Policy Campaign: One State’s Journey to Influence the Reauthorization of the Children’s Health Insurance Program

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KEY WORDS
Advocacy, campaign, Children’s Health Insurance Program, health policy

Nurses encompass the largest body of health care professionals in the United States, with nearly 3.1 million registered nurses and advanced practice nurses (APRNs) nationwide (American Nurses Association, 2015). The report by the Institute of Medicine (IOM, 2011) on the nursing profession addressed the importance of nursing leadership in health care policy-making for the nation. To fully realize the IOM’s call to action, APRNs must create and participate in campaigns to inform and shape health care policy with an agenda of issues that are crucial to the nursing profession. Partnering with a professional organization can assist in realizing these priorities.

Prior successful legislative initiatives such as the Vaccine Assurance for all Children, a federally funded program since 1994, can serve as models upon which to build new advocacy campaigns. The Vaccine Assurance for all Children campaign was a model for the campaign described in this article for renewing the Children’s Health Insurance Program (CHIP), which has passed both the U.S. House of Representatives and Senate in March and April of 2015, respectively. The purpose of this article is to present an advocacy campaign model that was created to support the passage of CHIP in consultation with the legislative division of The National Association of Pediatric Nurse Practitioners (NAPNAP). It presents one model from a state in the southeastern United States that could be a useful tool to others when advising legislators and key health care stakeholders about children’s health care policy priorities in the future.

BACKGROUND
As the health care marketplace undergoes 21st-century revisions, it is imperative that health care providers inform the health care policy-making process (Milstead, 2016). Before renewal in 2015, CHIP was last renewed in the Children’s Health Insurance Program...
Program Reauthorization Act of 2009, and the enrollment in Medicaid and CHIP has consistently risen since then; 87.2% of all U.S. children were insured in 2011 (Robert Wood Johnson Foundation, 2013). From 1997 to 2011, enrollment grew from 1 million to 5.3 million children (American Academy of Pediatrics [AAP], 2014). Provisions of the Patient Protection and Affordable Care Act (ACA) of 2010 extended authority for CHIP until 2019; however, no funding was provided beyond fiscal year (FY) 2015 (Patient Protection and ACA, 2010). Additionally, Medicaid expansion under the ACA affects CHIP coverage for children. Medicaid has a variable effect on CHIP enrollment depending on state eligibility requirements and how each state designs its CHIP program—stand-alone or combined with the Medicaid program (Kaiser Family Foundation, 2014).

The U.S. Supreme Court ruling on Medicaid expansion gave states the option of expanding Medicaid. As a result of this ruling, about half of the states participated in Medicaid expansion. The ruling complicates coverage based on family earnings that make some children eligible for Medicaid and others eligible for CHIP, sometimes within the same family (Kaiser Family Foundation, 2014). Estimates from the Kaiser Family Foundation and the AAP suggest that up to 4 million children could have been left without insurance had CHIP not been renewed (AAP, 2014; Kaiser Family Foundation, 2014). The June 2014 Medicaid and CHIP Payment Access Commission (MACPAC) report states that many children currently enrolled in CHIP would have experienced difficulty transitioning to another source of coverage, including those that could be obtained through the exchanges within the ACA. Research indicates that the number of uninsured children would have increased if CHIP was not reauthorized (Kenney, Buettgens, Guyer, & Heberlein, 2011). A major flaw for children within the ACA is the “family glitch” that resulted from the Internal Revenue Service rule that bases affordability on employee status and not family. As a result, children older than 6 years who reside in families with incomes above 138% of the poverty level might not qualify for subsidies through the marketplace if they were offered an “affordable” employer-sponsored plan, even if the plan was unaffordable to the family (McMorrow et al., 2014). The coverage offered in CHIP has been found to be more comprehensive and better aligned with pediatric quality care indicators than care offered within the ACA exchanges (Wakely Consulting Group, 2014).

Analyzing how CHIP funding is spent was essential to successfully advocate for CHIP renewal. By examining spending patterns and accounting for demographic factors and health quality indicators among respondents, researchers demonstrated that Medicaid and CHIP funding are highly concentrated in children with special health care needs, and those in the top three deciles of spending accounted for more than 90% of expenditures (Kenney, Ruhter, & Selden, 2009). Furthermore, 30% of children enrolled in Medicaid and CHIP received little to no spending. A majority of these children are black and impoverished (Kenney et al., 2009). This information allows for targeted campaigns to assist children who do not access services and for ways to improve services to children who are high utilizers of care. Concurrently, keeping eligible children on the CHIP roster is a priority. A 2011 study found that children in the lowest income level are most likely to maintain CHIP coverage and children in the highest income range are the most vulnerable to losing CHIP coverage, with the steepest drop-off rates occurring at the renewal period (Fairbrother et al., 2011). Enrollment outreach efforts can be targeted to these groups and may be more effective if combined with Medicaid enrollment efforts.

