

# REPORT

FINAL REPORT

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## **Supporting Advocacy to Achieve Universal Children's Health Coverage: Final Report on the KidsWell Campaign**

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## EXECUTIVE SUMMARY

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### Introduction: The KidsWell Campaign

When the Patient Protection and Affordable Care Act (ACA) passed in 2010, about 6.2 million children were uninsured; of those, nearly 70 percent were already eligible for coverage through Medicaid or the Children’s Health Insurance Program (CHIP) but not enrolled (Kenney et al. 2012). Recognizing the many benefits for children from having health insurance and identifying the ACA as an opportunity to close the children’s coverage gap, in 2011 the Atlantic Philanthropies (Atlantic) created the KidsWell campaign. KidsWell’s theory of change hypothesizes that if advocates at both state and national levels could leverage new funding and coverage opportunities created by the ACA, such as encouraging states to adopt the optional Medicaid expansion or to create user-friendly enrollment portals in their state marketplaces, eventually universal children’s health insurance coverage could be achieved. Atlantic invested nearly \$29 million over six years to support advocates in seven states, as well as 10 national advocacy groups, to advance a coordinated agenda to accelerate progress in covering children in the short term, while building a lasting child advocacy infrastructure to maintain these gains in the long term.

In 2013, Atlantic contracted with Mathematica Policy Research to evaluate the KidsWell campaign. Since that time, evaluators have produced case studies and an interim report, and published issue [briefs](#) based on those findings (Hoag et al. 2015; Hoag et al. 2014). This is the final evaluation report, and is based primarily on interviews with KidsWell grantees and policy leaders in the seven KidsWell states, as well as analysis of coverage trends for children before and during the KidsWell grant period.

### Findings

Key findings from this final assessment include:

**In 2014, the year in which the key coverage expansions authorized by the ACA provisions took effect, children’s coverage rates reached a new all-time high—94 percent of children had some form of health insurance.** 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; this suggests that the ACA is serving an important mechanism for improving children’s coverage (Alker and Chester 2015). KidsWell states showed patterns in coverage gains similar to national trends. As expected, 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 non-expansion states made important strides in improving children’s coverage.

**Across states, more than three-quarters of state policy leaders agreed that the KidsWell grantees are credible, but policy leaders had varied opinions about the degree to which KidsWell grantees influenced policy decisions on coverage.** To understand how the KidsWell advocates are perceived in their respective states, we interviewed knowledgeable health policy leaders in each state (such as governors’ advisors, state Medicaid or insurance agency directors, and legislators serving on state budget and health policy committees, among others). In Florida, New York, and Texas, half or more of the policy leaders interviewed noted

that the KidsWell advocates had a “big influence” on the particular policy we inquired about (the policy state grantees reported focusing on most during their KidsWell advocacy campaigns) (Table ES.1). More often, policy leaders said grantees had a moderate influence on policy changes, or said they could not tease out the degree of influence grantees had on a particular policy. In all states, policy leaders noted that other factors beyond the KidsWell groups’ advocacy efforts affected policy decisions, such as legislative backing and state budget pressures.

**Table ES.1. 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 <sup>a</sup>	Policy leader perceptions of grantee influence on policy win	Policy leader perceptions of main factor(s) influencing win
California (6)	<b>Medicaid expansion,</b> protection of Medicaid and CHIP budgets, state exchange design		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.
Florida (5)	<b>Elimination of five-year waiting period for Medicaid/CHIP for lawfully residing immigrant children</b>		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 calculated the cost to the state of this policy.
Maryland (6)	<b>Exchange benefit design,</b> avoiding coverage gap for youth aging out of foster care		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.
Mississippi (6)	None <sup>b</sup>		Policy leaders agreed that political issues prevented any serious consideration of issues related to Affordable Care Act implementation.
New Mexico (6)	<b>Medicaid expansion</b>		Policy leaders agreed that the main factor influencing Medicaid expansion was the governor, as well as the state economy.
New York (6)	<b>Basic Health Plan (BHP),</b> consumer-friendly state-based exchange		Policy leaders agreed that the grantee’s 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.

State (Number of policy leaders responding)	Policy win <sup>a</sup>	Policy leader perceptions of grantee influence on policy win	Policy leader perceptions of main factor(s) influencing win												
Texas (5)	<b>Averting cuts to the Medicaid program, including defeat of a proposed 10% cut to Medicaid provider fees</b>	<table border="1"> <caption>Policy leader perceptions of grantee influence on policy win in Texas</caption> <thead> <tr> <th>Influence Category</th> <th>Number of Policy Leaders</th> </tr> </thead> <tbody> <tr> <td>Big</td> <td>3</td> </tr> <tr> <td>Mod</td> <td>1</td> </tr> <tr> <td>Small</td> <td>0</td> </tr> <tr> <td>None</td> <td>0</td> </tr> <tr> <td>Unkn</td> <td>1</td> </tr> </tbody> </table>	Influence Category	Number of Policy Leaders	Big	3	Mod	1	Small	0	None	0	Unkn	1	Policy leaders agreed that the final decision was attributable to political decisions and budget factors; the business community's support also was influential.
Influence Category	Number of Policy Leaders														
Big	3														
Mod	1														
Small	0														
None	0														
Unkn	1														

Note: 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; Unkn = policy leaders said they did not know how much influence KidsWell grantees had on the policy win.

Source: KidsWell grantee reports of policy wins in 2014 surveys and 2016 grantee interviews; interviews with 40 policy leaders in the seven KidsWell states (6 per state in California, Maryland, Mississippi, New Mexico, and New York, and 5 per state in Florida and Texas), November 2015–April 2016.

<sup>a</sup> The primary policy win we asked policy leaders about is in bold text; for each state, the policy win we asked about was based on grantee reports of their primary policy focus.

<sup>b</sup> 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).

**Policy leaders in all seven KidsWell states agreed that the KidsWell groups play important roles in mitigating challenges to children’s health care coverage primarily by providing credible information to state officials and serving as a voice for underserved constituencies.** Policy leaders credited the KidsWell advocates for organizing strong coalitions and developing strong relationships with key stakeholders to promote children’s health coverage priorities. Several policy leaders commented that advocates help keep children’s health care issues “front and center,” conducting analyses about potential impacts to coverage or budgets that sometimes no one else is providing. In six of the seven states, policy leaders also emphasized that the KidsWell advocates are skilled at consensus building and leveraging the expertise of members within their coalitions to promote children’s health issues.

