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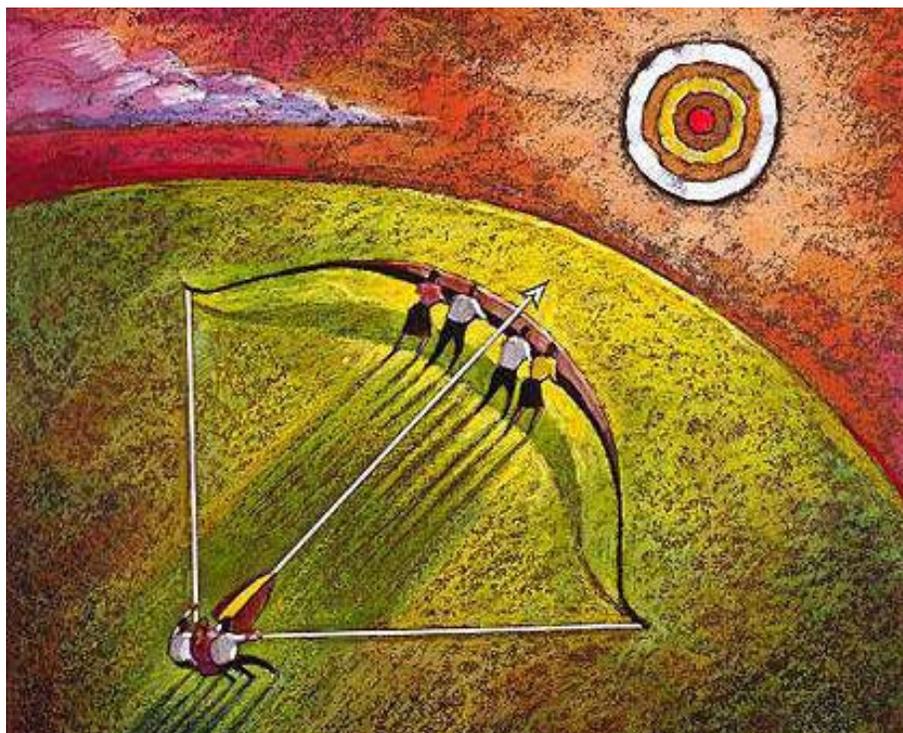
Counting in Connecticut: Arming Advocates to Protect Health

A foundation provides a Medicaid coalition with the hard numbers that help sway a statehouse.

At a very late hour on a very late night in summer 2003, legislators in Hartford's capital building did something that cash-strapped lawmakers under the gun to create next year's budget do more often than they would like. They approved a large omnibus budget that most of them did not have the chance to fully understand.

Hard times forced the Democratic-controlled legislature to spread the pain widely in the 2004-2005 budget (also called the fiscal year 2005 budget). Looking for savings everywhere possible, they imposed premiums and copays on Medicaid recipients. What most did not realize was that the savings would come by forcing more than 86,000 of the state's 3.5 million people to lose health coverage because the payments would be unaffordable. About 70 percent of those affected would be children. Moreover, the copays and other changes would result in 30 percent fewer children's visits to health care providers, and would put at risk the health of 40,000 children with special health care needs.

Many lawmakers did not fully appreciate the damage done in their



quest to balance the budget. "I didn't know I voted for this," some of them were said to have responded, when in fall and winter 2003 advocates and their lobbyists explained to them, with precise numbers, the effects the budget's Medicaid provisions would have on

constituents. By spring, both houses overwhelmingly voted to repeal the changes; the governor signed the repeal.

The win was especially sweet for the coalition that worked so hard to reverse the changes. When state coffers are tight, victories for nonprofit

advocate groups that lobby for poor and vulnerable populations are rare. In this case, the odds seemed to be against them. Advocates had been told from the start by general assembly leadership staff, “Yes, we think the budget is bad, too, but it’s done. Let’s move on.”

