this flexibility benefited them:

Atlantic let us pivot when we needed to, giving us the freedom to address not just the primary issues but also to focus on [ancillary] issues that will also improve children's coverage.

Finally, we also wanted to understand whether the strategy of selecting both state and national groups enhanced advocacy capacities or strengthened advocacy networks. In our 2014 grantee survey, both state and national groups separately reported that they commonly collaborated. They also agreed that this collaboration benefited them: State grantees said the support they received from national groups enhanced their own advocacy capacity by increasing their knowledge of policy issues and skill in planning campaign strategies, while the national groups used information gained from the KidsWell state advocates about policy implementation to inform national campaign strategies with states outside the KidsWell group. Despite the availability of all national grantee organizations' resources to state grantees, the strongest state-national collaborations were between those grantees that had worked together before KidsWell. However, state grantees' exposure to national organizations during the KidsWell grant period sets the stage for future collaboration.

2. Which advocacy activities used by KidsWell grantees appear to be most effective in securing policy advances or preventing policy setbacks to expand or maintain access to children's health care coverage?

Since KidsWell began in 2011, there have been important policy wins for children's coverage in all of the KidsWell states except Mississippi. (See Table 4.) More than 70 percent of state grantees believed that coalition building, relationships with elected officials, lobbying, and policy analysis were most effective in securing policy advances to date. Policy leaders corroborated grantees' reports, and across states cited coalition building and policy analysis as KidsWell grantees' most effective activities, followed by relationships and contact with elected officials.

TABLE 4 Policy Wins Reported by Grantees and Assessment by Policy Leaders of Grantees' Contribution to the Policy Win

State (Number of policy leaders responding)	Policy Win ^a	Policy Leader Perceptions of Grantee Influence on Policy Win	Policy Leader Perceptions of Main Factor(s) Influencing Win												
California (6)	Medicaid expansion , protection of Medicaid and CHIP budgets, state exchange design	<table border="1"> <tr><th>Influence</th><td>Big</td><td>Mod</td><td>Small</td><td>None</td><td>Unkn</td></tr> <tr><th>Count</th><td>0</td><td>2</td><td>0</td><td>2</td><td>2</td></tr> </table>	Influence	Big	Mod	Small	None	Unkn	Count	0	2	0	2	2	Policy leaders agreed that the primary motivation for adopting Medicaid expansion was the state budget, and that this likely would have happened without the grantees' work.
Influence	Big	Mod	Small	None	Unkn										
Count	0	2	0	2	2										
Florida (5)	Elimination of 5-year waiting period for Medicaid/CHIP for lawfully residing immigrant children	<table border="1"> <tr><th>Influence</th><td>Big</td><td>Mod</td><td>Small</td><td>None</td><td>Unkn</td></tr> <tr><th>Count</th><td>3</td><td>1</td><td>0</td><td>0</td><td>1</td></tr> </table>	Influence	Big	Mod	Small	None	Unkn	Count	3	1	0	0	1	Policy leaders said important factors included support among Hispanic and Latino voters for Florida's Medicaid/CHIP program (this policy was passed in an election year) and research done by the state, with the grantees' help, that helped to calculate the cost to the state of this policy.
Influence	Big	Mod	Small	None	Unkn										
Count	3	1	0	0	1										
Maryland (6)	Exchange benefit design , avoiding coverage gap for youth aging out of foster care	<table border="1"> <tr><th>Influence</th><td>Big</td><td>Mod</td><td>Small</td><td>None</td><td>Unkn</td></tr> <tr><th>Count</th><td>0</td><td>5</td><td>0</td><td>0</td><td>1</td></tr> </table>	Influence	Big	Mod	Small	None	Unkn	Count	0	5	0	0	1	Policy leaders were unsure what the main factors were affecting exchange design – while the grantees had an important voice, the administration also strongly supported a state-based exchange.
Influence	Big	Mod	Small	None	Unkn										
Count	0	5	0	0	1										
Mississippi (6)	None ^b	<table border="1"> <tr><th>Influence</th><td>Big</td><td>Mod</td><td>Small</td><td>None</td><td>Unkn</td></tr> <tr><th>Count</th><td>0</td><td>1</td><td>2</td><td>3</td><td>0</td></tr> </table>	Influence	Big	Mod	Small	None	Unkn	Count	0	1	2	3	0	Policy leaders agreed that political issues prevented any serious consideration of issues related to ACA implementation.
Influence	Big	Mod	Small	None	Unkn										
Count	0	1	2	3	0										
New Mexico (6)	Medicaid expansion	<table border="1"> <tr><th>Influence</th><td>Big</td><td>Mod</td><td>Small</td><td>None</td><td>Unkn</td></tr> <tr><th>Count</th><td>1</td><td>1</td><td>0</td><td>2</td><td>2</td></tr> </table>	Influence	Big	Mod	Small	None	Unkn	Count	1	1	0	2	2	Policy leaders agreed the main factor influencing Medicaid expansion was the governor, as well as the state economy.
Influence	Big	Mod	Small	None	Unkn										
Count	1	1	0	2	2										
New York (6)	Basic Health Plan (BHP) , a consumer-friendly state-based exchange	<table border="1"> <tr><th>Influence</th><td>Big</td><td>Mod</td><td>Small</td><td>None</td><td>Unkn</td></tr> <tr><th>Count</th><td>4</td><td>1</td><td>0</td><td>0</td><td>1</td></tr> </table>	Influence	Big	Mod	Small	None	Unkn	Count	4	1	0	0	1	Policy leaders agreed the grantees' economic analysis showing that BHP would financially benefit the state was critical, as was the fact that the grantees brought in other powerful interest groups that supported BHP; the political will to pass BHP was also strong in the state.
Influence	Big	Mod	Small	None	Unkn										
Count	4	1	0	0	1										
Texas (5)	Averting cuts to the Medicaid program, including defeat of proposed 10% cut to Medicaid provider fees	<table border="1"> <tr><th>Influence</th><td>Big</td><td>Mod</td><td>Small</td><td>None</td><td>Unkn</td></tr> <tr><th>Count</th><td>3</td><td>1</td><td>0</td><td>0</td><td>1</td></tr> </table>	Influence	Big	Mod	Small	None	Unkn	Count	3	1	0	0	1	Policy leaders agreed the final decision was attributable to political decisions and budget factors; the business community's support also was influential.
Influence	Big	Mod	Small	None	Unkn										
Count	3	1	0	0	1										

