Georgetown University Health Policy Institute
Center for Children and Families

Summary of The Children's Health Insurance Program Reauthorization Act of 2007

OVERVIEW

The House and the Senate have approved the Children's Health Insurance Program Reauthorization Act of 2007 (CHIPRA). If enacted into law, the Congressional Budget Office (CBO) projects that nearly four million children would gain coverage, reducing the number of uninsured children by close to one half. All eyes are now focused on President Bush who has said that he intends to veto this legislation. Key provisions of the CHIPRA legislation are summarized in this report.

The Consequence of A Veto: Millions More Uninsured Children

New Census Bureau data show that after years of steady decline, the percent of children without health insurance has grown for two consecutive years. Over the most recent two-year period, one million more children became uninsured. If children continue to lose coverage at the rate they lost coverage this past year, every day nearly 2,000 children will join the ranks of the uninsured.

This recent upturn reverses a nearly decade-long trend during which uninsured rates for children, particularly for low-income children, dropped sharply as a result of the State Children's Health Insurance Program (SCHIP) and Medicaid. Many states are now poised to make further progress, but their ability to do so will depend in large part on the strength of SCHIP reauthorization legislation. Without adequate and predictable SCHIP funding and new tools to encourage and support coverage efforts, the number of uninsured children is certain to continue to rise.

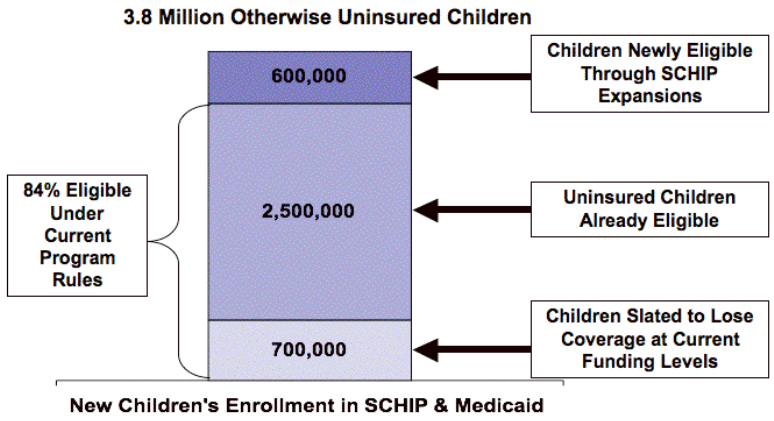
CHIPRA

After several months of debate, the Senate and the House passed separate SCHIP bills in July of 2007. In an attempt to secure broad bipartisan support, the agreed-upon House-Senate compromise bill, known as CHIPRA, primarily adopts the Senate's approach. It would offer states an additional $35 billion in federal funding over the next five years, considerably less than the $50 billion in the House bill. In addition, the bill does not include many provisions designed to expand coverage that were in the House bill, including an option to allow states to cover low-income children and pregnant women who are legal immigrants and who are currently barred from coverage until they have been in the United States for five years.

CHIPRA would nonetheless result in substantial gains for millions of children. The new funding levels and funding formula would put the program and children's coverage on more secure financial footing. It would avoid future shortfalls and give states the resources to cover more uninsured children. Overall, with this funding, states are expected to cover close to 4 million children who otherwise would have been uninsured. President Bush has proposed $4.8 billion in new SCHIP funding over five years, a level that the CBO projects would result in no new coverage gains but rather in the loss of SCHIP coverage for over one million children.

Perhaps most notable, CBO estimates that most of the children (84 percent) who would gain coverage under CHIPRA would be low-income children—children who already are eligible for SCHIP or Medicaid under existing guidelines (Figure 1). Research shows that nearly seven out of ten of all uninsured children are already eligible for SCHIP and Medicaid but are not enrolled. The bill targets the newly available resources to reach this group of low-income children.

FIGURE 1: CHIPRA Would Cover Almost 4 Million Otherwise Uninsured Children



Source: CBO, September 24, 2007. Note: Average monthly enrollment for fiscal year 2012.

Both the House and the Senate passed CHIPRA with significant bipartisan support. Similarly, lawmakers across the country are investing in efforts to make health coverage available to more children in their states by building on the foundation of SCHIP and Medicaid. With children's coverage a clear national priority, the final approval of the SCHIP reauthorization bill offers the opportunity for the federal government to renew and strengthen its commitment to reaching the finish line for America's children.

CHIPRA Summary

This summary provides a brief description of the major child and family health provisions in CHIPRA, but it is not intended to be exhaustive. The full text of CHIPRA is available at http://www.rules.house.gov/110/text/senate_hr976.pdf

Financing

- **Offsets**. The bill is funded through a 61-cent increase in the federal tobacco tax.

SCHIP Funding For States

- **Capped Funding Levels**. CHIPRA maintains capped funding, but increases the national SCHIP allotment levels from $25 billion over the next five years to $61.4 billion, in accordance with the schedule outlined in Table 1 (Page 3). While the level of funding represents a significant increase, in the event that there is not enough SCHIP funding to give each state its full allotment, the bill calls for proportionately reducing the size of each state's allotment to fit within the national cap.