Critical to allowing a group known informally as the Medicaid defense coalition to undo much of the “bad” in the budget was a potent injection of smart, timely research provided by the Connecticut Health Foundation (CHF). This story shows how a strategy-minded, policy-interested foundation partnered with a group of seasoned, highly focused advocates and lobbyists to win the hearts, minds, and votes of state legislators to squash a grave threat to the health of the state’s poor.

Not Business As Usual

Connecticut is a small state with a tight and active network of nonprofit health and poverty organizations. Many of the advocate groups that care deeply about the Medicaid program have worked on and off together “practically forever,” in the words of one of their lobbyists. The same players often appear and reappear in various overlapping coalitions working on issues affecting low-income women, children, the elderly, and the disabled. The kinds of Medicaid changes proposed by the state’s lawmakers in summer 2003 would acutely affect all of these groups.

“This was not going to be business as usual,” explains Betty Gallo, a long-time state lobbyist with her own firm. Connecticut is pretty generous around Medicaid, she says, and the groups she represents had been very lucky. The new budget’s effect on Medicaid, however, was a wake-up call; the policy changes were frightening and unexpected.

Judith Blei, another Hartford-based lobbyist and a legislative monitor since 1985, recalls that the impetus to come together over the proposed Medicaid changes was a late summer

2003 meeting of the Connecticut Women’s Health Campaign, a coalition of organizations working for the health and well-being of the state’s women that is part of the Connecticut General Assembly’s Permanent Commission on the Status of Women. Running the meeting was Leslie Gabel-Brett, then executive director of the commission and the campaign’s cochair. According to Blei, the two women decided that the fresh blow to Medicaid warranted their summoning a larger group of people to focus on the issue.

That very summer, Baker says, the foundation’s board and staff had “come to a philosophical and organizational decision that we would integrate public policy into our work and the approaches we take.” So the timing, in her words, was “just right.”

So in September 2003 Gabel-Brett coordinated an ad hoc gathering of the people who had always worked together on Medicaid and SAGA (State-Administered General Assistance) matters. Ten to twelve of those sitting around the table were what several participants call “the usual suspects.” Also present was Pat Baker, president and CEO of the Connecticut Health Foundation. Baker was well aware of the new budget policies, having been briefed by Judith Blei, the foundation’s legislative monitor.

Baker, a longtime women’s health advocate and policy wonk, knew the group had to act swiftly. She offered the foundation’s resources to commission research estimating how many and which state constituents would feel the effects of the new Medicaid budget. Baker felt comfortable helping to move the coalition’s agenda forward. Its members were familiar faces as foundation grantees or former colleagues. The Connecticut Health Foundation—the product of HMO ConnectiCare’s conversion into a for-profit entity—was

only four years old at the time. But many of the groups whose health the foundation seeks to protect receive Medicaid. Thus, the funder’s goals—improving access to children’s mental health services, expanding access to and use of oral health services, and reducing racial and ethnic health disparities—could be threatened by a weakened Medicaid program. The foundation already had ventured into policy by issuing grants to advocacy organizations, and by producing a few educational reports. One of these,

published in 2001 in conjunction with the Washington, D.C.-based Center on Budget and Policy Priorities, analyzed the state’s Medicaid spending cap and made recommendations on how to change the parameters of the cap to protect the state’s vulnerable populations. Baker says that the foundation published these reports but did not have a strategy for them to get picked up by the media.

The intent and intensity of this new effort, however, would be ratcheted up. Baker knew that the kind of assistance the foundation was offering the Medicaid-concerned group—this time not just the research but a concentrated, strategic effort to make the research count—differed from previous foundation work. By coincidence, that very summer, she says, the foundation’s board and staff had “come to a philosophical and organizational decision that we would integrate public policy into our work and the approaches we take.” The foundation hadn’t figured out exactly how to do that, she says, but it had resolved the fundamental

question about whether to do it before the September 2003 Medicaid group meeting, so the timing, in her words, was “just right.”