Source: KidsWell grantee reports of policy wins in 2014 surveys and 2016 grantee interviews; interviews with 40 policy leaders in the seven KidsWell states (six per state in California, Maryland, Mississippi, New Mexico, and New York, and five per state in Florida and Texas), November 2015–April 2016.

^a The primary policy win we asked policy leaders about is in bold text.

^b Although no policy wins occurred in Mississippi, we asked policy leaders if the grantees had any influence on state policy debates on Medicaid expansion (for example, changed the minds of any policy leaders or the public on the issue).

Big = policy leaders said KidsWell grantees had a big influence on the policy win; Mod = policy leaders said KidsWell grantees had a moderate influence on the policy win; Small = policy leaders said KidsWell grantees had a small influence on the policy win; None = policy leaders said KidsWell grantees had no influence on the policy win; Unknown = policy leaders said they did not know how much influence KidsWell grantees had on the policy win.

Which advocacy activities work best in any given situation appears to depend on state context and the specific policy goal. For example, where key policymakers were seriously considering Medicaid eligibility expansion and state-exchange sponsorship, as in California, Maryland, New Mexico, and New York, policy analysis was more likely to be cited as an important input to the debate. In Florida, Mississippi, and Texas, where state policymakers were opposed to these policies for primarily political reasons, advocates focused on trying to make it easier for eligible children to enroll in and renew coverage under existing Medicaid and CHIP programs. Along with coalition building and contact with elected officials, grantees in these states viewed administrative advocacy (in Florida and Mississippi), grassroots organizing (Mississippi), and public media campaigns (Texas) as the most effective activities they used to pursue these policy objectives.

3. To what extent did policymakers and leaders in the KidsWell states perceive grantees to have shaped or influenced policies that advanced children's coverage?

