BIG IDEAS

CHILDREN IN THE SOUTHWEST

Prospects for Continued Progress on Children's Health Insurance in the Seven Southwestern States

The Perceptions of State-based Advocates

by

Eugene Lewit and **Pilar Mendoza**
David and Lucile Packard Foundation

with

Karen Crompton, Voices for Utah Children
Anne Dunkelberg, Center for Public Policy Priorities
Kelly Hardy, Children Now
Matt Jewett, Children's Action Alliance
and **Bill Jordan**, New Mexico Voices for Children

FIRST FOCUS

MAKING CHILDREN & FAMILIES THE PRIORITY

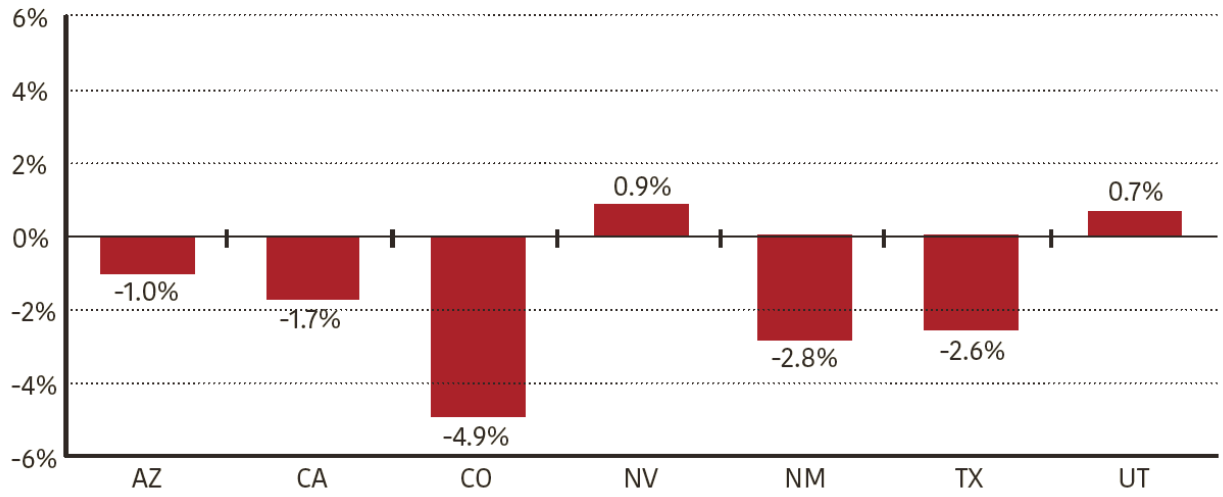
1110 Vermont Avenue NW, Suite 900 | Washington, DC 20005 | 202.657.0670 | www.firstfocus.net

Introduction

One of the most important good news stories of recent years is that the percent of children in the U.S. without health insurance fell to record low levels. The rate of uninsurance among children in low-income families also fell to an historical low. These developments are notable because health insurance can help children get the health care they need to alleviate the pain and discomfort of illness and provide a foundation for success in school and life. Health insurance also helps mitigate the family stress and insecurity associated with large and unexpected health care expenses.

Children in the seven Southwestern states, Arizona, California, Colorado, Nevada, New Mexico, Texas, and Utah, benefited from the growth in health insurance coverage as well. Despite having in the aggregate higher rates of uninsured children than other states, the Southwestern states as a group made more progress reducing uninsurance among children than the balance of the country in the period 2004-5 to 2009-10.[1] During that five year period, the rate of uninsured children in the Southwestern states declined from 15% to 13% compared with a small aggregate increase to 9% from 8% in the same period for the rest of the country. Five of the seven Southwestern states showed a decline in the rate of uninsured children during this time, with the largest decrease (almost 5 percentage points) reported for Colorado (Figure 1). The rate of uninsurance in California only declined by 1.7% during the period studied. Because of its large population base, however, California accounted for approximately two-thirds of the reduction in the number of uninsured children in the Southwest. Texas and Colorado also had strong reductions in the number of uninsured children during the five year period.[2]

Figure 1: Change in Percent Children Uninsured by State, 2005-2010



[3]

The main reason for the decline in uninsurance among children in recent years, despite a weak economy and declining rates of employer sponsored coverage, has been the growth in Medicaid and the Children's Health Insurance Program (CHIP). Medicaid and CHIP are state and federally funded and state administered public health insurance programs for children in poor and moderate-income families. In the Southwestern states, CHIP and Medicaid enrollment increased by almost two million children between 2005 and 2010 – more than offsetting the decline of approximately 700,000 in the number of children with employer sponsored coverage.

1110 Vermont Avenue NW, Suite 900 | Washington, DC 20005 | 202.657.0670 | www.firstfocus.net

(The balance of the U.S. saw an increase in children's Medicaid and CHIP enrollment of approximately 3.7 million and decline in employer sponsored coverage of 3.5 million over the same period.)

The significant economic decline of the recent past likely accounted for most of the decline in employer sponsored coverage and growth in public coverage. When incomes fall because of rising unemployment, more children become eligible for public coverage, as job loss frequently means the loss of coverage as well. In those cases, the public programs serve as a safety net for children, and to some extent, their parents. In situations where access to employer coverage was limited or nonexistent, declining family income can make family members eligible for benefits that would otherwise be inaccessible.

Encouraged by advocates, supported by philanthropy, and incentivized by the federal government (in particular through the Child Health Insurance Program Reauthorization Act (CHIPRA) that passed in February 2009), states have been simplifying eligibility requirements and enrollment processes and procedures for Medicaid and CHIP. These changes in state policies and procedures can help boost enrollment, providing access to critical health care for children in challenging circumstances. Sometimes relatively minor changes in practice, such as changing the hours of operation of state enrollment entities, staff work rules, or documentation requirements, can make noticeable differences in enrollment.

The federal CHIPRA legislation identifies eight state policies which can help increase coverage for children:

1. 12-month continuous eligibility in Medicaid;
2. no family asset test or administrative, verification of assets;
3. no face-to-face interview requirement;
4. common forms and uniform procedures in Medicaid and CHIP;
5. administrative renewal;
6. presumptive eligibility;
7. Express Lane Eligibility; and
8. premium assistance in CHIP.[4]

States which implement five of the eight policies and meet enrollment targets are eligible for "performance bonuses" to help offset the costs of enrolling additional children. By 2010, all of the Southwestern states had adopted at least one of these policies, and two states – Colorado and New Mexico – had earned performance bonuses totally $33.2 million (Table 1). In 2010, Colorado also raised its CHIP income eligibility level to 250% of the federal poverty level ($46,325 for a family of three in 2011).