However, both Medicaid and CHIP enrollment have grown under the ACA (Kaiser Family Foundation, 2014). Legislative priorities for CHIP within this renewal are clear, with 25 measures recommended for the core set of quality indicators; a majority of these measures are related to preventative care (Mangione-Smith, Schiff, & Dougherty, 2010). This prioritization provides a method to frequently assess children’s health care priorities in a standardized way and at multiple levels to foster change.

Gaps in knowledge exist relative to overall health care status of children who receive CHIP, financial burden for families, mental health use, prescription drug use, and emergency room use (Howell & Kenney, 2012). Evidence indicates that CHIP funding increases public health care coverage, complements the ACA if fully enacted, increases access to medical and dental care, and decreases rates of those who are not insured.

**METHODS**

To establish the context for a process model, a literature search related to CHIP was undertaken to determine priorities for renewal in 2015. To look specifically for health care policy information related to CHIP, the
Cumulative Index to Nursing and Allied Health Literature (CINAHL) and PubMed were searched using the terms “health legislation,” “Medicaid,” and “CHIP.” Of note, no results were found using medical subject heading (MeSH) terms because CHIP is not in MeSH. Additionally, PubMed’s evidence-based medicine search, Clinical Queries, was searched using the same terms.

The search resulted in 10 articles in CINAHL, 104 results in PubMed, and 4 results in Clinical Queries. Four studies from PubMed’s Clinical Queries were eliminated based on a lack of relevance as reflected by title. There were 19 duplicate articles from the databases PubMed and CINAHL that resulted in a total of 95 unique articles from the 2 databases. The remaining 95 articles from PubMed and CINAHL were first examined for relevance within the title and by publication date; 84 of these articles were excluded because of publication dates that were prior to the CHIPRA or because they did not contain information that was essential to informing an advocacy campaign based on the abstract. From these, 11 articles were selected and reviewed. Not all were research studies; consequently, six were chosen for detailed review, as noted in the Table. The sample consisted of data related to children who received CHIP since the legislation’s incorporation in 1997, and in particular, since it was last renewed in 2009.

Based on the findings from the literature review, the PRECEDE/PROCEED Model (PPM) was chosen as the framework for the policy campaign (Green & Rabinowitz, 2014). This model is shaped by the community in order to influence quality of life for its members. Additionally, the process model utilized Deming’s plan-do-check-act quality improvement methodology to interpret synthesized literature review results into an actionable plan for advocacy, as demonstrated in the Figure. The cyclical and iterative process of the PDCA methodology is helpful in improving and accelerating change related to clinical and political issues (Seidl & Newhouse, 2012).

DEVELOPMENT OF A HEALTH POLICY ADVOCACY MODEL
Using information generated from the literature review to establish recommendations for renewal, NAPNAP collaborated with the AAP, The Children’s Hospital Association, and Nurse Practitioner Roundtables and participating professional organizations interested in pediatric health care. These organizations included the American Association of Nurse Practitioners and the National Organization of Nurse Practitioner Facilities to advocate for CHIP renewal. The groups outlined future goals for the program based on findings from the literature review. Thus an advocacy campaign was initiated in consultation with NAPNAP’s Health Policy Committee for one state in the South-eastern United States that anticipated the largest increase in federal CHIP spending in the nation.

The health policy advocacy campaign described in this article reflects the process carried out in one state as a case study for CHIP renewal advocacy nationwide. The campaign was accomplished by creating a toolbox for advocacy materials; a link to the toolbox was placed on the national NAPNAP Web site. The toolbox contained (a) a draft policy statement; (b) template letters to the governor, state budget office, and Medicaid office; and (c) information needed to contact federal legislators voting to reauthorize CHIP. The template letters contained information about CHIP’s success in insuring more children and asked the governor and state agencies for support in CHIP renewal. Information about the toolbox was sent by e-mail to all state NAPNAP members. In the state where this case study took place, a policy brief was generated that synthesized the best evidence from the literature and incorporated information specific to the CHIP program in this state. The policy brief was sent by e-mail to members for dissemination to state officials. Support from local legislators was used to gain backing from U.S. Senators and House of Representative members to reauthorize CHIP.

During the campaign, the Chairmen and Ranking Members of the Congressional committees with jurisdiction over the CHIP program forwarded a letter to each state governor’s office asking for information regarding (a) how the state determined the number of children currently served by CHIP, (b) how CHIP has changed as a result of the ACA, (c) how CHIP benefits compared with those from exchanges available through the ACA or employers, (d) whether the state recommended that CHIP coverage be extended, (e) whether state funding allotments were working, and (f) whether federal policies could do a better job enrolling eligible children, reducing the number of uninsured children, and improving outcomes for children in the state.