**Policy leaders believe grantees are effective at conducting various advocacy activities.** Atlantic sought to maximize its KidsWell investment by intentionally funding capable children’s advocacy organizations with different strengths that could partner to advance policy changes within the target states. To understand how the KidsWell advocates are perceived externally, we asked policy leaders to rate each KidsWell grantee’s effectiveness in carrying out six key advocacy activities. On average, policy leaders reported that at least one grantee within each state was very or moderately effective at each activity we asked about, with one exception (in New Mexico, the majority of respondents said they did not know whether or not either grantee was effective at grassroots organizing). Policy leaders most often reported grantees’ greatest strengths were coalition building and policy analysis. These findings corroborated findings from a 2014 survey of grantees, in which they rated their greatest strengths as coalition building, allowable lobbying, policy or legal analysis, communications/media, and relationships with elected officials (Hoag et al. 2015). Taken together, grantees’ and policy leaders’ views suggest that Atlantic’s approach to grantee selection was effective, and that the grantees selected in the states were capable at undertaking advocacy campaigns.

**Grantees attributed their successes in KidsWell to two prominent features of Atlantic’s grant-making approach: (1) providing multiyear funding and (2) trusting the grantees to deploy campaigns that would work in each state environment, rather than taking a prescriptive approach to advocacy campaigns.** Half of the national and state grantees interviewed mentioned the benefits of multiyear KidsWell funding, such as giving groups the confidence to hire new staff and alleviating the burden of annual grant writing. A majority of grantees also cited Atlantic’s flexible approach to the grant, letting grantees 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.

**An important legacy of the project is that grantees expect the within-state networks built through KidsWell to continue after the grants end, although at a lesser intensity because few have identified new funds to support this work.** In a 2014 survey, the state grantees cited the most important contribution of KidsWell support as giving them the resources to build strategic partnerships with KidsWell partners and others within their states. In the 2016 interviews, all grantees in the seven states expect their within-state KidsWell partnerships to continue, which will help support continuing efforts needed to maximize coverage.

However, grantees reported that due to funding constraints, the coalitions will not necessarily operate at the same intensity or level of interaction, despite strategic efforts by Atlantic to help the grantees focus on sustainability before the grant ended. For example, midway through the grant period, Atlantic organized “funder roundtables” in each of the seven states 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. By the spring of 2016, only one national grantee and five state grantees had secured any additional funding for their children’s coverage advocacy work. Consequently, grantee partners in Florida, Maryland, and Mississippi said they would continue advocacy on children’s coverage issues, 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 with less funding, they will have less capacity to collaborate and organize coordinated advocacy campaigns.

## **Discussion and implications**

Through this evaluation, we assessed the KidsWell groups using a variety of metrics, all of which suggest that the Atlantic Philanthropies’ investment in KidsWell over an extended period has been successful in achieving policy changes and increasing coverage rates. Grantees also developed strong state advocacy networks and strengthened their capacity to undertake advocacy campaigns. With support from the national grantees and staff at Atlantic, grantees closely collaborated, 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 at least in part from grantee efforts. Most important, nearly 600,000 more children gained coverage in the seven KidsWell states since KidsWell began in 2011.

Policy leaders corroborated grantees' assessments that the KidsWell groups are needed and effective at most advocacy activities. In our interviews, policy leaders consistently told us that they value how the KidsWell advocates do the ground work necessary to provide the context needed to inform decisions and conduct unbiased analyses; this makes them credible and trustworthy partners. The grantees have formed coalitions that speak with one voice, coordinating their strategies and messages, and leveraging each group's strengths; by doing so, they can amplify findings and implications drawn from solid policy analyses, often using social media channels to widen their reach. Finally, policy leaders credited the grantees for their long-term investments in relationship building with elected and administrative officials, which is critical to getting those officials engaged and involved in the issues. Although these findings are not new, they are important reminders to advocates in other states about capacities that warrant ongoing improvement and strengthening. While many policy leaders cited factors such as legislative backing and state budget pressures as having played a large part in policy decisions, more than half of the policy leaders interviewed credit KidsWell grantees with influencing policy wins to either a moderate or large degree.

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 living within 8 states—Alaska, Arizona, Florida, Montana, Nevada, Oklahoma, Texas, and Utah—still lacked coverage, 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.

This means that 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, there are numerous benefits to maintaining a strong network ready to advance the work; moreover, the amount required to keep making an impact now may be lower. Children's advocacy networks and capacities have already been built. 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. Such support is still needed to continue momentum toward universal health coverage for all children, and to focus on new issues that accompany coverage, such as access, utilization, and equity.

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## I. INTRODUCTION

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The Patient Protection and Affordable Care Act (ACA), enacted in 2010, held great promise for expanding insurance coverage to millions of uninsured Americans. Beginning in 2014, it provided new coverage opportunities for low-income adults who previously had no access to coverage through employers or public options. Children were also expected to benefit from ACA implementation. For example, public coverage for children with family incomes of less than 138 percent of the federal poverty level (FPL) would shift from separate Children’s Health Insurance Program (CHIP) programs to Medicaid (which provides slightly enhanced benefits compared to CHIP); some families with incomes up to 400 percent of the FPL 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 et al. 2016; Hoag et al. 2015).<sup>1</sup> When the ACA passed in 2010, about 6.2 million children were uninsured; of those, nearly 70 percent were already eligible for coverage through Medicaid or CHIP but not enrolled (Kenney et al. 2012).

Recognizing the many benefits from having health insurance, such as improved access to care and better health outcomes compared to those without insurance, many national funders began investing in new programs that would support ACA implementation and increase coverage.<sup>2</sup> 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. In addition, Atlantic realized that operationalizing health reform would require action by both states and the federal government, since they jointly finance and administer Medicaid and CHIP.

Atlantic’s efforts culminated in the creation of the KidsWell campaign. KidsWell’s theory of change hypothesizes that if advocates at both state and national levels could leverage new funding and coverage opportunities created by the ACA (such as encouraging states to adopt the optional Medicaid expansion or to create user-friendly enrollment portals in their state marketplaces), then health insurance coverage among children would increase. Launched in 2011, KidsWell was designed as a two-pronged strategy, investing nearly \$29 million in state and national advocacy groups to (1) advance a coordinated agenda to accelerate progress in covering children in the short term, and (2) build a lasting child advocacy infrastructure to

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<sup>1</sup> The ACA also extended CHIP funding through September 30, 2015 (prior legislation, the Children’s Health Insurance Program Reauthorization Act, only funded CHIP through 2013). Subsequently, the Medicare Access and CHIP Reauthorization Act of 2015 extended CHIP funding through September 30, 2017, even though CHIP is authorized to run through September 2019.