CHIPRA also provided increased funding for Medicaid and CHIP outreach and offered federal matching funds to help states cover legally residing immigrant children and pregnant women in Medicaid and CHIP, without a five-year waiting period. In addition, CHIPRA offered states other important tools and strategies to boost enrollment in Medicaid and CHIP including: the highly efficient option of verifying citizenship through an electronic data match with the Social Security Administration database; and Express Lane Eligibility, which allows states to enroll or renew children in Medicaid or CHIP by relying on eligibility information from other income based public programs. As of January 2012, four of the Southwestern states had taken up the legally-residing immigrant coverage option and all were doing some form of electronic citizenship verification, but none had adopted Express Lane Eligibility. CHIPRA's impact was so profound that, in the three years since it was enacted, the number of children in the U.S. with coverage increased by 1.2 million, reducing the children's uninsurance rate to record lows even as the uninsured rate for adults increased.[5]

Table 1: Simplified Enrollment and Renewal Procedures in Children's Regular Medicaid, CHIP-funded Medicaid Expansions, and Separate CHIP Programs 2012

State	12 Month Continuous Eligibility	Joint Applica-tion	Face-to-Face Interview Not Required (Medicaid/ CHIP)	No Asset Test (Medicaid/ CHIP)	Presump-tive Eligibility (Medicaid/ CHIP)	Admin-istrative Renewal	Express Lane	Premium Subsidy in CHIP
AZ		Y	Y/Y	Y/Y				Y
CA	Y/Y		Y/Y	Y/Y	Y/Y			
CO	N/Y	Y	Y/Y	Y/Y	Y/Y	Y/Y		Y
NV	N/Y		Y/Y	Y/Y				Y
NM	Y		Y	Y	Y	Y		
TX	N/Y	Y	Y/Y	$2,000 $10,000				Y
UT	N/Y	Y	Y/Y	$3,025 Y		N/Y		Y

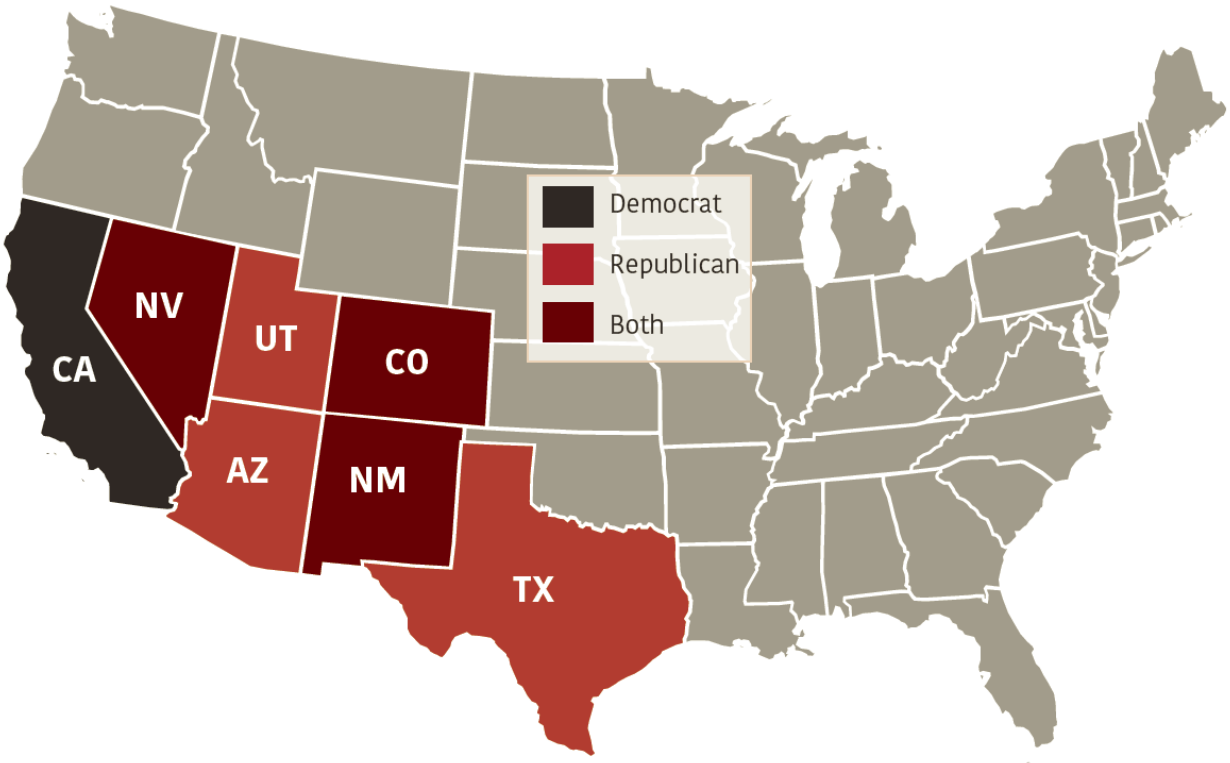
6

Looking to the future, the Patient Protection and Affordable Care Act (ACA), enacted in 2010, builds on CHIPRA to provide many more coverage opportunities, including important reforms in the private health insurance market for both children and adults and the expansion of Medicaid for low-income adults, which will also benefit many parents and parents-to–be and their children.

There are, however, a number of issues which may make further progress on children's coverage challenging. These include a persistently weak economy and accompanying state and federal budget shortfalls, which make it difficult to finance program growth and sometimes even sustain established and efficient programs. In addition, a highly partisan political environment has undermined support for the ACA, also called "Obamacare," and created legislative gridlock at the federal level and in some states. This partisanship is evident in the Southwestern states as well (Figure 2): in three, Republicans control both the legislature and the

governorship. In one, Democrats control both branches of government. And in four, control is split between the two parties. Lastly, although the recent Supreme Court decision upheld key pieces of the ACA, the finding that the Federal government could not penalize states for failing to take up the required Medicaid expansion for low-income adults effectively made that important ACA provision optional. Although there is strong opposition to the expansion in some states and support in others, the majority of states appear to be taking a "wait and see" approach to date, creating uncertainty about how the issue will play out and where children and families will benefit from Medicaid expansion.