To capitalize on this information, NAPNAP asked members to deliver a template letter included in the toolbox and asked state chapters to contact governor’s offices to ask for support for CHIP renewal at the same time that the governor’s office received the request from the federal government. The advanced practice nursing professional organization roundtable was continually briefed and asked to advocate for reauthorization of CHIP. The deputy director of the Department of Health and Human Services in the case study state indicated increased knowledge of CHIP after discussing the legislation in more detail. The governor’s office indicated that they would support CHIP given the enhanced matching rate from the federal government and level of need within the state. Additionally, the state wrote the 2015-2016 fiscal year budget to include
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<th>Variable</th>
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<td>Purpose</td>
<td>To develop strategies to measure sustainability and target policies to improve retention of Medicaid coverage and CHIP</td>
<td>Examine spending in Medicaid and CHIP to examine the overall distribution in spending for children in Medicaid/CHIP by examining the results from the Medical Expenditure Panel Survey</td>
<td>Describe the process used to identify the recommended core set of quality measures as mandated by CHIPRA in 2009</td>
<td>Assess the impact of CHIP on the distribution of coverage for low-income children</td>
<td>Synthesize findings of 38 studies in peer-review literature related to the impact of Medicaid/CHIP expansions to provide summary of the important impacts</td>
<td>Examine the impact of health reform (ACA) on Medicaid and CHIP</td>
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<td>Design, methodology</td>
<td>Longitudinal cohort study</td>
<td>Pooled data 2002-2005 from the Household Component of the Medical Expenditure Panel Survey</td>
<td>Using a measure nomination process, key information was obtained to measure validity, feasibility, and importance; Oxford Centre for Evidenced Based Medicine (CEBM) criteria were used to assess evidence supporting the validity/scientific soundness of nominated measures</td>
<td>Quasi-experimental designs and tests of the sensitivity of the results using instrumental variable and difference-in-difference approaches; a detailed Medicaid and CHIP eligibility model were used for this study; balanced repeated replicate weights were used to account for the complex sample; descriptive and multivariate analyses were conducted</td>
<td>Systematic literature review using guidelines from Campbell Collaboration, IOM, Shea, et al.</td>
<td>Microsimulation model to derive estimates at baseline and under the ACA of insurance coverage and Medicaid and CHIP eligibility for children and parents; the model allowed for assumptions about key implementation choices and outcomes</td>
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<td>Sample, setting</td>
<td>Newly enrolled children for the 1-year time period in Ohio between July 2007 and June 2008 and followed for 18 months</td>
<td>18,345 children ages 1-17 years who had either Medicaid or CHIP coverage in any month of the year of whom 13,603 had Medicaid/CHIP coverage for the entire year and 4,742 had such coverage for just part of the year</td>
<td>AHRQ National Advisory Council on Healthcare Research and Quality (NAC) Subcommittee (SNAC)</td>
<td>62,497 children from low-income families in 13 states from 1997-2002</td>
<td>38 studies published in peer-reviewed journals assessing the impact of Medicaid/CHIP</td>
<td>2009 and 2010 March supplements to the Current Population Survey; a policy variable considered in this analysis was the effect on children in separate, stand-alone CHIP programs of allowing CHIP to funding to lapse after FY 2015</td>
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<td>Variable</td>
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<td>Major variables, interventions</td>
<td>Income eligibility group, age, race, gender, county type, change in unemployment</td>
<td>Spending patterns were analyzed with respect to sex, age, race/ethnicity, health status</td>
<td>Validity, feasibility, and importance</td>
<td>Family and county-specific work patterns, state and time-fixed effects, utilization of a low-income comparison group</td>
<td>Impacts were estimated under two alternative implementation scenarios</td>
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<td>Findings</td>
<td>Children in the lowest income group returned sooner and in higher proportions than other children; income eligibility seems to be a strong indicator of stability</td>
<td>Medicaid/CHIP spending on children is highly concentrated with those enrolled continuously for more than 72% of spending; high spending persists over time, particularly for children with chronic health care problems</td>
<td>An open national public process combined with an evidenced-informed evaluation methodology resulted in identification of a balanced core set of measures that should become feasible to implement on a widespread scale over time</td>
<td>Results varied based on approach, but CHIP led to significant increases in public coverage and declines in employer-sponsored coverage; the estimated share of CHIP enrollment attributable to crowd-out was from 33% to 44% with smaller crowd-out effects for Medicaid-eligible children</td>
<td>Not uniformly positive but Medicaid/CHIP expansion leads to improved health insurance coverage for children while increasing their access to care and service use; more cautiously stated, expansions also lead to improvements in status with increased research needed here</td>
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<td>Significance for practice and patient care outcomes</td>
<td>Monitoring coverage stability is important for policy development to increase retention of eligible children</td>
<td>How to better manage children with chronic health care needs (case management, ambulatory services, preventative care, meeting needs of low spenders not accessing care)</td>
<td>Can be used to routinely assess our nation’s child health care quality by means of standardized methods; could facilitate benchmarking data, identification of quality deficits at multiple different levels; list is not comprehensive</td>
<td>Many CHIP-eligible children remain uncovered, target aims at getting these children covered</td>
<td>Gaps in knowledge of health status, health and functioning of children, financial burden for families, mental health use, prescription drug use and ER use; how can this translate to provision of care for adults under the ACA as a newly insured group?</td>
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additional funding from the state as maintenance of effort in the event that CHIP legislation was not reauthorized and the enhanced federal matching rate was lost. The state Medicaid office expressed its willingness to work with APRNs to advocate for CHIP and other children’s health care policy priorities. The state budget office was not able to confirm or deny support of CHIP.