<sup>2</sup> For 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 coverage.

maintain these gains in the long term, including a deliberate focus on sustainability throughout the grant.<sup>3</sup> In choosing where to invest, Atlantic targeted states with large numbers of uninsured children, and 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. The selected states— California, Florida, Maryland, Mississippi, New Mexico, New York, and Texas—accounted for 45 percent of all uninsured children in the nation in 2011, varied in political leadership, and, except in Maryland, more than 20 percent of children in these states lived under the poverty level that year (Table I.1). The seven KidsWell states also spanned a continuum in their embrace of the ACA: at one end was California, the first state to pass legislation creating a health insurance marketplace after enactment of federal health reform, while at the other end, legislatures in Florida, Mississippi, and Texas actively opposed actions supporting ACA implementation.

**Table I.1. Key indicators in the KidsWell states, 2011**

State	Number of uninsured children, 2011	Uninsured children as a percentage of all child residents, 2011	Percentage of children living in poverty, 2011	Medicaid/ CHIP participation rate, 2011	Political context, Governor/Senate/ House, 2011
California	745,000	8%	23%	87%	D/D/D
Florida	475,000	12%	24%	83%	R/R/R
Maryland	61,000	5%	13%	90%	D/D/D
Mississippi	61,000	8%	32%	90%	R/R/D
New Mexico	47,000	9%	30%	90%	R/D/D
New York	181,000	4%	22%	92%	D/R/D
Texas	917,000	13%	26%	82%	R/R/R

Notes: CHIP = Children’s Health Insurance Program; Governor = governor’s political party; Senate = Senate control; House = House control; D = Democrat, R = Republican.

Medicaid/CHIP participation rate is the percentage of children eligible for Medicaid or CHIP coverage who enroll.

Sources: Mathematica analysis of American Community Survey data; Kenney et al. 2013; Kids Count Data Center 2015a, Kids Count Data Center 2015b; Multistates Associates 2011.

Because it knew no one advocacy organization would have all the advocacy skills needed, Atlantic intentionally funded capable children’s advocacy organizations with different strengths that could partner to advance ACA implementation within the seven target states (Table I.2). In each state, Atlantic chose a fiscal lead organization; many of these state leads were regarded as the leading advocacy group for children or health coverage in that state. Atlantic then purposely funded other organizations whose advocacy skills complemented those of the lead grantees.<sup>4</sup> Atlantic also supported 10 diverse national groups to provide strategic support and advice to state grantees’ campaigns in a variety of areas, such as communications, grassroots organizing, or policy advice; this helped expand state grantees capacities to engage in advocacy campaigns.

<sup>3</sup> For example, to facilitate connections with local funders, Atlantic convened funder roundtables in each of the KidsWell states during the grant period to introduce the grantees and their work to local philanthropic groups.

<sup>4</sup> Specific advocacy skills are further discussed in Chapter II, Section C.

**Table I.2. State and national KidsWell grantees**

State	KidsWell state grantees <sup>a</sup>
California	Children Now, 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
Maryland	Maryland Advocates for Children and Youth, Maryland Citizen's Health Initiative Education Fund (also known as 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 Accion y de Fe (CAFÉ)
New York	Community Service Society of New York, Schuyler Center for Analysis and Advocacy, Children's Defense Fund of New York, Make the Road New York, Raising Women's Voices
Texas	Engage Texas, Center for Public Policy Priorities, Children's Defense Fund of 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
Moms Rising	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 United States; 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 The Atlantic Philanthropies.

<sup>a</sup> The fiscal lead grantee in each state is listed first.

## A. Focus of this report

This report builds on an interim evaluation in which state grantees reported that KidsWell support helped to achieve several key intermediate goals, including strengthening within-state partnerships and networks, and expanding their advocacy skills and capacities to undertake advocacy campaigns. The state grantees also reported that they believe their most effective advocacy activities were coalition building and direct contact with elected officials to lobby for support of issues (Hoag et al. 2015).

Given the many federal and state policy, budgetary, and political factors influencing ACA implementation, 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. Instead, this final evaluation report presents findings on the following research questions:

- How and to what extent did children’s health insurance coverage rates change during the KidsWell era?
- What role do state policy leaders think KidsWell grantees played in shaping policies that supported children’s coverage?
- How effective do state policy leaders think the KidsWell state grantees are at undertaking advocacy activities? What are their strengths and weaknesses?
- How do grantees think KidsWell enhanced their work?
- Are the networks built through KidsWell likely to be sustained?

Chapter II summarizes key findings for each of these questions, and Chapter III discusses overall implications of our findings for the field.

## **B. Study methods**

Most of the information in this report is drawn from a series of interviews designed to obtain comprehensive insights from various respondents:

- **For the 40 state policy leaders interviewed**, the interview protocol inquired about respondents’ 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,<sup>5</sup> and their views on future health coverage topics and other issues that might affect coverage (such as the state budget or political landscape). Those interviewed included 11 elected officials, 12 Medicaid or state insurance agency leaders, and 17 health policy insiders, a group which included knowledgeable leaders of local health policy institutes or local health foundations who had an understanding of how health policy decisions were made in the state.<sup>6</sup>
- **For staff from 22 state KidsWell grantees**, the interview protocol inquired about their main policy focus since the evaluation’s 2014 survey, any policy changes in the state, the 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). We interviewed grantee staff who were most knowledgeable about the grant project (for example, staff interviewed in 2016 had

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<sup>5</sup> We tried to offset sampling bias by purposely seeking out interview respondents with different political ideologies. For example, in each state, we sought an interview with a Republican and Democratic health policy legislative leader. In a few instances, targeted respondents refused our interview requests.

<sup>6</sup> We targeted 42 state policy leaders—6 per state. In California, Maryland, Mississippi, New Mexico, and New York, we interviewed 6 respondents per state; in Florida and Texas, we interviewed 5 respondents per state, due to refusals to participate. Our response rate was 95 percent.

completed a previous grantee survey in 2014, and generally had worked on the KidsWell grant since the project's inception).<sup>7</sup>

- **For staff from 5 national KidsWell grantees**, the interview protocol inquired about the 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, the 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. As with the state grantees, for each national grantee, we interviewed staff who had been involved in the project since its inception.<sup>8</sup>

Following standard qualitative methods (Miles et al. 2013; Bradley et al. 2007), all 67 interviews conducted in 2015 and 2016 were recorded and professionally transcribed, then reviewed by research staff for accuracy and quality. The research team identified the main research themes of interest to develop a coding scheme, including code names and definitions; these codes were applied to the transcripts in NVivo, a software tool used to manage and analyze qualitative information. After coding, we reviewed and analyzed the results to inform our findings.

To enhance the analysis, the research team also reviewed (1) publicly available documents and media reports on state policy developments and children's coverage statistics, including American Community Survey (ACS) data from 2009 to 2014,<sup>9</sup> and (2) key program documents, such as background reports developed in the first year of the grant, media stories, policy briefs produced by grantees, and key findings from the survey of KidsWell grantees fielded in 2014.