Figure 2: Political Party Control of State Government, August 2012



7

With all of these factors at play, we convened via teleconference two focus groups of advocates from five of the seven Southwestern states. These conversations, on July 9th and 10th, 2012, explored the recent gains made in advancing children's coverage in those states, lessons learned from their experiences, and prospects for future gains – including their "big" ideas. The participants included Karen Crompton from Voices for Utah Children, Anne Dunkelberg from the Center for Policy Priorities (Texas), Kelly Hardy from Children Now (California), Matt Jewett from Children's Action Alliance (Arizona), and Bill Jordan from New Mexico Voices for Children. All participants were affiliated with organizations which are or had been grantees under the David and Lucile Packard Foundation's Insuring America's Children grantmaking strategy.[8] The focus group conversations were recorded, transcribed and edited for length and to help draw conclusions and highlight the key points. A summary, interspersed with verbatim quotes from the focus group participants, is presented below.

Historical Perspective

The conversation opened by asking the participants to comment on the most important gains in child and family coverage in their state in the last five years. All participants first cited the reversal of policies that restricted enrollment in their states' Medicaid and CHIP programs as key advances. Some of the restrictions were enrollment practices per se, while advocates from three states cited success in lifting caps on CHIP enrollment in their states.

Bill Jordan (NM): During the period 2002 to 2004, we had a number of cost containment measures put into place which limited enrollment in our Medicaid and CHIP programs. One was to go from 12 month continuous eligibility to six-month eligibility. And the second was an auto closure policy, which meant that if parents did not reenroll or recertify a child's eligibility immediately at the end of the six month period, the computer would automatically disenroll the child. To reinstate the child, parents would have to start the whole application process over again.

As a result, we lost about 30,000 kids from Medicaid and CHIP. But about five years ago, when Governor Richardson started to campaign for president, he reversed those harmful policies. And over the next couple of years, enrollment went back up by over 30,000 children and so that was very, very helpful. And he did that under a lot of pressure from advocates, and a lot pressure from the legislature as well.

Anne Dunkelberg (TX): In the last five years, our biggest accomplishment in terms of the size of the impact is similar – in that we took the state from a near total collapse of the eligibility system to near full recovery that, as of today, also involves the ability to apply and renew online as we continue to modernize. We went from being in violation of federal timeliness standards to a very high level of performance. And in the pipeline is the use of online application for renewal, we also created a kind of community based navigator program for Medicaid and CHIP. In addition, we also had CHIP coverage restored to a 12 month continuous eligibility period after it had been reduced to six months for a period of several years by the legislature.

Karen Crompton (UT): I think one of the most significant commitments our state made to children's coverage was eliminating the cap on CHIP enrollment, which had been in place since 2002. As a result of the cap, there had been very limited opportunities to enroll, sometimes as short as five days out of a year. But in 2008, the legislature unanimously approved lifting the enrollment cap. The governor signed it and it instructs the Department of Health to enroll all eligible children who apply, so that was probably the biggest commitment they'd made to child health since the original passage of CHIP.

Matt Jewett (AZ): We also opened our CHIP program KidsCare after enrollment had been frozen for over two years. We are using a limited amount of funding from an intergovernmental transfer of funds from hospitals to the state, matched with federal CHIP funds, to bring in 25,000 additional kids into the program. But once we fill those slots, we will go back to having a waiting list, and our experience has been that initially enrolling the additional kids was very slow because after over two years the waiting list was not very useful.

Kelly Hardy (CA) also cited elimination of the cap and waiting list from the state's Healthy Families program as a big win and acknowledged that "waiting lists are bad. I think that's a good takeaway. They create a lot of confusion and disruption and misinformation among families."

In addition to Anne Dunkelberg (TX), several others including Kelly Hardy (CA) and Karen Crompton (UT) cited enrollment simplifications and implementation of electronic enrollment systems as important advances.

Matt Jewett (AZ): Number one was our electronic application for our CHIP and Medicaid programs, which went online first for the Community Health Centers and other organizations. Then in December of 2008, the electronic application was released as a public access website that people could use on their own. It was a soft launch and not promoted at all, but this application found much more acceptance among the public than was anticipated. And the state found it difficult to keep up with enrollment, but they did see a strong increase in enrollment after the online application was implemented.

Among other gains cited, Matt (AZ) mentioned a brief period when parents were covered along with their children in CHIP, which helped boost enrollment of children as well. Kelly (CA) pointed to the county Children's Health Initiatives, which "really began a movement for a culture of coverage in which every child should be covered and can be covered. Children just need to come and we'll get you into the right program."

In closing, Karen (UT) focused on some more intangible gains which nonetheless may lay the ground work for continued progress.

Karen Crompton (UT): I think our policymakers have a better understanding of these programs than they did before. Almost any time somebody talks about Medicaid in a committee hearing, they reference that they know that most of the enrollees are kids, which I think is a huge step forward in how they think and talk about the programs.

But I also think a real important step is that the state has not tried to move backwards in anyway, in terms of coverage. Even before the MOE,[9] they didn't try to reduce eligibility or change the program. Obviously now there's the Affordable Care Act MOE in place, and even though it doesn't necessarily lead to the outcomes of getting every kid covered, it was a general commitment to this program of getting kids covered. So I think those are the big things.

Despite the cut in state funds for outreach, this year we worked with the two providers for the CHIP program in our state, Molina and SelectHealth, to get support for aggressively doing outreach, so that was another way to find funds to do what the state isn't able to do right now or has chosen not to do.

Participants cited effective coalition building, policy advocacy and good relationships with state and federal officials as the important factors that made those gains possible.

Bill Jordan (NM): You know I think that there was a lot of pressure from advocates when we were able to show the large decline in enrollment. We were able to make a pretty strong case that it was a harmful policy and should be reversed. It certainly helped that the Governor was running for president and that healthcare was a major issue. So I think he wanted a little better record to show for it and began enrolling kids much more easily in the last year or two of his administration.

Matt Jewett (AZ): I would say probably the fact that we had some great partnerships with community organizations, but that we also had some investments by organizations inside and outside of Arizona in purchasing ad time and going out and getting some major spokespersons. We had a pitcher from the Arizona Diamondbacks who served as one of our spokespersons.

Today, as we're doing outreach again, trying to get kids back into our CHIP program, our state Medicaid agency actually came to us and said, we don't have people to answer the phones anymore so we can't do that, and we need you to do that for us. And it's fortunate that CMS had given us a grant under CHIPRA to do outreach because the hotline that people call is operated by the community organizations that have the

CHIPRA grant from CMS. It's important for people to call when they have questions. It's better if it's the people who are doing the enrollment, i.e. the state Medicaid agency, but there needs to be someone.

Anne Dunkelberg (TX): Obviously one of the great things about working on kids' health is that you do and can attract such a diverse crowd of different kinds of folks who feel really good about supporting it. And the work we had done with the Narrative Communications Project helped us build that over the last few years.