Being Nimble, Adding Value

Advocating for poor people, says Betty Gallo, is really hard. Your base is powerless. You need powerful partners. She views the CHF as a potent partner for poor people. With the pressures of litigating and fundraising, most advocacy organizations rarely have the time or resources to produce their own research.

Coalition members say that it is often tough to capture lawmakers’ attention in budget debates because they lack the hard evidence to show just how bad the policy is. This time was different. The concrete data the foundation put in the coalition’s hands provided needed “new arrows in our arsenal,” says Betty Gallo. Anecdotal evidence, which can be easier to come by, isn’t enough, she says from experience.

Just as important as the data themselves was their source. Even if the advocates could have come up with hard numbers, they knew that legislators would likely consider their data biased. The foundation’s lack of a particular ax to grind made it a credible, neutral source of information. The foundation further legitimized the coalition’s cause by hiring Georgetown University Medicaid expert Joan Alker to team with in-state analyst Judith Solomon, then with Connecticut Voices for Children, to do the research. Coalition members believe that Alker’s federal perspective and knowledge of other states’ Medicaid programs strengthened their case.

Legislators “kind of believe us when the advocates say ‘this is bad and it is going to hurt people,’” says Leslie Gabel-Brett, “but they expect to hear that from us.” The message does not carry the same weight, she says, as research from a university that

signals “it is not just the advocates who are saying the sky is going to fall.” As one coalition member observes, Connecticut’s advocates and lawmakers know each other all too well. “Sometimes you really need to hear something coming from a fresh voice.”

Baker also understood the importance of the work being on a fast track. Leslie Gabel-Brett says that the foundation could have put out an RFP, but that would have taken too long. “If you are going to be part of the public policy discourse, you have to be nimble,” she says. The foundation listened carefully to coalition members to understand the kind of data needed. Then Alker and Solomon got to work.

Getting the Numbers and Running with Them

Alker and Solomon were familiar with a methodology for estimating Medicaid policy impacts on states that was developed in the late 1990s by Leighton Ku and Teresa Coughlin. Applying the same model to predict the impact of Medicaid premiums on Connecticut’s program recipients, they found dramatic effects that the foundation published in the first (November 2003) policy brief. One particular figure that was quoted repeatedly by advocates and the press until it became part of every conversation: More than 86,000 Connecticut individuals, mostly children, could lose coverage if the proposed Medicaid cost sharing was implemented.

This number and others that appeared in subsequent briefs between fall 2003 and April 2004, lent credence to advocates’ concern for the health of the state’s poor if the changes were carried out. But it wasn’t the numbers alone that were so persuasive. How they were presented made the difference between being widely cited and largely ignored.

Solomon credits the foundation for keeping her and Alker from “being wonky,” for making them stick to a few

simple points per four-page brief, and for designing the briefs to be attractive and easy to read. Indeed, Monette Goodrich, CHF’s vice president for communications and public affairs, had learned from previous experience working for members of Congress about the importance of data presentation. She made the decision to spread the data across five briefs, rather than cramming them all into one large report, and for good reason. She felt that the nuances of the dire effects resulting from the Medicaid budget would get lost if presented in one large report. “People have a hard time looking at the big picture,” she says. It is easier, especially for advocates and legislators, she says, to pick out something from a series of briefs that they are interested in. To this purpose, the briefs focused, respectively, on how the proposed Medicaid changes would affect children and parents, the low-income elderly and disabled, and the state’s economy.

Goodrich says the foundation learned a lesson from a large Medicaid study that it had previously commissioned Alker to coauthor. That report “was very well-written,” she says. “But you know what? We still have 3,000 copies.” The earlier report might have attracted less interest than the policy briefs simply because it dealt with future federal policy change, she speculates, while the adverse effects of the state’s fiscal year 2005 Medicaid budget were going to take place soon and close to home. More likely, Goodrich imagines, that earlier publication was simply too much for readers to digest. The foundation designed the policy briefs for readers to see the key statistics on the first page and then again on the last, so that even those who did not open the mailer could readily scan its salient points.