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<sup>7</sup> We excluded three state KidsWell grantees from the interviews: Make the Road New York, Raising Women's Voices, and Engage Texas. Make the Road New York and Raising Women's Voices received pass-through funding from the lead grantee in New York. Engage Texas was the fiscal intermediary for the KidsWell grant in Texas but was not actively involved in the work.

<sup>8</sup> We selected five of the 10 total national KidsWell grantees to interview. These five grantees were selected because they received the largest amount of grant funding and they reported having the most contact with state grantees in our 2014 survey.

<sup>9</sup> Due to lags in availability, only data through 2014 were available when we wrote this report.

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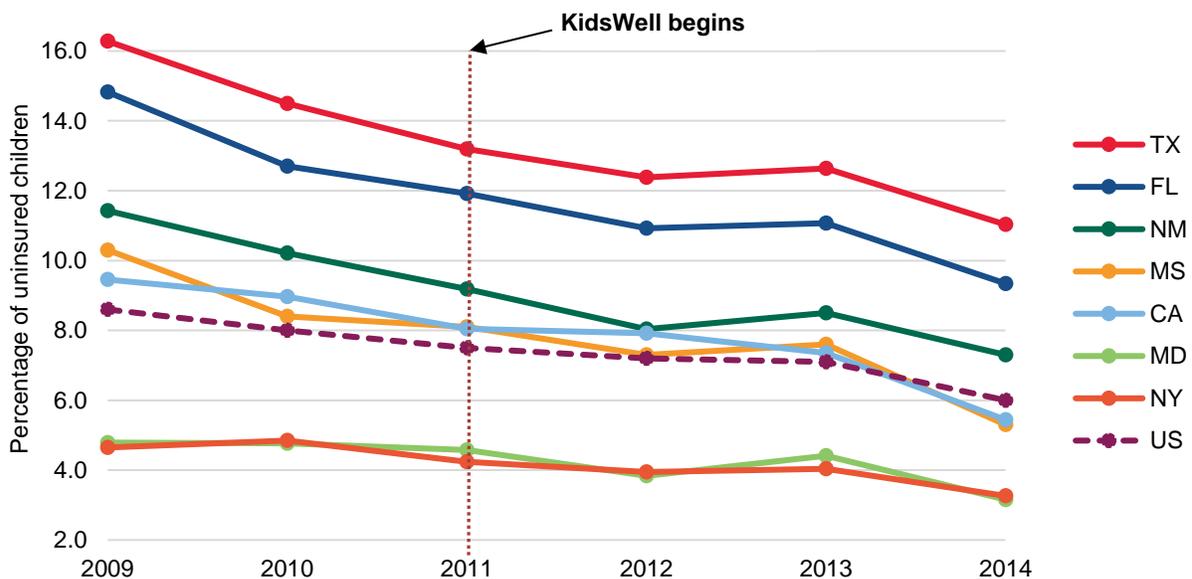
## II. KEY FINDINGS

This chapter presents key findings on each of the major research questions. First, it reviews children’s coverage trends before and during the KidsWell grant period, starting in 2009 and extending through 2014. Second, it presents state policy leaders’ views on the role of the KidsWell advocates in shaping children’s health coverage policies. Third, it highlights policy leader views on the KidsWell grantees’ effectiveness at various advocacy activities, including strengths and weaknesses. Fourth, it discusses the main ways that KidsWell support enhanced the grantees’ work. Finally, it summarizes grantee expectations about the prospects for sustaining the capacities and networks that KidsWell built.

### A. How and to what extent did children’s health insurance coverage rates change during the KidsWell era?

In 2014, the year in which the key coverage expansions authorized by the ACA provisions took effect, children’s coverage rates reached an all-time high—94 percent of children had some form of health insurance. Although the number and rate of uninsured children in the United States have declined each year since 2009, the decline from 2013 to 2014 was greater than in any previous year (Figure II.1); this suggests that the ACA is serving an important mechanism for improving children’s coverage (Alker and Chester 2015). Many children gained insurance through Medicaid and CHIP: by 2014, Medicaid and CHIP participation rates among eligible children reached more than 90 percent in 32 states and approximately 80 percent participation in all states (Kenney et al. 2016). As noted earlier, the KidsWell states were purposely chosen because of their high rates of uninsured children; since 2011 when KidsWell began, the rate of uninsured children dropped 29 percent on average in the KidsWell states.

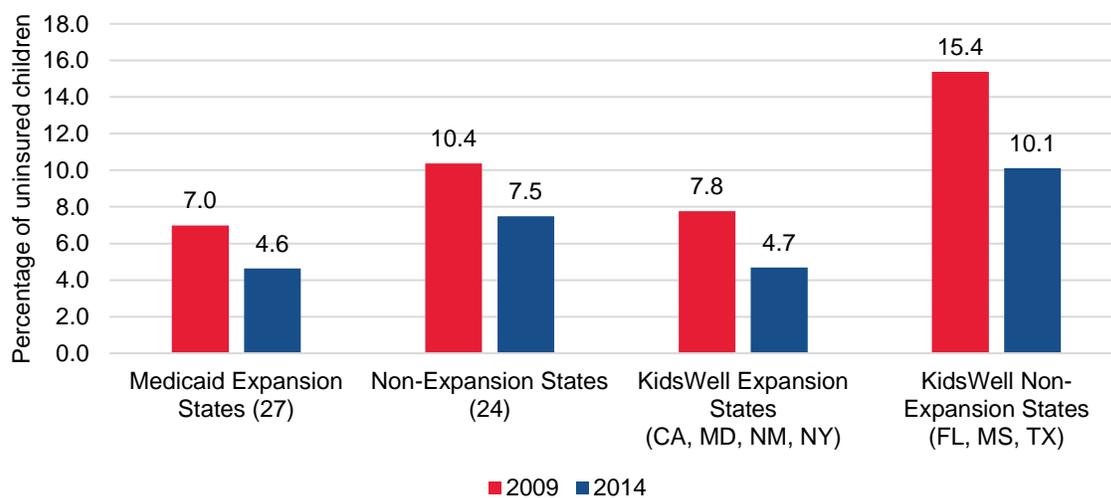
**Figure II.1. Rate of uninsured children in KidsWell states and the United States, 2009–2014**



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

**As expected, 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 non-expansion states made important strides in improving children’s coverage.** On average, gains in Medicaid and CHIP participation between 2013 and 2014 were larger in the 27 states that expanded Medicaid under the ACA (3.0 percent) compared with non-expansion states (1.8 percent) (data not shown). KidsWell states showed patterns in coverage gains similar to national trends. The rate of uninsured children in all seven KidsWell states declined each year, with the steepest drop occurring between 2013 and 2014 (Figure II.1). KidsWell states that expanded Medicaid coverage—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) (Figure II.2).