But also we were fortunate that there are federal authorities, in particular on the Food Stamp side of the equation, who actually will complain to states when eligibility systems collapse. And since we have an integrated system here in Texas for all our benefits, when it collapsed it didn't just take down Medicaid and CHIP, it took down Food Stamps too. So the Food Stamp authorities helped us by putting pressure on the state, and our legal services community helped us by filing a class action lawsuit … so, it helped that we had cover from potential fiscal penalties for the things the state was doing wrong. It helped that there was actually a lawsuit that the state was going to have to deal with. It helped that constituents were complaining directly to their legislators about it. All of those things helped create the momentum for change. And then it helped enormously that all of that pressure, I think, led to a new Health and Human Services Commissioner coming on, who made it his first and top priority to reform the collapsed eligibility system.

Kelly Hardy (CA): I think that pulling in the doctors and business groups and some of the heavier hitters always helps our cause. And family stories have been particularly important for us with the media and in using social media as well. Being able to get coverage because it is such a big state, really being able to get media stories that resonate emotionally and can be used to pressure decision makers.

Relationships with the agencies at the state level have also been very important. Relationships with CMS officials, particularly in the past couple of years have been super important, those formal relationships and also the ability to get more informal reads and guidance on things that the state is doing.

Participants all agreed that tight state budgets were an on-going challenge, although Karen from Utah acknowledged her state's budget was not that bad. Bill Jordan described the impact of the recession on the state budget.

Bill Jordan (NM): Well the budget issue clearly is the biggest challenge. In the last five years, we've had a difficult time with the recession, and that has put the crunch on state budgets. But it's also increased the demand for services and programs like Medicaid for low-income kids and families. So we've been squeezed from both sides and I would say that even before the budget crunch and the recession, we were already facing a bit of a mantra, if you will, from lawmakers that the Medicaid budget was growing faster than anything else. That it was a runaway train. That it was out of control, and so they were already looking at ways to try to contain costs or cut the program. So I think the challenge was to both talk about the financial effectiveness of the program – that it had low cost, low overhead, low administrative costs, that it was a cost effective program – but also to talk about the importance of coverage for kids and to try to keep both of those arguments front-and-center and not be drawn into the other side's argument that it was that costs were out of control or unmanageable.

Other challenges mentioned included the loss of champions, rise of "Tea party" politics, breaches in state data systems and other state complexities.

Karen Crompton (UT): We had two real champions who led the effort back in 2008. The Speaker of the House at that time, Greg Curtis, was the one who carried the bill to eliminate the waiting period. He lost his election that fall – but not because of this – and we also lost Governor Jon Huntsman, who might have taken

Utah on a path to look like Wisconsin, but who left to become the ambassador to China. Those were two really big losses. Now maybe we didn't take enough advantage of the window of opportunity we had to move more aggressively while they were still here because we thought we'd have more time with them.

Matt Jewett (AZ): (Another challenge was) losing a governor who was a champion in January 2009 as we were starting to make progress, and replacing her with a governor who is not a big champion for our CHIP program.

Bill Jordan (NM): In addition, the rise of the Tea Party has made effective communications even more critically important to advancing any public policies with regard to providing healthcare coverage for kids and that has I think also been a challenge for us.

Karen Crompton (UT): In Utah, we have two agencies that administer our programs, the Department of Health, that oversees the program per se, and the Department of Workforce Services that does enrollment and has the caseworkers. The two don't always have the same goals in mind and it's been a challenge working between the two agencies in some cases.

Breaches in the security of our state data systems have also had a direct impact on immigrant children and also on all children. Two years ago the Department of Workforce Services had a caseworker who released close to 2,000 names of people who – the worker believed – were illegal immigrants whose children or family members were receiving benefits, whether it was CHIP, Medicaid, or Food Stamps. The state responded and fired the worker and it's been in court, but that's had a chilling effect in immigrant communities. Then just this year, we had a huge data breach in the Department of Health Records for Medicaid and CHIP families, 780,000 records were hacked by Romanians. The state has implemented a credit monitoring program for people who were affected, but again there is concern about what happens with personal information that I share with the state. So there's going to be a period of time of rebuilding trust around sharing information and being willing to step up.

Despite the substantial progress made on advancing children's coverage in the past 5 years, none of the participants were completely satisfied. Three were disappointed that some of the systems simplifications they had worked on were not achieved while others cited unfinished work on quality and access.

Karen Crompton (UT): Obviously we're not satisfied totally with the accomplishments because we still have too many uninsured kids but we do feel good about what we did get done. This year the state applied to be certified for five of the eight program simplifications specified in the 2009 CHIPRA legislation. They're not the five simplifications we hoped for. Two of the biggest ones that we fought for were not requested including 12-month continuous eligibility for Medicaid and the elimination of the asset test for Medicaid. The legislature did pass a 12-month eligibility "Light" bill during the recent session, which gave the Department permission to move to 12-month eligibility if the Department could prove 12 continuous eligibility is cost effective. So the legislators sort of get why you need 12 months, but they weren't ready to say, "Let's do it," and then again the asset test piece was not one of the five of eight. So we're working ahead and hoping that those policies will move forward prior to 2014 and full implementation of Affordable Care Act.

Bill Jordan (NM): I would say no, because we didn't achieve implementation of Express Lane Eligibility, one of our key objectives, and unfortunately it's still not on the horizon. We also pushed very hard for a data match using personal income tax records from our Tax and Revenue Department. New Mexico did that 10 or 12 years ago, and we were pretty successful with it. But we have not been able to convince the administration

to do that data matching again. So we could've enrolled more kids had we been able to get Express Lane Eligibility and the matching of eligible children with tax data.

Anne Dunkelberg (TX): We were certainly very disappointed in 2009 when just on the cusp of passing a CHIP expansion to include higher income kids, the measure got drowned in the sea of the voter ID showdown, which caused over 100 bills to get killed and caused everyone in the Legislature to be at war with everyone else. That was a big loss for us, which looms large as we try to tackle the issue of getting our state to implement the Medicaid expansion under the Affordable Care Act.

Kelly Hardy (CA): In the past, we were too busy focusing on other priorities to focus on deficiencies in quality and access in the Medi-Cal program [California's name for Medicaid], but we're very much focused on those concerns now. We want to ensure that having an insurance card really means something including timely access to quality care.

Anne Dunkelberg (TX): We would like to get to focus on the kinds of issues Kelly mentioned, but Texas is not there yet. What I would really love is to get to the point where coverage is no longer the issue and we have the time and resources to focus on quality and access within those coverage programs. I think there are many, many issues with respect to that that simply have to be left on the table because of limited resources, and because we're sort of working at a lower level on the hierarchy of needs. They're very important concerns but we are not going to go work on quality of our HMOs until I can actually get our kids into the HMOs.