NAPNAP successfully advocated with the AAP and The Children’s Hospital Association and other children’s health care advocacy groups to produce ads for CHIP renewal. Continual assessment of information related to CHIP and re-examination of legislative priorities were essential in preventing the legislation’s expiration. The advocacy campaign was influenced by these two key factors and remained adaptive to any changes in the political landscape during the CHIP renewal period.

LESSONS LEARNED
In this model, the best practices that were incorporated within the model were interdisciplinary/professional collaboration, development of the Web-based toolbox, and the early initiation of contacts with state officials and legislators. Contact with state officials and legislators encouraged support of this campaign and influenced the campaign at key times within the process.
The policy brief was unique to one state and provided widespread dissemination to legislators and key stakeholders, including those running for office during the time of the campaign. The brief was made available as a template for use in other states as a part of the toolbox, in addition to information about how to find legislators and a template letter to use to contact legislators and key stakeholders.

Consensus building among professionals was key to the collaborative effort of several of the major professional organizations. Work with the legislative division of NAPNAP strengthened consensus by developing a process model for the campaign, including tools for carrying out the advocacy campaign. The model engaged nurses, legislators, key stakeholders, and professional organizations. The model was useful for consensus building at the state level and within one professional organization for issues that impact children’s health care and nursing practice.

However, as learned during the process, barriers existed in the campaign related to the extent of professional organization collaboration, the amount of information accessed from contact with each of the three state offices, and tracking and determining the effectiveness of the toolbox. Despite collaboration between several professional organizations for the campaign, it could have been further strengthened by an official consensus document such as a white paper supporting CHIP renewal. The governor’s office and state Medicaid office quickly vocalized support of the campaign and shared information about their plans to recommend that CHIP coverage be extended. The toolbox was used by members and was an effective advocacy tool. During this period, however, there was no mechanism to track how frequently it was used and how effective it was when contacting legislators and state officials.

Another lesson learned was that recommendations made by the campaign to improve CHIP coverage based on the literature went unfulfilled. The literature suggested that the following points might be helpful for legislators: increased access to mental health care, decreased emergency room utilization, increased access for children with low utilization of services, identification of ways to contain costs for children with complex health care needs, and increased access to prescription drug benefits (Dubay & Kenney, 2009; Fairbrother et al., 2011; Howell & Kenney, 2012; Kenney et al., 2009, 2011; Mangione-Smith et al., 2010). However, it was decided that for the campaign to be successful in a short period, it had to solely focus on getting CHIP reauthorization passed and was not attentive to the literature recommendations at this time. However, these issues generated from the literature review could be useful in the future when advocating for other pieces of legislation within the same state for child health advocacy. This process model is adaptable to other states when advocating for children’s health care legislation by following the key processes of building consensus, development and dissemination of tools for advocacy, and organization of a campaign that remains adaptive to change.

This legislative campaign sought to inform nurses and key children’s health care policy stakeholders of the significance of CHIP renewal and the need for continued advocacy for children’s health care legislation. The advocacy process described is an adaptable model for nurses to apprise legislators and other government policy makers about children’s health care policy issues. Developing an advocacy campaign and carrying it out in one state can inform other states on priorities for child health advocacy. The result was an organized advocacy process campaign that was engaging and easily carried out by members of NAPNAP. The model was well received by members, legislators, and key stakeholders. Many legislators and key stakeholders vocalized increased understanding of the importance of CHIP reauthorization after being contacted by members of the nursing professional organization.

This advocacy campaign provides a useful framework for a policy campaign. Nurses and children’s health care advocates can influence health care policy by following the steps in this model. A well-organized, effective advocacy campaign from the nursing community ensured that legislators and key stakeholders understood the need to renew CHIP funding as a national health care priority and thus supported the eventual passage of CHIP funding renewal in 2015.

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REFERENCES