**Figure II.2. Children’s uninsurance rates in Medicaid expansion states and non-expansion states, 2009 and 2014, total United States and KidsWell states**



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

## **B. What role do policy leaders think KidsWell grantees played in shaping policies that expanded children’s coverage?**

Since 2011, KidsWell state grantees have reported important policy advances as well as setbacks for children’s health care coverage in their states.<sup>10</sup> Major policy wins reported by KidsWell grantees included:

- In **California**, adoption of Medicaid expansion, design of the state exchange, and protection of Medicaid and CHIP budgets
- In **Florida**, elimination of the five-year waiting period for lawfully residing immigrant children
- In **Maryland**, design of the state exchange and avoiding a coverage gap for youth aging out of foster care
- In **New Mexico**, Medicaid expansion
- In **New York**, adoption of a Basic Health Plan and design of state exchange
- In **Texas**, averting cuts to the Medicaid program budget, to prevent further coverage retractions

KidsWell grantees in Mississippi saw no state-level policy wins for children, although they pursued simplifying Medicaid and CHIP enrollment and expanding advocacy capacity to support children’s health access and coverage issues. Grantees in Florida, Mississippi, and Texas also all supported Medicaid expansion and state-based exchanges, but to date these policies have been politically infeasible.

**Across states, more than three-quarters of 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.** An exception was in New Mexico, where only half of the policy leaders interviewed viewed the lead grantee as credible and influential (Table II.1). Policy leaders from New Mexico noted the grantees’ role as a legal advocacy organization often puts them at odds with state agencies, since they have frequently sued the state and thus are often viewed as adversaries rather than collaborators. As this evaluation noted earlier, this effectively limits the New Mexico grantees’ ability to play an “inside” advocacy game with Medicaid officials, a role that requires a greater level of trust between advocates and Medicaid administrators (Hoag et al. 2014). Even in Mississippi, the only one of the seven states with no policy advances under KidsWell, most policy leaders viewed the grantees positively; they also noted that the political opposition to coverage expansions in Mississippi was impossible to overcome. As one policy leader there said, “Opposition here to Medicaid expansion is political. It has nothing to do with health care.... It doesn’t make any difference what facts you put out there.” Mississippi policy leaders concluded that advocacy remained important, to set the stage for policy change when political winds change in the future; and the

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<sup>10</sup> This evaluation defines a state policy advance or “win” as legislation or an administrative rule, budget decision, court case, or other state policy action that increased or accelerated gains in children’s health care coverage. A state policy setback or “loss” is defined as legislation or an administrative rule, funding decision, court case, or other major policy action that reversed, prevented, or hindered gains in children’s health coverage.

advocates focused on changing what was feasible, such as the procedural ways existing policies were implemented.

**Table II.1. Policy leader views on credibility and influence of KidsWell-funded groups**

State	Policy leaders view lead KidsWell grantee as credible and influential/total number of policy leaders (n = 40)	Policy leaders view KidsWell grantee partners as credible and influential/total number of policy leaders (n = 36)
CA	5/6	5/6
FL	5/5	5/5
MD	5/6	6/6
MS	4/6	5/6
NM	3/6	2/2
NY	6/6	6/6
TX	5/5	5/6

Source: Interviews with 40 policy leaders in the seven KidsWell states (6 per state in California, Maryland, Mississippi, New Mexico and New York, and 5 per state in Florida and Texas), November 2015–April 2016. In response to questions about KidsWell grantee partners (last column), four respondents in New Mexico were not at all familiar with the KidsWell partners there, and therefore the question about whether partners were credible and influential could not be answered.

**In Florida, New York, and Texas, half or more of the policy leaders interviewed noted that the KidsWell advocates had a “big influence” on the particular policy grantees reported focusing on during their KidsWell campaigns (Table II.2).** For example, policy leaders in Florida cited the grantees’ ability to provide data to the state legislature, as this helped to change some of the state’s assumptions about the cost of implementing the expansion of coverage to lawfully residing children. In Texas, policy leaders noted that the grantees organized legislative testimony and presented data analysis on the impact of cuts to the Medicaid budget, both of which helped their case. In New York, policy leaders agreed grantees were influential in the Basic Health Plan (BHP) design—particularly with respect to an economic analysis commissioned by the lead grantee. More often, policy leaders said grantees had a moderate influence on policy change or said they could not tease out the degree of influence grantees had on a particular policy.

**Table II.2. 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 <sup>a</sup>	Policy leader perceptions of grantee influence on policy win	Policy leader perceptions of main factor(s) influencing win
California (6)	<b>Medicaid expansion</b> , protection of Medicaid and CHIP budgets, state exchange design		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.
Florida (5)	<b>Elimination of five-year waiting period for Medicaid/CHIP for lawfully residing immigrant children</b>		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 calculated the cost to the state of this policy.
Maryland (6)	<b>Exchange benefit design</b> , avoiding coverage gap for youth aging out of foster care		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.
Mississippi (6)	None <sup>b</sup>		Policy leaders agreed that political issues prevented any serious consideration of issues related to Affordable Care Act implementation.
New Mexico (6)	<b>Medicaid expansion</b>		Policy leaders agreed that the main factor influencing Medicaid expansion was the governor, as well as the state economy.
New York (6)	<b>Basic Health Plan (BHP)</b> , consumer-friendly state-based exchange		Policy leaders agreed that the grantee's 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.
Texas (5)	<b>Averting cuts to the Medicaid program, including defeat of a proposed 10% cut to Medicaid provider fees</b>		Policy leaders agreed that the final decision was attributable to political decisions and budget factors; the business community's support also was influential.

Note: 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; Unkn = policy leaders said they did not know how much influence KidsWell grantees had on the policy win.

Source: KidsWell grantee reports of policy wins in 2014 surveys and 2016 grantee interviews; interviews with 40 policy leaders in the seven KidsWell states (6 per state in California, Maryland, Mississippi, New Mexico, and New York, and 5 per state in Florida and Texas), November 2015–April 2016.

<sup>a</sup> The primary policy win we asked policy leaders about is in bold text.

<sup>b</sup> 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).

**In all states, policy leaders were quick to note that other factors beyond the KidsWell groups’ advocacy efforts, such as legislative backing and state budget pressures, also affected 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. For example, California policy leaders had mixed views on the degree of influence grantees had on the state’s adoption of Medicaid expansion, with several noting that the expansion decision was largely a budget and financial determination made at a “higher level” than advocacy groups and heavily involved public hospitals operated by counties serving large percentages of the uninsured. Despite this uncertainty, California policy leaders agreed that grantees played a role, in particular as providers of trustworthy information: “There’s no doubt that what they’re telling you is accurate or completely appropriate in terms of what they’re lobbying for.... I think multiple members [of the legislature] and a lot of staff go to them as a source of information, and just in facts, useful policy information, and pointers.”