Participants cited a number of lessons learned from their work on children's coverage including the value of solid proactive messaging.

Karen Crompton (UT): We found that we've been able to change the language policymakers use about kid's healthcare coverage as a result of the Narrative Communications Project. This is an etch-a-sketch moment for implementation of the Affordable Care Act, and as we look ahead, messaging again is going to become a huge part of what we do. So this is an opportunity for us all to go back to our earlier messaging work to help shape the discussion on the Affordable Care Act as it moves forward between now and the end of next year.

Bill Jordan (NM): I agree we all could've done better messaging about the Affordable Care Act and the opportunities that it provides. Now that we're going to have to revisit Medicaid for low-income adults under the Affordable Care Act, we're going to get a chance to hit the reset button and try to get the messaging right.

Other lessons that participants cited: "don't count your chickens" (be prepared for the unexpected); and know that circumstances tend to repeat themselves, so advocates need to learn from the past.

Kelly Hardy (CA): A very recent lesson that's top of mind is not to count your chickens before they're hatched. Even if a policy has been approved by every committee in the legislature and it appears to be solid, things can be overturned by political maneuvering at the last minute. You know despite your best intentions and despite working the formal process, sometimes things don't work out the way that you wanted them to. So I guess the lesson is to be as prepared for every eventuality as you can be.

Anne Dunkelberg (TX): The lesson Kelly laid out from California reflects our experience in 2009 when the meltdown in our legislature scuttled the CHIP expansion legislation. And I think one of the things that we've taken to heart is no matter how early we've gotten started working on things and building coalitions and finding allies and partners and trying to educate decision makers and educate the public, we've got to keep starting earlier and earlier and earlier.

I've been doing this for 20 years and have learned that there's nothing but Groundhog Day in my experience here. I have to teach the same lessons over and over again and pull out the same arguments about block grants that we were literally using in the '90's. So yeah, I think the only lesson I have that's really and truly a lesson, is just that I've got to identify and recruit and engage as many partners as I possibly can, as early as I can. And I think the thing that we've learned and benefited from through these projects is just how incredibly powerful it can be to get a lot of different people singing off the same song sheets and using similar language, because we're up against such rabid sound-bite politics here.

Matt Jewett (AZ): I too feel it's Groundhog Day. I feel like whatever it is that you do, learn from it because you are going to be doing it again. And I guess it seems to be the case with a lot of our issues that things go in cycles. We're moving forward and then moving back.

Despite the frustration they all expressed in having to repeat their efforts many times, all of the advocates emphasized being prepared for unexpected opportunities when they materialize.

Matt Jewett (AZ): But I think it's important for us to remember what we did to make the gains, because even when we have setbacks, we're going to have opportunities, and don't give up when there are setbacks, because at some point you're going to have the opportunities to get back to where you were. And hopefully we're actually taking two steps forward and only one step back, and not the other way around.

Kelly Hardy (CA): I think I would just build on what's been said and say that we've learned to really try to be ready for those windows of opportunities that Matt alluded to when they do open. For instance, right now we're trying to leverage the fact that many legislators had concerns and reservations when they voted to move the Healthy Families [California's name for CHIP] kids over to Medi-Cal. So we're trying to seize the window of opportunity to press for improvements in Medi-Cal, rather than spending too much time licking our wounds. I think we need to quickly assimilate what happened and move forward and grab the opportunity.

Future Perspectives

After having reflected on the lessons learned over the last five years, the conversation then shifted towards focusing on the future. Given the recent Supreme Court ruling and the current state of the economy and political environment, participants discussed the future of child and family coverage over the next five years. Participants agreed that states' reaction to the Affordable Care Act ruling, and its implications for implementation, will dictate the future of coverage in their states.

Bill Jordan (NM): We're still not doing well enough on the implementation of the Affordable Care Act and the implementation of the exchange. If New Mexico opts to cover low-income adults in Medicaid, then that'll provide us with an opportunity to really bring a lot more children into coverage. If we don't expand Medicaid to cover low-income adults, then I think we're in real trouble because if the political will is not there to expand coverage to low-income adults, it's certainly is not going to be there to make it easier for children to enroll.

Karen Crompton (UT): The good news is post decision, the state has not said, "There's no way we're going to do a Medicaid expansion," unlike some states. The governor's basic line has been: We need to look at what it will cost… I think the other piece that's kind of positive for Utah, is that Utah has initiated its own version of health reform, kind of a ten-year plan, ahead of what the Affordable Care Act did, so there is that underlying commitment to health reform. The state continues to move forward with that. Utah was one of

the first states to create a health exchange. Granted it has some problems, it only takes care of small businesses, doesn't take care of individual markets, but there is that general commitment.

Like Karen, other participants also discussed ways that they anticipated their future work would be impacted. Anne Dunkelberg was optimistic that by using the flexibility of Medicaid waivers, there would be an increased investment in improving access, while Karen Crompton cited the challenge of securing future funding for CHIP.

Anne Dunkelberg (TX): So I think there's going to be a lot of investment in improving access to primary care at the community level, even though it falls far short of the kind of resources that we would gain through direct Medicaid coverage. But I think that that we are going to get more and more buy-in and understanding at the community level of the value of having systems of care, of doing these reforms, of having that public investment in those systems.

Karen Crompton (UT): I think looking forward, one of the other challenges we face is the federal funding of CHIP. As you all know, CHIP was reauthorized to 2019 but with funding only through 2015. Given the current budget debate and having to find offsets, funding for CHIP in 2015 could be really hard to do. And if the exchanges are not in place, we potentially end up with a really big problem for those kids.

While other participants highlighted potential challenges moving forward, an exception was Kelly Hardy, who cited California's progress moving forward with Affordable Care Act implementation, and was hopeful about the future.

Kelly Hardy (CA): I think in California I'm optimistic about moving forward to more of this culture of coverage that I was talking about where everybody's in the pool and we have more family based coverage rather than different members of the family getting coverage in very different ways… I'm hoping that we move more towards a true no wrong door approach where there's more customer service to help people get into coverage. I am definitely working on getting to a place where kids have health homes where we're addressing more than just their medical needs, but addressing more of their health needs, so all of the factors that impact health, including medical care, but also dental, social support, food access, housing --that they're able to connect more with the total package of support for their health.

Lastly, Matt Jewett and Anne Dunkelberg agreed about the significant progress their states have made in modernizing eligibility systems, creating a foundation for continuing to expand coverage.

Anne Dunkelberg (TX): Like, Kelly, I'm also optimistic especially about the progress that we've made in Texas and modernizing our eligibility system and moving to an online platform. Also, trying to build up our network of community based navigators in our 254 counties, is something that can help us out going forward.