The briefs were also crafted for fast release. “What is important from the perspective of the funding community to take away from this project,” says

Joan Alker, “is that this was not research that sat on the shelf. It was not research that took a long time to produce.”

Alker says she spent two to three months on the project—a reasonable timeframe for seasoned researchers like her and Solomon.

With concrete numbers in hand that showed clearly and unequivocally the serious threat to low-income children, elderly, and the disabled that the Medicaid budget would have if implemented, the foundation, coalition advocates, and lobbyists got going. Early on, the CHF staff gave key legislators a heads up so that they didn’t first hear about these impacts from the press. “There was intentionality about everything in terms of how we released each brief,” recalls Judith Solomon. The

says, but CHF “has a stake in how it is done, not just that it is done.”

Changing Minds

“I voted for that but I had no idea,” was the response that many lawmakers had to the data, according to Baker. Legislative leaders such as Democratic Senator Toni Harp, cochair of the appropriations committee, already had an inkling of what the budget would mean for Medicaid recipients, because she also chaired the Medicaid Managed Care Council. But the briefs, she says, “certainly were helpful to others” who were not in a position to know. Solomon remembers hearing one legislator “say after our briefing how important it was to hear about the

other coalition activities. For instance, researcher Joan Alker traveled from Washington to Hartford to testify before the state legislature, to help brief a broad range of community groups, and to attend editorial board meetings at the *Hartford Courant* and other state newspapers. Months before the lawmakers were scheduled to reconvene, coalition lobbyist Betty Gallo collected signatures from legislators for a bill to repeal the budget’s Medicaid provisions. The aim, says Gabel-Brett, was to show overwhelming support for the issue as soon as the door opened in February—in this case, to prove that the coalition had the votes before the new session even began.

To complement the numbers, the Medicaid coalition found individuals and families who would be affected by the budget to testify at legislative hearings held after the new session began in early 2004. Senator Toni Harp, who would eventually cosponsor the bill to repeal the Medicaid budget, says that personal stories matter. Numbers can be questionable, she says. “If you have a number and a story, it resonates better.” And the coalition had both.

The fact that the majority of legislators signed on to a proposal to repeal the budget’s Medicaid provisions before the 2004 legislative session began was crucial, says Senator Harp. It helped the general assembly leadership “get that this needed to happen,” she says, and it helped then (Republican) Governor John Rowland understand that, too. The work done by the foundation, the advocates, and their lobby, she believes, fueled the momentum within the statehouse to fast-track the repeal as an emergency certified bill. Such bills are rarely used, she says. Of the 300 bills that get passed by both houses and sent to the governor each session, only a small handful garner emergency status that allows them to bypass the lengthy public hearing process.

In late April 2004, at the end of a session shortened because of the election

The work done by the foundation, the advocates, and their lobby fueled the momentum within the statehouse to fast-track the repeal as an emergency certified bill. Such bills are rarely used.

CHF rolled out the policy briefs almost once a month between November and April. The foundation sponsored a widely publicized, well-attended press conference at the legislative office building to release the first brief. Immediately after that event, the brief’s authors, a few of the advocates and lobbyists, and Pat Baker held a private briefing for legislators on the research findings. For the second brief, Solomon says the foundation relied on a write up in the *Hartford Courant* to highlight the data.

All of this careful planning underscores a basic ingredient to success—the foundation’s commitment to staying involved. Susan Yolen, of Planned Parenthood of Connecticut, credits the CHF for its follow through. “Most foundations would probably give out the money and say, God bless,” she

impact, because he never understood.”