Similarly, in New York, policy leaders all mentioned the grantee’s study on the economic effects of adopting a BHP as very important to its eventual passage.<sup>11</sup> 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. In Maryland, policy leaders noted the strong political acumen and experience of grantees with the legislative and regulatory process to help with exchange design, but policy leaders also said intensive executive-branch efforts helped to shape the exchange. In New Mexico, policy leaders said analysis by the grantees showing the economic benefits of Medicaid expansion was considered influential, as were personal stories the grantees presented to legislators and administrators about those who would benefit from Medicaid expansion. However, as a poor state with 40 percent of residents on Medicaid, policy leaders felt the governor’s decision to expand Medicaid was largely a result of state economics.

**Policy leaders in all seven KidsWell states agreed that the KidsWell groups play important roles in mitigating challenges to children’s health care coverage primarily by providing credible information to state officials and serving as a voice for underserved constituencies.** In all seven states, policy leaders noted the continued importance of advocacy organizations in preparing analysis about the potential impact of coverage and budgets. As one policy leader in Mississippi reported, “[These advocates] are looking at the data and the facts realistically and not from an ideological political spectrum.” Several commented that advocates help keep children’s health care issues “front and center,” conducting analysis that sometimes no one else is providing. Consumer advocacy groups provide input to key stakeholders and, in so

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<sup>11</sup> For more detail, see the KidsWell [case study](#) on New York.

doing, they maintain the presence of the consumer perspective amidst many competing legislative and budgetary priorities. For example, policy leaders in Maryland noted that lawmakers and policymakers in the health care domain have to “keep a lot of groups in mind.” Without advocacy organizations that can vocalize the needs of specific populations, those needs and that group are more easily brushed aside or not as recognized.

Policy leaders in six of the seven states (all but New Mexico) also emphasized that the KidsWell advocates are skilled at consensus building and leveraging the expertise of members within their coalitions to promote children’s health issues. Policy leaders credited the KidsWell advocates for organizing strong coalitions and developing relationships to promote children’s health coverage priorities. As one policy leader in Florida reported, “It’s the idea of bringing together a coalition of people around a consensus of priorities on children’s health coverage issues. I think there’s real value in that. . . . We have strong advocates in the state and they have expertise in different areas [such as] the policy analysis, the budget analysis piece.”

Policy leaders in California, Maryland, Mississippi, New Mexico, and Texas noted the KidsWell groups’ skill at promoting the needs of underserved constituencies or organizing grassroots constituencies. In these five states, policy leaders credited the KidsWell 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. Policy leaders said these advocates speak on behalf of populations that may otherwise be overlooked and that they provide perspectives “we sometimes don’t always see or we forget about in our roles within state government.” For example, they said the KidsWell groups have been able to mobilize their constituencies to contact their legislators to help show the human cost to decreasing funding or eliminating a program. As one policy leader in California reported, “Unless you have people who are vocalizing the needs of a specific population, it can easily happen that that particular group is forgotten; they’re lumped in with the greater population, and if they have special needs, it’s not necessarily recognized. The advocacy community plays a really important role in raising some of those issues to the consciousness of those who are making the decisions.”

### **C. How effective do state policy leaders think KidsWell grantees are at undertaking advocacy activities? What are their strengths and weaknesses?**

**Policy leaders corroborated grantees’ self-reports of effectiveness in conducting various advocacy activities.** Atlantic sought to maximize its KidsWell investment by intentionally funding capable children’s advocacy organizations with different strengths that could partner to advance ACA implementation within the target states. In the 2014 survey of grantees, we asked the state grantees to assess their strengths at undertaking seven core advocacy activities, described in Table II.3. The grantees rated their greatest strengths as coalition building (27 of 29 state grantee respondents); allowable lobbying (25 respondents); and policy or legal analysis, communications/media, and relationships with elected officials (21 respondents each) (Hoag et al. 2015).<sup>12</sup> Also, at least one grantee organization in each state cited strengths in each of these core skills, with one exception. Neither of the two organizations funded in New Mexico reported having a strong relationship with the state Medicaid agency, which may have put them

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<sup>12</sup> No grantees reported fundraising or grassroots organizing as their greatest strength.

at a disadvantage in advocating for administrative rules and procedures to help low-income families enroll their children in Medicaid and fulfill renewal requirements.

**Table II.3. Definition of core advocacy activities**

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

Earlier analyses found that the specific advocacy activities that work best depend on the state political context and the specific policy goal (Hoag et al. 2015). 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 strategies to achieving these goals.

To determine policy leaders' views on the effectiveness of KidsWell grantees' advocacy activities, we asked policy leaders to rate each KidsWell grantee's effectiveness in carrying out each activity.<sup>13</sup> On average, policy leaders reported that at least one grantee within each state was very or moderately effective at each activity we asked about, with one exception (in New Mexico, the majority of respondents said they did not know whether or not either grantee was effective at grassroots organizing) (Table II.4). Taken together, grantees' and policy leaders' views suggest that Atlantic's approach to grantee selection was effective, and that the grantees selected in the states were capable at undertaking advocacy campaigns. As one policy leader in Texas said, "I can't even imagine what coverage would be like in Texas or what Medicaid would be like in Texas if these three [KidsWell grantee] organizations were not involved. They give

<sup>13</sup> We asked policy leaders to rate the grantees as very effective, moderately effective, weak or ineffective, or don't know for six advocacy activities. We did not ask policy leaders to rate grantees' effectiveness at fundraising, because through pretesting our interview instrument, we realized most policy leaders were unfamiliar with grantees' fundraising efforts.

testimony. They hold educational sessions. They provide data and research for members or for people throughout the state of Texas. Anyone throughout the state of Texas that has an issue or concern about Medicaid or CHIP, these three organizations will provide them support and information and coaching and training on advocacy and everything else to help people get their voices heard.”

**Table II.4. Policy leaders’ rating of KidsWell lead or partner grantees as moderately or very effective at various advocacy activities**

State	Coalition building		Direct contact with elected officials		Administrative advocacy		Policy analysis		Grassroots organizing		Public education/mass media	
	Lead	Partners	Lead	Partners	Lead	Partners	Lead	Partners	Lead	Partners	Lead	Partners
CA	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
FL	✓	✓	✓	✓		✓	✓	✓	✓			✓
MD	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓
MS	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
NM	✓	✓	✓	✓	✓		✓				✓	
NY	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
TX	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Source: Interviews with 40 policy leaders in the seven KidsWell states (6 per state in California, Maryland, Mississippi, New Mexico, and New York, and 5 per state in Florida and Texas), November 2015–April 2016.