Matt Jewett (AZ): I would really not underestimate the role that modernizing eligibility plays as we talked about that being a big part of our gains the last five years, and we're going to see even more if things go as they are supposed to go, where you have real-time eligibility, versus being able to take up to 45 days for an application. I think that when they talk about the "woodwork" or "welcome mat" effect[10] part of that is that if you have people who get enrolled more quickly, you're going to have more people enrolled.

Participants then discussed the political implications of the upcoming national and state elections on their future state advocacy work. All participants agreed that if the Republican presidential candidate wins the national election, moving forward will be more difficult as the election may be interpreted as a referendum on the health care reform law. As the Affordable Care Act and Medicaid

coverage have become central issues during the 2012 election season, advocate Bill Jordan best summed up participants' sentiment on how critical the presidential election will be:

Bill Jordan (NM): The outcome of the election for better or for worse, will likely be interpreted as a desire on the part of the public to move forward with healthcare reform implementation or not. And that certainly is going to play out politically at the state level for all of us.

Each participant also projected how current state legislature compositions and upcoming state elections will impact the future of their work. Some states' electoral probabilities posed threats to continued progress, while others offered opportunities. Karen Crompton emphasized the importance of finding opportunities to develop new champions within the legislature:

Karen Crompton (UT): I think we have an opportunity to find champions. As I said, I think it was maybe a missed opportunity for us with the loss of Huntsman and our speaker of the house that we didn't have more champions in the queue if you will. But we've recruited a couple of Republicans who are both involved very deeply in the Utah health reform piece, who may be carrying legislation in the next session, one around waving the five-year waiting period for immigrant children and the other one to wave the asset test. They both have a good track record of getting bills passed… So that's an opportunity for us moving forward to have some new voices.

Participants then offered their "Big Ideas" on child and family coverage for the next five years. Participants' ideas were grounded in the somber political and economic situation facing many of their states. Nevertheless, these ideas represent a commitment from advocates to move forward. First, Karen Crompton and Anne Dunkelberg discussed moving forward independently of Affordable Care Act implementation and the outcome of the 2012 election.

Karen Crompton (UT): Our big idea is that regardless of what happens with the Affordable Care Act, we can still move forward on the job of covering all kids with current programs – or covering nearly all kids. So I think that's an important takeaway. And to a certain extent – at least right now while the wounds are still fresh from the Supreme Court ruling – to not put it in the context of the Affordable Care Act but that we have the tools, we need the commitment to get the job done. So that's part of the big idea going forward. The other big idea we have is as Utah's government develops its exchange to encourage them to really go to that no wrong door approach. That we don't want to settle for the SHOP (Small Business Health Options Program) exchange. That we want to be sure that people know what their options are in the private market or whether they're eligible for a public program, CHIP or Medicaid, whichever it be. So that's our big goal moving forward, with or without Affordable Care Act. Because right now Utah's SHOP exchange doesn't do anything for the majority of adults who are uninsured in the state of Utah in terms of finding coverage or connecting them with plans.

Anne Dunkelberg (TX): If the Affordable Care Act is to go off track, then I think that we might be able to reactivate our earlier efforts to expand children's coverage through CHIP, and to try to create a system modeled more on the Illinois model where there's something for a child at every income level.

The second big idea that participants discussed was creating a more integrated health care system that improves overall access and is better coordinated across other social service systems.

Matt Jewett (AZ): We'd like to move to a system with more integrated coverage options. Because even under health reform, we could still have a system where we're going to have parents who may be in the exchange with or without subsidies with kids who might be in CHIP. Participants in a qualified health plan in

the exchange may or may not have a health plan that covers their dental and vision benefits. They may have to go outside to get those, and so it's a system with many, many moving parts, and I think we've found in the past that when we have systems that are very segmented, families fall through the cracks. And so I would say that that's a high priority, making sure that services are as integrated as possible.

Kelly Hardy (CA): And more coordination across programs, with social services programs as well, a more horizontal integration so that if a child is eligible for food stamps and CalWorks and Medi-Cal, that that all happens, and it all happens more or less seamlessly and easily for the family. Expansions of school based health centers, so that we can help all kids who go to school, including undocumented kids. And integration within healthcare so that dental care and mental health are more a part of everybody's picture when they think of health.

Bill Jordan (NM): We need to change the question that we're asking. The question has always been: How do we get kids covered? We now have universal coverage available. The question now is not how do we get coverage for them, the question is where do we cover them, under which program? If we can be successful in changing the narrative to under what program does this child get coverage, we will have been successful.

Related to improving accessibility, Anne discussed her desire to make adult coverage more affordable because ACA subsidies for low-income families in the exchange may be inadequate.

Anne Dunkelberg (TX): So you know probably a big idea in a world where I had the Medicaid expansion and exchange moving forward would be some very dedicated work to make the Exchange affordability provisions work better for families, particularly those with incomes below 300% of poverty.

Lastly, participants were asked to react to the idea of moving to five years of continuous eligibility in Medicaid for young children from birth to five. In general, all participants agreed it was a good idea, but perhaps unrealistic. Bill Jordan cited a current challenge in continuous eligibility for children in New Mexico as an example.

Bill Jordan (NM): One of the policies that we're fighting right now is that when a child is born in New Mexico and immediately gets on Medicaid, they're obviously a U.S. citizen because they're born in the state when they are enrolled in Medicaid as a new birth. But one year later, the state requires proof of citizenship. And we're losing a number of children on their first birthday because the parents can't, or don't provide proof of citizenship in a timely way. So we're advocating with our Human Services Department saying, you know the child is a citizen because they were born here, that's what made them eligible a year before. Can we please waive this requirement? And to date they haven't done that. So you know that if we're fighting at that level, five-year eligibility would be a pretty heavy lift. Then again, I do believe that if we can change the way we think about healthcare coverage in the country and we can begin to talk, perhaps after the election about the fact that the United States now has universal coverage, then the only question becomes under what program are you covered? If we can begin to think about children's coverage, especially in that way, I think many of the questions or many of the strategies that are used to keep kids out of coverage will begin to fall by the wayside. They will be seen as a hindrance to achieving the overall goal of universal coverage.

Next participants discussed strategic ideas that would help achieve their "Big Idea" goals. Participants referenced the earlier discussion on lessons learned to inform and develop new strategies. Throughout the discussion, participants discussed the importance of building coalitions.

Bill Jordan (NM): One of the strategies that we're working on right now is building alliances with the hospital associations, with the medical societies, pediatric societies, family practice doctors, the managed care

organizations to build support for the adult Medicaid expansion. That is really number one. And if and when we achieve that, then I think will work with those same folks who try to get a few dollars in the state budget for outreach and enrollment for children specifically.