- **Fiscal Year 2008 Allotments.** In an effort to better target SCHIP funds and use more reliable data sources, CHIPRA establishes a new formula for distributing SCHIP funds among the states. Instead of relying on Census Bureau survey data, the proposed formula is based on a state's actual use of and need for SCHIP funds. In general, a state's allotment level for fiscal year 2008 is set at 110 percent of: 1) a state's fiscal year 2007 SCHIP spending (adjusted for inflation and population growth); 2) its fiscal year 2007 allotment (adjusted for inflation and population growth); or 3) its August 2007 projected need for funds in fiscal year 2008, whichever is greatest.[1] By including 10 percent more than a state likely needs to simply sustain its existing program, the formula provides every state with new funds that can be used to reach a greater share of already-eligible children, improve benefits, or expand coverage. (See Table 2, pages 9-10, for state-specific allotments.)

TABLE 1: CHIPRA'S SCHIP Allotment Levels (In Billions)

Year	*Baseline*	*CHIPRA*	*Dollar Increase*
2008	$5.04	$9.125	$4.125
2009	$5.04	$10.675	$5.675
2010	$5.04	$11.85	$6.85
2011	$5.04	$13.75	$8.75
2012	$5.04	$16.00[2]	$11.00
Total (2008-2012)	$25.00	$61.40	$36.40

Source: CHIPRA, September 2007.

- **Allotments in Future Years**. In future years, allotments are adjusted annually to reflect inflation and population growth. In addition, if states receive additional federal funding from the "child enrollment contingency fund" (see below), these funds are built into their future allotments. To ensure that limited SCHIP funds are preserved for states that will use them, the bill periodically "rebases" states' allotments (and shortens the period of availability, see below). Beginning in 2010 and every two years after that, a state's actual use of SCHIP funds will serve as the basis for its new allotment. For example, when allotments are rebased in 2010, a state that used only $10 million of a $20 million allotment in the prior year will receive an allotment of $10 million (adjusted for inflation and population growth). In addition, the bill allows states with approved plans to expand eligibility or benefits to receive an increase in their allotments, but states can request the adjustments only for fiscal years 2009 and 2011.

- **Child Enrollment Contingency Fund.** To promote more stable funding and reduce the need for Congress to adopt new legislation to fill SCHIP funding shortfalls in the future, CHIPRA establishes a capped child enrollment contingency fund. The fund provides states with additional funds when they face an SCHIP funding shortfall[3] and their enrollment of children

[1] A number of provisions allow states that recently scaled back their SCHIP programs due to federal SCHIP funding shortfalls—and, as a result, their projected need for funds—to receive allotments based on their original projections of what was needed to operate their programs prior to cutbacks.
[2] In 2012, the bill drops the SCHIP allotment level to $3.5 billion (compared to $13.75 billion in 2011), but also provides for a supplemental one-time appropriation of $12.5 billion to bring the total amount of funding available to $16 billion. This was done to lower the long-term cost of the bill and allow it to meet the 10-year budget target. By setting the standard allotment for 2012 at $3.5 billion (instead of the full $16 billion), the Congressional Budget Office must assume under standard budgeting rules that SCHIP funding will remain at $3.5 billion for 2013 and beyond.
[3] For purposes of the child enrollment contingency fund, a state is considered to be in shortfall if it does not have enough federal matching funds—excluding redistributed funds—to finance its SCHIP program.

exceeds a target level. Specifically, to address the shortfall a state will receive a per capita[4] increase in its available SCHIP funding for each child it enrolls above the target level.[5] As noted, a state's use of child enrollment contingency funds is reflected in its future allotments.

- **Redistribution of Unused SCHIP Funds.** To help ensure that SCHIP funds are sent to the states that need them for children's coverage, the bill reduces the period during which a state can use an annual SCHIP-allotment from three to two years, beginning with the fiscal year 2008 allotments. Unlike in the past when it largely was left to the discretion of the Secretary of Health and Human Services (HHS) to decide how to redistribute unused SCHIP funds, the bill outlines a system for redistributing funds to states facing an SCHIP funding shortfall. After this, any remaining unspent funds are used to finance performance bonuses (discussed below).

Reaching Eligible But Unenrolled Children

- **Performance Bonuses**. CHIPRA includes new performance bonuses to encourage states to enroll more of the uninsured children who are already eligible for SCHIP and Medicaid. States that streamline their enrollment procedures (see below) and increase enrollment of these children above a target level[6] receive a federal payment for each extra child enrolled to help defray the added cost of successful efforts. The size of the payment can vary from 10 to 60 percent of the average cost to a state of enrolling a child and is determined by: 1) whether the extra payment is for enrollment of a Medicaid or an SCHIP child; 2) the average cost to the state of covering such a child; and 3) the extent to which a state's enrollment exceeds target levels. In general, a state will receive greater federal financial assistance the more already-eligible children that it reaches and the more those children are Medicaid-eligible (i.e., particularly low-income).