Many of the rank and file legislators mistakenly thought that instituting Medicaid premiums and copayments would help in the budget balancing act by generating a new source of revenue. It wasn’t until they read the policy briefs and attended educational sessions with Medicaid defense coalition members that they understood that the savings would come from people dropping coverage. Then, explains Gabel-Brett, “They said, ‘Wait a minute. That is not a good policy. That is not what we wanted to vote for.’” And that, she adds, is what the research showed everyone so clearly and what “really helped us to change the debate and win.”

The messages of the policy briefs and briefings for lawmakers, which the foundation held throughout the 2004 session, were reinforced by a flurry of

year, the legislature voted overwhelmingly to repeal the Medicaid provisions of the budget. Governor Rowland signed the repeal into law on May 6.

Delving into Public Policy

The Medicaid defense coalition effort “was about making sure poor families didn’t lose health coverage. It was all about mission,” says Pat Baker. What the CHF brought to the table, she says, was solid research that informed the policy debate. Although the foundation was funding some coalition members for work on other matters, its financial support here was limited to funding the research and its dissemination. The foundation’s job, she says, was putting that research “in the right hands to create change.” The foundation could not have made the contribution it did without being comfortable working with the advocates and lobbyists who share the foundation’s goals. “We feel we can educate aggressively, and we can advocate for what’s good for the health of the state,” says Baker.

The CHF is committed to policy involvement as a means of furthering its mission and is highly strategic about its approach. At inception in 1999, says Baker, the board was clear that it wanted the foundation to be “an agent of change.” At the time, the CHF lacked a collective understanding or definition of public policy. In summer 2003—nearly coinciding with the state’s imposition of Medicaid premiums and copays—a board and staff ad hoc committee was formed to gain clarity and buy-in about the CHF’s definition of public policy and what was legal for the foundation to do. Baker says that the committee asked, “Where is the line that we as a private foundation can’t cross? What could put us at risk? Are there means we would choose to not employ in reaching our goals?” The group looked at the legal framework and its interpretations by the Council on Foundations and the

Alliance for Justice. It also examined the paths other foundations had taken.

The Internal Revenue Service code states that most foundations may not lobby without incurring a tax on lobbying expenditures. This includes direct lobbying—any communication with legislators or their staff members that refers to and takes a position on specific legislation—and grassroots lobbying, communication with the public that refers to and reflects a view on specific legislation and contains a call for action. Opportunities do exist, however, for foundations to engage in public policy through many types of nonlobbying advocacy. Foundations may, for instance, conduct and release



nonpartisan research, testify at legislative hearings in response to a written request, and educate legislators about broad issues. (For more information, see the Alliance for Justice’s *Investing in Change: A Funder’s Guide to Supporting Advocacy*, as well as its many fact sheets, www.afj.org; and GIH’s *Strategies for Shaping Public Policy*, www.gih.org/usr_doc/53198.pdf.)

What emerged from the CHF’s quest to define the parameters of its policy engagement, says Baker, “is that the line may be clear on no lobbying, yet how one educates is very open.” Underlying the discussion, she says, was whether the foundation was going to fund research to inform policy and leave it at that, or also actively disseminate the research to advocates, stakeholders, decisionmakers, and the

media. The CHF opted for the latter. “Not only did the ad hoc committee recommend that we use public policy as a means of accomplishing our mission,” says Baker, “but that strategy and means be tied to chances of successful outcomes” rather than to fear of risk about our activism. It also recommended forming a standing public policy committee within the board, which the foundation created in 2004.

That new committee then asked what form this public policy work should take: “Do we fund a policy institute? Do we fund others to do this work? Do we take on this work internally? How do you balance control of an agenda with reputation risk?” The CHF hired organizational consultants to help it determine a systematic approach to its policy work. The foundation ultimately took an incremental approach by assuming the work internally rather than contracting it out or creating a new body. “No one institution had the capacity to take on our full agenda,” says Baker. “Whether we created a new institute or farmed it, we had to do so knowing we could not control the agenda, although these alternatives might protect the foundation in terms of reputation risk.” The foundation hired a new communications staff member, freeing Monette Goodrich to spend more time on policy issues.