Karen Crompton (UT): In terms of coalitions, we see two key players that we're engaging with because of the Affordable Care Act. Community health centers, which we have worked with but maybe not as strategically, who have a big stake in the Affordable Care Act staying intact and the Medicaid expansion, and then the hospitals that lose their DSH (Disproportionate Share Hospital)[11] payments under Affordable Care Act but gain other things as compensation.

Kelly Hardy (CA): Children Now is spearheading a children's movement in California, and that's a way to really activate the many child serving organizations in California that aren't necessarily connected with policy at all to take action on policy issues, and to call the Governor's office. And I think that that is one of our big strategies moving forward for engaging a larger number of allies and also atypical allies in moving our agenda forward.

Anne also acknowledged the importance of coalition building, and emphasized social media as a strategy:

Anne Dunkelberg (TX): In Texas, things are sort of coming together in terms of our ability to bring more people together through online and social media. It's by no means perfect, but our reach is a little better, because of our partners and allies, and we've learned a lot about how to keep things simple enough so that people can be comfortable getting activated. In Texas, we do have not huge advocacy resources, but at least some partners and resources today are true organizing efforts, so we have partners in the 501(c)(4)[12] world who are contributing to these efforts. And that helps because it means that we can have some friends and allies who are able to use tools that aren't available to us 501(c)(3)s

Bill Jordan, Karen Crompton, and Matt Jewett also emphasized budget advocacy and analysis as a strategy to push forward the Medicaid expansion by making "the economic argument." Matt along with Bill highlighted the need for budgetary analysis tied together with a communications strategy.

Matt Jewett (AZ): And I think we need to be prepared to make sure we have good analysis of what the costs and the benefits are; that we have good messaging about why this is something that needs to be done. And I mean my gosh, I remember one of the talking points when we were in the Narrative Communications Project was this is a really good deal, it's a three to one federal match. I mean now it's a nine to one federal match, we should be talking about how great that is when the other side talks about how much this is going to cost.

Bill Jordan (NM): You know a big part of our strategy is a communications plan. Get out the word about the economics of healthcare, get out the word about the importance of healthy child development. We're also doing some racial analysis to show who is impacted and to ensure that we can reduce some health disparities.

Some participants cited candidate education as a strategy, but Matt was the only participant that discussed the importance of voter education and advocacy given the upcoming election.

Bill Jordan (NM): So yes in our state legislature, we've had a lot of retirements this year. We are in for big changes, and we're losing all of our healthcare champions in the legislature. So we're doing a lot of candidate education right now.

Matt Jewett (AZ): I think our strategies are to engage the right folks in terms of building a coalition. But between now and August and between now and November, we need to be engaging voters around issue advocacy, and we need to be doing that in every election, and a lot of nonprofits and advocacy organizations haven't been as good on that.

Participants were then asked to discuss what resources would be needed to make these "Big Ideas" operational. Participants cited resources needed to implement their specific strategies, and ended the conversation with a discussion of resources needed overall to be able to achieve the "Big Ideas." One of the common themes that emerged was using existing resources more efficiently. Bill stressed that no advocate can do this work alone and therefore needed to be strategic in allocation of resources. Illustrating this point, Karen gave an example of a partnership with new funders:

Karen Crompton (UT): The Molina and SelectHealth health plans are partnering with us for our August CHIP and Medicaid outreach enrollment event. It's when we're going to release our new storybook with Medicaid and CHIP families in it. They help defray a lot of the costs associated with the event, and that kind of approach may work for some other events around children's health.

A few participants also discussed using social media as a way to do more with less. Three participants provided examples of how social media is becoming a necessary component of their advocacy work to reach diverse stakeholders.

Karen Crompton (UT): So finding a way to look like we're doing more with the same amount or less is really important. You know Utah is a big state geographically, and to drive around the state to meet with groups of ten people here and there just is not a very efficient use of our time or resources. Is there a way we can create a bigger virtual presence using our social media work? Part of what we're going to try to do with our August event to get a lot of people responding to Facebook and Twitter that day. We're working with MomsRising and our other partners in the state to really engage people so that it looks like something is happening everywhere in the state, even though the focus of it that day is at the Boys and Girls Club in Murray, Utah. There is a statewide presence. And I think that becomes an important part of our work. Probably every state has to deal with that to a certain extent. But in these big states with remote places, we're not going to have second offices.

Kelly Hardy (CA): I'd also add that social media is becoming a bigger and bigger part of our job and that's something that we're just doing a lot of and kind of learning as we go, with the help of many. You know I think there are many funders and others who are willing to help people learn how to best use social media. But it's something that's becoming a bigger part of the advocacy work.

Anne Dunkelberg (TX): You know it's wonderful that we have all these new channels of communication, but we have a lot of people who are only operating on one channel or two channels, and so if we really want to engage diverse partners, we have to be broadcasting on many different channels and it's sometimes hard to figure out how to bring people together with so many different channels playing out there.

Kelly Hardy and Anne Dunkelberg considered data to be a key resource needed in order to make the case for their Big Ideas. Specifically, Kelly cited the need to tie education and health outcomes together.

Kelly Hardy (CA): We in California are trying to get a better sense of the different sources of data about kids outcomes related to education and health, other metrics of wellbeing, and to get a more global picture, so that we can then see which direction kids are going in a more coordinated way. And I think that that project

is underway, and so we are marshaling the resources that are needed in general to do that. But it's a pretty big task to figure out all the different data sources and so that's where that project is at.

Lastly, participants from the two largest states – Texas and California – discussed the dismal status of their state budgets, and additional revenue and reforms that would be needed in order to reach integrated family coverage.

Anne Dunkelberg (TX): Another thing that's huge in Texas, and it probably is in California too, is that there's just no separating state revenue issues from health care access. We have such a horrific fiscal struggle here and such a major structural deficit because of our last two governors both making permanent tax cuts—long-term tax cuts that reduced not just one time tax revenues, but reduced the fiscal capacity of the state. I mean the actual, not the potential fiscal capacity, but the actual revenue generating capacity. So we're so far below what we need for basic services that a growing part of many of our partners' and allies' portfolios right now is trying to devote a portion of our resources to issues around building support for having a rational revenue system that can keep up with the growth of the state. We cut $5.3 billion out of K-12 education in our last budget, in addition to the stuff that happened with Medicaid and CHIP. We're trying to be part of a broader effort that reaches across a lot of issue and advocacy areas to move forward the support for rational revenue reform.