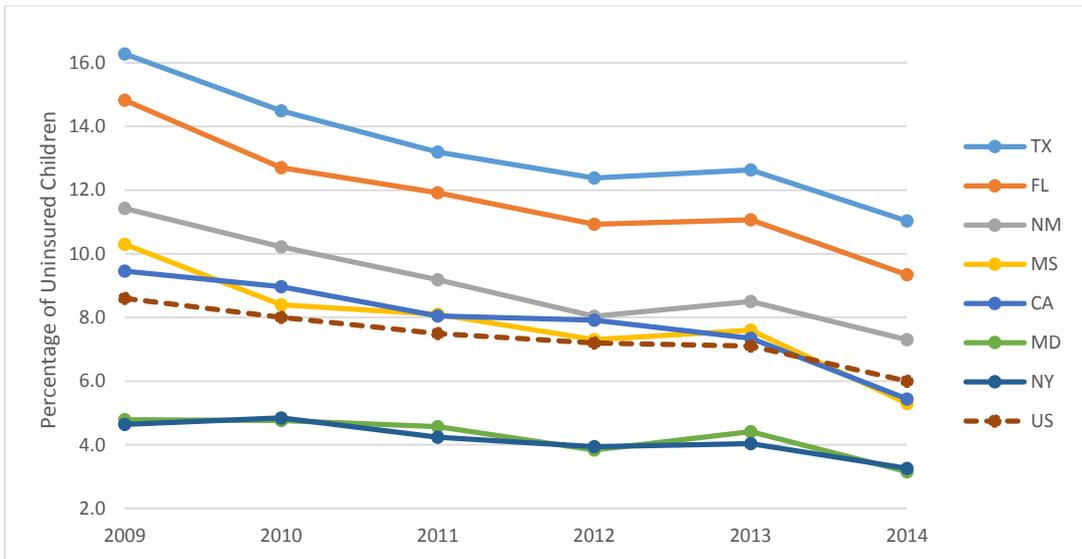
Across states, most state policy leaders agreed that the KidsWell grantees are credible and were influential in shaping or advancing policy issues related to health coverage of children and families. However, only in Florida, New York, and Texas did half or more of the policy leaders interviewed note that these advocates had a “big influence” on the policy we inquired about. (See Table 4.) More commonly, policy leaders said grantees had a moderate influence but noted that other factors, such as legislative backing and state budget pressures, played a part in policy decisions. Some policy leaders in California, Maryland, New Mexico, and New York noted that even though many of the reforms passed during the KidsWell era would likely have happened in the absence of the advocates, the KidsWell grantees accelerated or improved the end result.

More broadly, policy leaders in all seven KidsWell states agreed that these advocacy organizations played an important role in mitigating political and budgetary challenges to children's

More broadly, policy leaders in all seven KidsWell states agreed that these advocacy organizations played an important role in mitigating political and budgetary challenges to children's health care coverage. They consistently cited the role of advocates in providing credible information to highlight children's health issues, advocating on behalf of underserved residents, and working collaboratively to achieve a common goal of making gains for children's coverage.

health care coverage. They consistently cited the role of advocates in providing credible information to highlight children's health issues, advocating on behalf of underserved residents, and working collaboratively to achieve a common goal of making gains for children's coverage. For example, policy leaders in all seven states noted the importance of advocacy organizations in preparing analyses about potential impacts of policies on children, noting their presence and information helps keep children's health care issues “front and center,” as one respondent reported. They credited advocates with bringing more equity and fairness to the decision-making system by demonstrating the impact of decisions on health quality and access for children and families. As one California policymaker stated,

FIGURE 2 Children’s Uninsured Rates in the United States and the KidsWell States, 2009–2014



Source: Mathematica analysis of American Community Survey data, 2009–2014, August 1, 2016.

The kids’ groups bring a different perspective that is good for government to have. You can’t just make decisions in a vacuum and expect them to be perfect. We get course corrections from those groups all the time, and it’s both appropriate and welcomed.

New Mexico policy leaders noted that advocacy organizations provide empirical information to inform decisions and creative approaches to problem solving. In Florida, policy leaders interviewed emphasized the continued value the KidsWell advocates have in consensus building and leveraging the expertise of members within their coalitions to promote children’s health issues.

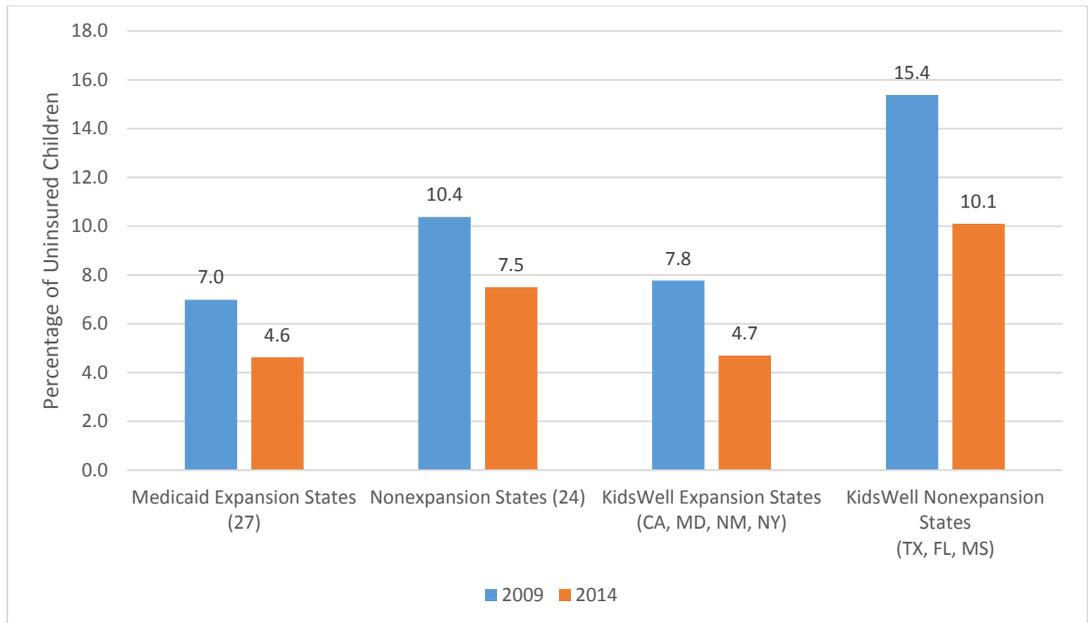
In addition to providing information to the legislature and other state decision-makers, policy leaders reported that KidsWell grantees in Mississippi and Texas also focused on educating consumers about health benefits. This was especially important because eligibility workers there had limited training and high turnover, and consumers had difficulty navigating the online eligibility and enrollment portals. In Mississippi, the grantees also conducted outreach to consumers