**Policy leaders most often reported grantees’ greatest strengths were coalition building and policy analysis, again corroborating grantees self-reports.** We also asked policy leaders to report the grantees’ greatest strengths. Out of 38 responses, 9 policy leaders identified coalition building and policy analysis (across five states each) (Table II.5). For example, one policy leader in Mississippi said, “During the legislative session they have Monday noon meetings, and they’ve been doing this for years, and they’ve done a really good job at getting a variety of advocacy groups together to communicate with one another [about] what the issues are and to look at crosscutting issues.” In terms of policy analysis, one policy insider in New Mexico reported, “They [the grantee] actually were a resource that many legislators turned to when we need to have a little information [and] insight into some of the regulations or implications of them that are coming down the pipe.”

**Table II.5. Policy leaders’ assessment of grantees greatest strengths**

State	Coalition building	Policy analysis	Contact with elected officials/relationship building	Grassroots organizing	Public education/mass media	Other
CA	✓	✓✓✓	✓	✓✓		✓✓
FL					✓	✓
MD	✓		✓✓	✓		
MS	✓	✓	✓			✓✓
NM		✓				✓✓
NY	✓✓✓	✓✓	✓	✓	✓	✓
TX	✓✓✓	✓✓	✓			
Total	9	9	6	4	2	8

Notes: There were 38 responses to the question about grantees’ greatest strengths; policy leaders could report more than one greatest strength of the grantees, and some did, while other policy leaders did not report a

greatest strength. Other issues policy leaders cited include: identifying issues, legal advocacy, legislative knowledge, being viewed as a “major voice” or trusted organization, understanding of the state budget, and that the grantees have complementary skills.

Source: Interviews with 40 policy leaders in the seven KidsWell states (6 per state in California, Maryland, Mississippi, New Mexico, and New York, and 5 per state in Florida and Texas), November 2015–April 2016.

Policy leaders also reported relationship building or contact with elected officials as areas of strength among the KidsWell groups (six policy leaders each across five states). For example, a policy leader in Texas reported how the grantees worked to address political challenges, saying, “They make it a point to visit with us, including [visiting] the Republicans. They testify. They send letters. They have their position papers that they put out. With that data [the KidsWell groups provide], anybody who runs for office or who is in office and looks at that can’t bury their head in the sand and say I didn’t have the information because they provide it. And so they are influential in that sense.”

**Across states and grantees, policy leaders were more likely to rank the advocates weak for their administrative advocacy and grassroots organizing skills.** Six grantees in four states were ranked as weak or not effective at administrative advocacy and grassroots organizing. Three of these policy leaders noted that the policy environments in their states may have contributed to difficulties with administrative advocacy. As one policy leader said, “I think that says more about how difficult it can be to work administratively here, than it does about the [KidsWell groups]. [The KidsWell grantees] are at the table ... but at the end of the day, the rough part about working with the administration is that there isn’t anybody really there forcing [state administrators] to do that. You don’t have to pass a bill to require the department to change regulations, and they don’t have to listen to anyone, but the KidsWell grantees are there, they’re trying, which is great.” A policy leader in another state echoed this sentiment, saying, “I would again say that’s not for a lack of having a good strategy or skills. I think the [KidsWell grantees’] efforts have been there and appropriate, I just think it’s a big mountain to climb.” In self-reported data, state grantees infrequently reported weaknesses, although three grantees in two states did identify grassroots organizing as a weakness in their coalitions. A few state policy leaders ranked grantees’ grassroots activities as weak because they felt the grantees lacked a strong social media presence, or they were not familiar with their social media activities.

#### **D. How do grantees think KidsWell enhanced their work?**

**Grantees attributed their successes in KidsWell to two prominent features of Atlantic’s grant-making approach: (1) providing multiyear funding and (2) trusting the grantees to deploy campaigns that would work in each state environment, rather than taking a prescriptive approach to advocacy campaigns.** When asked in 2016 what aspects of the KidsWell grants were most helpful, half of the national and state grantees interviewed mentioned (unprompted) the benefits of multiyear KidsWell funding. For example, grantees said the multiyear funding provided more security compared to a single year of funding, such as the confidence to hire new staff, and alleviated the burden of annual grant writing. As one state grantee commented, “Multiyear funding is a gift. It means we can spent 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 also 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. “Atlantic took a very hands-off approach, and trusted the groups they were investing in. That’s not very common. I appreciated that it allowed us to do the work in the way we know it has to be done,” said one state grantee. One national grantee said, “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.”

### **E. Are the networks built through KidsWell likely to be sustained?**

**An important legacy of the project is that grantees expect the within-state networks built through KidsWell to continue after the grants end, although at a lesser intensity.** In the 2014 survey of KidsWell grantees, the state grantees cited the most important contribution of KidsWell support as giving them the resources to build strategic partnerships with KidsWell partners and others within their states. In the 2016 interviews, all grantees in the seven states expect their within-state KidsWell partnerships to continue. However, grantees reported that due to funding constraints, the coalitions will not necessarily operate at the same intensity or level of interaction, despite strategic efforts by Atlantic to help the grantees focus on sustainability before the grant ended. For example, midway through the grant period, Atlantic organized “funder roundtables” in each of the seven states 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.

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. Although grantees in California and Florida both noted some local funders who might support this type of work, overall prospects 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 9 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 they will shift their focus to wage and labor issues. The groups in California, New York, and Texas report that 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 state policy leaders, 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, which could disrupt the progress made thus far.

Both state and national grantees interviewed expect to collaborate with each other when opportunities arise, although only three national groups noted explicit plans to continue collaborating on projects at the time of our interviews in 2016 (three with California grantees, one of whom is also working closely with the Texas grantees). National grantees most often mentioned California, New York, and Texas when discussing where they thought partnerships might be most frequent in the future. This echoes findings from our interim report, where we found that the strongest state-national collaborations were between those grantees that had worked together before KidsWell (Hoag et al. 2015). For example, California and Texas had the most extensive prior history with the national partners and appeared to have the strongest partnerships with national grantees during this grant. As one national grantee put it, “It helps to have a history” with partners. None of the state grantees expect to work with grantees in other states as a result of KidsWell: because state experiences and conditions varied so much, they reported that they did not form solid relationships with grantees in the other states through KidsWell.

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### III. DISCUSSION

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Through this evaluation, we assessed the KidsWell groups using a variety of metrics, all of which suggest that the Atlantic Philanthropies' investment in KidsWell over an extended period has been successful in achieving policy changes and increasing coverage rates. Grantees also developed strong state advocacy networks and strengthened their capacity to undertake advocacy campaigns. With support from the national grantees and staff at Atlantic, grantees learned to collaborate, 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 at least in part from grantee efforts. Most important, nearly 600,000 more children gained coverage in the seven KidsWell states since KidsWell began in 2011.