Goodrich and her colleagues now hew to a public policy agenda that is set yearly by the foundation’s public policy committee. That agenda is spelled out in a matrix, based on committee consensus, which defines the foundation’s goals for the year (nine for 2006) and specific activities to reach each. Importantly, the committee assigns to each goal a level of foundation involvement defined by the terms: leader, major supporter, active participant, or responder. (For guidelines the CHF uses to determine its policy involvement, see the *Inside Stories* link at www.gih.org). So, for instance, two 2006 goals that the funder decided

to be a “leader” on were helping to support Medicaid expansion and to add language interpretation services to the state’s list of covered Medicaid reimbursements. Being opportunity-sensitive, if the time is right for action and responsive to the environment, the foundation will move issues and goals from its yearly watch list to its public policy agenda. The foundation decides its priority issues based on information from board members, from its legislative monitor, and from many government and health organization listservs.

The importance that the CHF attaches to public policy can also be seen in how it integrates public policy with programs. The board’s program committee adds items to the policy watch list and provides comments and additions to the board’s public policy agenda. And although the public policy and program committees do not hold regularly scheduled joint meetings, they often propose ideas to each other. For instance, the public policy committee recommended to the program committee that it issue advocacy grants to increase awareness of health-related policy issues among community members and 2006 political candidates—a suggestion that was approved.

The issue now facing the public policy committee in considering the foundation’s next step, says Goodrich, is this: “Rather than just saying, ‘here’s

the research,’ if you really want to be at the forefront of changing a system, is the better action to take an official position and endorse a specific policy solution from our or others’ research?” That’s a big question, she says, “and we’re not really sure what the answer’s going to be.”

Reverberations, Replicability

When Medicaid premiums and copays now pop up as part of a solution to Connecticut’s budget challenges, says Betty Gallo, everyone says “That’s something we can’t do.” The harm such policies would impose on the state’s vulnerable, made crystal clear by the research that the foundation sponsored in 2003, remains in legislators’ minds. And success breeds momentum. In 2003 some Medicaid defense coalition members had been skeptical that they could muster the political power to change things. That doubt is gone.

Foundations like the CHF are uniquely situated to help coalitions, not only because of the resources they can provide but because of their neutrality. Indeed, the CHF views itself as a “connect-the-dots” agent, in the words of Baker. To help it play that role, the foundation attends the Medicaid defense coalition’s monthly meetings to keep abreast of how policies are affecting the state’s poor. The relationship between the CHF and

the coalition is somewhat symbiotic, observes Betty Gallo. The foundation is responsive to coalition members’ suggestions for up-and-coming topics to study, and tailors its research, says Gallo, to efforts that it knows advocates will rally around. For example, increasing Medicaid payment rates for dentists recently cropped up as a hot issue. The foundation has written two policy briefs, and was invited to participate in the oral health taskforce convened by the speaker of the house and led by the chair of the public health committee. When a public hearing on oral health was held in 2006, the foundation made sure that the relevant advocacy groups linked up with the funder’s oral health grantees so that the latter could tell their personal stories before the legislature.

Can foundations and coalitions in other states work together in a similar way with similarly positive results? Connecticut’s politically moderate landscape and the particular Medicaid changes that were originally built into the state’s fiscal year 2005 budget had some unique features that may not make the Medicaid defense coalition’s strategy and outcome entirely replicable elsewhere. This proposal, says researcher Joan Alker, lent itself to crisp analysis on its potential human impact. Demonstrating direct effects within a set timeframe is not always so easy. Moreover, she adds, Connecticut is a well-organized state with a sophisticated advocate community. Although she admits to not having seen “anything quite like it” elsewhere, she has written similar policy briefs for funders in other states (such as Florida) that were also very well received.

Foundations that want to be agents of change and wish, through policy engagement, to help create an environment that can better sustain the changes they seek through their grants, can learn from the Connecticut Health Foundation’s experience what can be accomplished.



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