about enrolling into available coverage, since the state was not doing so.

4. How and to what extent did children’s health insurance coverage rates change in the seven KidsWell states?

Although the number and rate of uninsured children have declined each year since 2009, the decline from 2013 to 2014 was greater than in any previous year (Alker & Chester, 2015). Children’s coverage rates reached an all-time high in 2014 — the year in which the key coverage expansions authorized by the ACA provisions took effect — with 94 percent of children having some form of health insurance. (See Figure 2.) This suggests that the ACA is serving as an important mechanism for improving children’s coverage (Alker & Chester, 2015).

States that expanded Medicaid coverage to low-income adults showed greater gains in children’s coverage compared to states that did not expand Medicaid coverage, but even nonexpansion states made important strides in improving

FIGURE 3 Children's Uninsurance Rates in Medicaid Expansion and Non-Expansion States, 2009–2014


Source: Mathematica analysis of American Community Survey data, 2009–2014, August 1, 2016.

children's coverage. (See Figure 3.) Among the KidsWell states, those that expanded Medicaid — California, Maryland, New Mexico, and New York — had a 40 percent decrease in children's uninsurance rates (7.8 percent in 2009 to 4.7 percent in 2014), while those not adopting the expansion — Florida, Mississippi, and Texas — experienced a 34 percent decrease in children's uninsurance rates (15.4 percent in 2009 to 10.1 percent in 2014). Medicaid and CHIP participation among eligible children rose in this same period — nationwide, 90 percent of eligible children now participate in these programs — and rose more in states that expanded Medicaid (Kenney, et al., 2016).

5. Will children's health care coverage advocacy capacities, activities, strategies, and productive networks built with KidsWell support be sustained?

An important legacy of the project is that the networks built through KidsWell will be sustained after the Atlantic grants end. In the 2014 survey, the state grantees cited the most important contribution of KidsWell support as giving them the

resources to build strategic partnerships and alliances with KidsWell partners and others within their states. In the 2016 interviews, all grantees in the seven states said they expect their within-state KidsWell partnerships to continue. One of the grantees credited the sustainability of the coalition to its growing influence:

[We] started to become known to certain legislators and people within state government ... as solid, larger than the sum of its individual parts.

Due to funding constraints, however, the coalitions will not necessarily operate at the same intensity or level of interaction. When we conducted interviews in spring 2016, only one national grantee and five state grantees (two in California, one in New Mexico, and two in Texas) had secured any additional funding for their children's coverage advocacy work (none of which was at a level that would fully replace KidsWell funds). All grantees were actively seeking funding, and some had submitted proposals for which they were still awaiting funding decisions at the time of our interviews. But prospects

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are poor; grantees report that few funders they have approached are willing to support advocacy, and foundation officials wrongly perceive the children's-coverage problem to be solved. This is in marked contrast with the situation in 2014, when nine of 10 national grantees and 10 of 20 state grantees said they leveraged Atlantic funding to secure additional support for children's-coverage advocacy between 2011 and 2014.

Consequently, grantee partners in Florida, Maryland, and Mississippi said they would continue advocacy for children's coverage but at a lower level of activity. In New Mexico, the grantees expect to collaborate but shift their focus to labor issues. The groups in California, New York, and Texas report their coalitions will be sustained, at least in the short term. While state and national groups expect to work together in the future, they also believe that without the same level of funding, they will have less capacity to collaborate and organize coordinated advocacy campaigns. According to both grantees and policymakers, the need for this type of advocacy

persists and may be heightened as upcoming policy decisions will be made on whether CHIP will continue after its current funding authorization ends in September 2017.

