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

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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

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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 affect 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 would 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.

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.

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. These factors made the April 2015 renewal of CHIP a top national advocacy priority for children's health care advocates, especially for members of the nursing profession.

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