Kelly cited the recent Healthy Families transfer into Medi-Cal as an example of the state's fiscal challenges. Both Kelly and Anne discussed the importance of messaging in battling state budget discussions that pit key social service programs against one another.

Kelly Hardy (CA): I just want to echo that I think the revenue conversation it's overarching and huge, and the state budget conversation impacts so much of our work. You know we're saving childcare programs by cutting Healthy Families, when those are the same children. And then childcare programs got cut anyway. It was very difficult to be careful with our messaging and to avoid trashing Medi-Cal when you're trying to argue against transitioning more children into Medi-Cal. And so as far as resources go, even though I do feel like we're getting much more sophisticated on the messaging side of things, there's just always going to be challenges and mine fields there that I think we need help navigating.

Anne Dunkelberg (TX): One of the things we have to work on is that we have an elected State Comptroller who's been out on the road telling people that Medicaid is taking money away from the schools. So we're trying to work with our public education allies to say don't pit children's healthcare against children's education. The Narrative Communications Project was the first grant- funded project I probably worked on in which messaging expertise was a dominant, an integral part of the project. And we have had a number of projects since then with strong messaging support, so obviously there's a lot more attention and thought being devoted to how we talk about these things.

But the struggles around revenue are joined at the hip with the discussion about how we can all contribute to reforming the perception of government. There are obviously a number of different folks working on that challenge out there in the community of thinkers and doers. The Public Works folks are one that comes to mind, but there are other folks as well. And making sure that in our rhetoric we're not trashing government – that we're not contributing to that. We have successfully convinced more and more partners and more and more people are in the boat with us saying to other people, you have to be engaged on this revenue discussion because no progress can be made on your issue without it. Or worse, nothing good could happen unless it's at the expense of something else that is equally critical because our government is so bare bones here in Texas, there's no fat. So I think having those alliances and just making sure that we're not out there

making arguments for social goods without there being any system to support those social goods. That makes us look clueless.

Conclusion

Looking towards the next five years, the "Big Ideas" that the five advocates offered reflect their overall desire to improve the culture of coverage by making coverage the "norm" and access to needed care easier. Advocates discussed ways to expand coverage by using electronic enrollment and retention systems and to make care more accessible by expanding the use of medical homes and other models that centralize and coordinate services for families. To implement these ideas, participants referenced key lessons learned over the last five years – most significantly the importance of coalition building, such as partnering with businesses, and identifying key champions like elected officials, as key to the gains made in their states. Participants also highlighted the ability to be flexible and open to innovative approaches to advocacy, such as using social media to expand and target their messaging. These ideas draw upon their individual successes and capitalize on the upcoming opportunities available through the Affordable Care Act.

Nevertheless, their "Big Ideas" are modest and reflect the reality of their states' budgets and uncertainty surrounding the outcome of the upcoming elections. While these ideas are primarily contingent on successful implementation of the Affordable Care Act, advocates discussed cautiously the future of children's health coverage within the context of the ongoing political battles that have pitted health care reform and Medicaid against education and other social services as states face weak revenues and limited prospects for a strong economic recovery or tax increases. The implications of the Supreme Court decision on their state-level work were on the forefront of their minds as participants discussed strategies to combat these ongoing challenges. Some advocates felt that the adult expansion of Medicaid is critical for the continuation of progress, mainly because a big driver of getting more kids insured and making the programs work better would be opening them up to parents. In order to successfully move forward, all mentioned the continued need for strong communication and messaging strategies, including the more effective use of social media to build their capacity.

Arguably many of the challenges to future progress on children's coverage are variants of ones encountered in the past (i.e., the Groundhog Day syndrome discussed in the focus groups). Despite such challenges, these advocates, their organizations and partners have accomplished much in growing children's coverage in the Southwestern states, and they remain committed to expanding coverage for all kids and their families. It is hoped that both the nation and individual states can move past the current challenges, so we can see continued progress and much bigger ideas in the future.

---

[1] Two-year averages of state data from the Current Population Survey are used in this paper to address the issues posed by small sample sizes in the less populous states. Based on these two-year averages, the overall rate of uninsured children in the seven Southwestern states was 13% in 2009-10, substantially above the rate for the U.S. as a whole (10%) and even more out of line with the rate of 9% for the U.S. when the Southwestern states are excluded. Colorado, with an uninsured rate of 8% in 2009-10, was the only Southwestern state with an uninsured rate below the U.S. rate (excluding the Southwestern states).

[2] Ibid.

[3] Source: U.S. Census Bureau, Current Population Survey, 2005, 2006, 2010, and 2011 Annual Social and Economic Supplement.

[4] For more information, see http://www.insurekidsnow.gov/professionals/eligibility/performance_bonuses.html.

[5] Cohen RA., Martinez ME. Health insurance coverage: Early release of estimates from the National Health Interview Survey, 2011. National Center for Health Statistics. June 2012. Available from: http://www.cdc.gov/nchs/nhis/releases.htm

[6] Source: http://www.kff.org/medicaid/upload/8272.pdf; https://www.dol.gov/ebsa/pdf/chipmodelnotice.pdf.

[7] Color of states represent whether the state is controlled by Democrats, Republicans, or both. Black: governor and state legislature majority both Democrat. Light Red: governor and state legislature majority both Republican. Dark red: governor and state legislature majority are different parties. Sources: Governor data from http://www.census.gov/compendia/statab/cats/elections/gubernatorial_and_state_legislatures.html. State legislature data from http://www.ncsl.org/documents/statevote/2012_Legis_and_State.pdf. Map template from: http://www.ametsoc.org/amsedu/dstreme/extras/bmap.gif.

[8] Advocates from Colorado and Nevada were invited to participate in the focus groups but could not because of scheduling conflicts. For more information on Insuring America's Children and grantees, see: http://www.packard.org/what-we-fund/children-families-and-communities/childrens-health-insurance/insuring-americas-children-states-leading-the-way/.

[9] The American Reinvestment and Recovery Act of 2009, included a "MOE" (maintenance of effort) provision requiring states to maintain coverage for children enrolled prior to the law's enactment.

[10] This colloquialism refers to the tendency for reforms designed to expand program eligibility to also substantially increase enrollment of those previously eligible but unenrolled.

[11] A provision in federal law that provides enhanced payments to hospitals serving a disproportionately high share of Medicaid patients as a way of helping to subsidize the costs of caring for the uninsured. The rationale for these payments is that hospitals with large Medicaid populations likely also serve large numbers of uninsured patients.

[12] A shorthand reference to nonprofit organizations permitted a wide but still limited range of political activities without compromising their tax-exempt status – the term refers to the section of federal tax law under which such organizations are chartered. The term 501(c) (3) refers to nonprofits with more restrictive political activities constraints.