Discussion and Lessons

By many metrics, Atlantic Philanthropies' investment in this advocacy effort over an extended period has been successful. Our evaluation found substantial progress in achieving KidsWell interim policy changes and coverage outcomes. Additionally, networks and capacities were strengthened, and grantees were highly collaborative, leveraging partners' strengths in order to mount advocacy campaigns during the period when critical state decisions about ACA implementation were being made. In six of seven KidsWell states, pro-child and family coverage policies and procedures have been adopted and implemented with help from the grantees. Finally, due in no small part to advocacy for children at the state and federal level, nearly 600,000 more children gained coverage in the seven KidsWell states since the program began in 2011.

While more than half of policy leaders interviewed credit KidsWell grantees with influencing policy wins to either a moderate or large degree, they were quick to note that other factors, such as legislative backing and state budget pressures, played a part in policy decisions. For example, in Florida, policy leaders cited grantees' work building and maintaining momentum with legislators and public-messaging campaigns as important to the policy decision to eliminate the five-year waiting period for Medicaid and CHIP coverage among legally residing immigrant children. At the same time, they cited other factors, especially election-year politics, as having played a role. As one policy leader said, the KidsWell grantees' "level of influence is not as great as it could be. That's not a reflection on how good they are. It's a reflection on the priorities of the legislature." In New York, policy leaders all mentioned the grantee's study on the economic effects of adopting a Basic Health Plan (BHP) as very important to its eventual passage. Yet, they also said that political support for BHP already existed, and that other studies confirmed that BHP would be a "financial windfall"

to the state. Texas grantees presented convincing data analyses that objectively demonstrated to legislators the negative financial impacts of proposed budget cuts to the Medicaid program; they also persuaded some legislators to champion the issue. While their advocacy was cited as effective, progress in the hostile Texas political environment was limited until an unexpected state budget surplus made cuts harder for legislators to support. Nevertheless, the robust assessment of grantees' influence on policy debates in Florida and Texas — which, along with Mississippi, are the most conservative of these seven states — demonstrates how critical the advocacy voice is to policy change.

While progress over the past five years on coverage policies has been impressive, children's health-coverage advocates still have a full agenda. In 2014, more than 8 percent of all children still lacked coverage in eight states — Alaska, Arizona, Florida, Montana, Nevada, Oklahoma, Texas, and Utah — and of the 4.5 million children without coverage in 2014, 62 percent were eligible for Medicaid or CHIP but not enrolled (Kenney, et al., 2016). Tightening state budgets in combination with the upcoming decrease in the enhanced federal match rates for CHIP programs will pose challenges to maintaining current coverage levels in many states. At the national level, the most pressing issue for children's coverage is whether CHIP will be funded past 2017; if Congress does not reauthorize funding for CHIP, millions could lose coverage, jeopardizing hard-won gains.

Like many capacity-building grants, Atlantic staff expected KidsWell grantees to sustain their work by attracting other funders to support advocacy activities after the Atlantic grant period ended. Atlantic went further than most other funders by organizing “funder roundtables” in each of the seven states during the grant period to engage local funders directly. These one- to two-day in-person meetings reviewed children's coverage trends, focusing on changes in the rate of uninsured children since implementation of the ACA; the benefits of coverage to children, parents, and communities; the accomplishments of

the KidsWell grantees; and the key policy issues in each state. While the KidsWell state grantees all reported that these meetings provided helpful introductions to local funders, to date only the Texas grantees said these meetings helped them secure new funds.

Thus, despite a full agenda, the KidsWell groups are concerned about their ability to support this work in the future, given that so few had secured additional funds as of early 2016. Grantees as well as funders' groups (such as the Council on Foundations; Bolder Advocacy, an initiative of the Alliance for Justice; and other funders committed to supporting children, youth, and families) need to redouble efforts to educate the larger foundation field about the type of advocacy that can legally be supported by funders, the gains in children's coverage achieved in part with such support, and what remains at stake for children's coverage.

While other funders may not be able to make investments as big or as long as Atlantic's was in KidsWell, the amount required may be lower. Children's-advocacy networks and capacities have already been built, and valuable knowledge and experience have been gained. Funders could target future investment to states and activities needing a short-term boost to exploit windows of political opportunity or to fight threats to children's coverage. Alternatively, funders could target support toward emerging issues that have become more pressing as coverage rates have increased under the ACA, such as health insurance literacy and increasing access to high-quality care once children secure health insurance coverage. Such support is still needed to continue momentum toward universal health coverage for all children.

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