Policy leaders corroborated grantees' assessments that the KidsWell groups are needed and effective at most advocacy activities. In our interviews, policy leaders consistently told us that they value how the KidsWell advocates do the ground work necessary to provide the context needed to inform decisions and conduct unbiased analyses; this makes them credible and trustworthy partners. The grantees have formed coalitions that speak with one voice, coordinating their strategies and messages, and leveraging each group's strengths; by doing so, they can amplify findings and implications drawn from solid policy analyses, particularly through strong use of social media channels. Finally, policy leaders credited the grantees for their long-term investments in relationship building with elected and administrative officials, which is critical to getting those officials engaged and involved in the issues. Although these findings are not new, they are important reminders to advocates in other states about capacities that warrant ongoing improvement and strengthening. While many policy leaders cited factors such as legislative backing and state budget pressures as having played a large part in policy decisions, more than half of the policy leaders interviewed credit KidsWell grantees with influencing policy wins to either a moderate or large degree.

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 living within 8 states—Alaska, Arizona, Florida, Montana, Nevada, Oklahoma, Texas, and Utah—still lacked coverage, 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.

Despite KidsWell's focus on and support of activities to promote sustainability, the KidsWell groups are concerned about their abilities to support this work in the future, given that so few had secured additional funds as of early 2016. Grantees noted several reasons that funders might be reluctant to fund advocacy for children's coverage. Some grantees suggested a misperception among funders that the ACA solved the children's coverage problem, and that advocacy on this issue is no longer needed. Others said they think foundations in general are fearful of funding advocacy. As one grantee said, "My sense is certain tax rules make them

reluctant to fund advocacy. I'm not sure how to alleviate those fears, but funders should know that you can fund advocacy without being partisan.”

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 in the past, and what remains at stake for children's coverage. As part of KidsWell, Atlantic sponsored “funder roundtables” in each of the seven states to try to initiate this type of funder education; while all the grantees were hopeful these introductions would lead to fruitful new partnerships with local funders, to date only the Texas grantees said these meetings helped them secure funds.

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. 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. Such support is still needed to continue momentum toward universal health coverage for all children, and to focus on new issues that accompany coverage, such as access, utilization, and equity.

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**REFERENCES**

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- Alker, J. and A. Chester. “Children’s Health Insurance Rates in 2014: ACA Results in Significant Improvements.” 2015. Available at [<http://ccf.georgetown.edu/wp-content/uploads/2015/10/ACS-report-2015.pdf>]. Accessed May 31, 2016.
- Bradley, Elizabeth H., Leslie A. Curry, and Kelly J. Devers. “Qualitative Data Analysis for Health Services Research: Developing Taxonomy, Themes, and Theory.” *Health Services Research*, vol. 42, no. 4, August 2007, pp. 1758–1772.
- BolderAdvocacy.Org. “Administrative Advocacy.” n.d. Available at [[http://bolderadvocacy.org/wp-content/uploads/2012/08/Administrative\\_Advocacy.pdf](http://bolderadvocacy.org/wp-content/uploads/2012/08/Administrative_Advocacy.pdf)]. Accessed March 11, 2015.
- Center for Effective Government. “Permissible Lobbying for 501(c)(3) organizations: Three Key Questions.” 2002. Available at [<http://www.foreffectivegov.org/node/484>]. Accessed March 11, 2015.
- Community Catalyst. “Consumer Health Advocacy: A View from 16 States.” Boston: Community Catalyst, 2006.
- Hoag, S., D. Lipson, M. Morzuch, and V. Peebles. “Securing Coverage for Children by Advocating for the ACA.” Princeton, NJ: Mathematica Policy Research, June 2014.
- Hoag, S., D. Lipson, and V. Peebles. “On the Road to Universal Children’s Health Coverage: An Interim Report on the KidsWell Campaign.” Princeton, NJ: Mathematica Policy Research, May 1, 2015. Available at [<https://www.mathematica-mpr.com/our-publications-and-findings/publications/on-the-road-to-universal-childrens-health-coverage-an-interim-report-on-the-kidswell-campaign>].
- Kenney, G.M., N. Anderson, & V. Lynch. “Medicaid/CHIP participation rates among children: An update.” Washington, DC: Urban Institute, September 2013. Available at [<http://research.urban.org/uploadedpdf/412901-%20Medicaid-CHIP-Participation-Rates-Among-Children-An-Update.pdf>]. Accessed June 29, 2016.
- Kenney, G.M., J. Haley, C. Pan, V. Lynch, and M. Buettgens. “Children’s Coverage Climb Continues: Uninsurance and Medicaid/CHIP Eligibility and Participation Under the ACA.” May 2016. Washington, DC: Urban Institute. Available at [[http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2016/rwjf429061](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf429061)]. Accessed May 31, 2016.
- Kenney, G.M., V. Lynch, M. Huntress, J. Haley, and N. Anderson. “Medicaid/CHIP Participation Among Children and Parents.” Washington, DC: Urban Institute, December 2012. Available at [<http://www.urban.org/sites/default/files/alfresco/publication-pdfs/412719-Medicaid-CHIP-Participation-Among-Children-and-Parents.PDF>]. Accessed May 31, 2016.
-

- Kids Count Data Center. "Children in Poverty." Baltimore, MD: The Annie E. Casey Foundation, 2015a. Available at [<http://datacenter.kidscount.org/data/tables/43-children-in-poverty#detailed/1/any/false/869,36,868,867,133/any/321,322>]. Accessed June 28, 2016.
- Kids Count Data Center. "Children Without Health Insurance By Age Group." Baltimore, MD: The Annie E. Casey Foundation, 2015b. Available at <http://datacenter.kidscount.org/data/tables/32-children-without-health-insurance-by-age-group?loc=1&loct=2#detailed/2/2-52/false/869,36,133,38/17,18,19/303,304>]. Accessed June 28, 2016.
- Miles, Matthew B., A. Michael Huberman, and Johnny Saldaña. *Qualitative Data Analysis: A Methods Source Book*, 3rd ed. Thousand Oaks, CA: Sage Publications, 2013.
- U.S. Census Bureau. "Poverty Status in the Past 12 Months by Sex by Age." 2013a. 2013 American Community Survey 1-Year Estimates, Table B17001. Available at [<http://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t>]. Accessed March 10, 2015].
- U.S. Census Bureau. "Poverty Status in the Past 12 Months of Related Children Under 18 Years by Family Type by Age of Related Children under 18 Years." 2013b. 2013 American Community Survey 1-Year Estimates, Table B17006. Available at [[http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS\\_13\\_1YR\\_B17006&prodType=table](http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_13_1YR_B17006&prodType=table)]. Accessed March 10, 2015].

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