- **Simplifying Enrollment Procedures**. To qualify for the performance bonus payments described above, a state must have adopted at least four of the following "best practice" methods for simplifying enrollment and renewal procedures in SCHIP and Medicaid for children:

  1) Adopting continuous eligibility in SCHIP and Medicaid;
  2) Eliminating the asset test for children, or, if an asset test is applied, allowing self-declaration unless otherwise warranted;
  3) Eliminating in-person interview requirements at application and renewal;
  4) Using joint applications and comparable application procedures for SCHIP and Medicaid;
  5) Allowing for streamlined or "administrative" renewal of coverage in SCHIP and Medicaid;
  6) Exercising the option to use presumptive eligibility determinations; and
  7) Exercising the new option to use Express Lane (described below) in SCHIP and Medicaid.

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[4] The size of a state's per capita adjustment is set as average per child spending on SCHIP in fiscal year 2007, adjusted for inflation and changes in a state's SCHIP matching rate.

[5] The target enrollment level for the child enrollment contingency fund is based on a state's average monthly enrollment of children in SCHIP in fiscal year 2007, adjusted by state-specific growth in the child population plus one percentage point.

[6] The method for determining target enrollment levels for the performance bonuses is the same as for the child enrollment contingency fund, but the performance bonuses rely on separate targets for SCHIP and Medicaid.

- **Outreach Funding**. The bill allocates $100 million for fiscal years 2008 through 2012 for outreach and enrollment grants. Ten percent of the funding will be dedicated to a national enrollment campaign and 10 percent to outreach grants targeting Native American children. HHS will distribute the remaining funds to state and local governments and other organizations—such as safety net providers, community-based organizations, or schools—to conduct outreach campaigns. The campaigns are geared to rural areas and racial and ethnic populations. The grants cannot supplant current state outreach and enrollment funding. CHIPRA also provides an enhanced matching rate in SCHIP and Medicaid for translation and interpretation services for families for whom English is not the primary language.

- **Express Lane Option.** In order to streamline enrollment and renewal procedures the bill gives states the option to use relevant findings from school lunch programs, WIC, and other public agencies when determining children's eligibility for SCHIP and Medicaid. For example, if a state has information about a child's income from a local school lunch program, it can use it without requiring the family to resubmit or re-verify the information it already provided to the school lunch program. To assist states with implementation, the bill outlines enrollment procedures states can take to meet "screen and enroll" rules under Express Lane, and it increases state access to various data sources. The bill also lays out evaluation and error rate procedures states must meet when implementing Express Lane and does not allow information from an Express Lane agency to be used to verify someone's citizenship status or nationality.

- **Citizenship Documentation Requirement**. CHIPRA extends the Medicaid citizenship documentation requirement to SCHIP, while giving states a new way to comply with it. The new option, effective October 1, 2008, is designed to ease the burden imposed on eligible children and pregnant women, parents and state agencies of a federal rule that requires children and others applying for Medicaid to provide certain documents to establish their citizenship. CHIPRA allows states to meet the citizenship documentation requirement by submitting the names and Social Security Numbers (SSNs) of individuals enrolled in Medicaid and SCHIP to the Social Security Administration (SSA). If SSA finds that the name and SSN do not match, the state must make a reasonable effort to address the discrepancy while providing coverage to the otherwise eligible individual. If the issue is not resolved, individuals have a certain amount of time to establish citizenship or fix the problem with their SSN after which they are dis-enrolled. HHS may impose penalties on states if more than three percent of the names and SSNs that they submit to the SSA are deemed "invalid".[7]

Eligibility Rules for Children

- **Income Rules**. Since SCHIP was first enacted, federal law has accorded states the flexibility to set the income levels for the children they will cover subject to available federal and state resources. CHIPRA imposes new constraints on that flexibility. If a state decides in the future to cover children with family incomes above 300 percent of the federal poverty level, the state may only receive the lower Medicaid matching rate.[8] In addition, by 2010 any state that covers children in that income range will have to show that they are implementing "best practices" designed to limit crowd out and meeting ambitious standards for coverage rates of low-income children. In the interim, the bill directs the General Accounting Office and the Institute of

[7] In addition, CHIPRA clarifies that newborn babies who currently automatically receive Medicaid coverage based on their mother's eligibility would no longer have to document their citizenship after that year of eligibility ends.

[8] Two states (New Jersey and New York) already cover or have enacted laws to cover children above 300 percent of the federal poverty level. Under CHIPRA, these states may receive the enhanced SCHIP matching rate for this coverage but are subject to the other restrictions.

Medicine to develop best practice guidelines and measures of crowd out and coverage rates. These new rules would replace the August 17, 2007 directive issued by the Centers for Medicare and Medicaid Services.[9]

- **Legal Immigrants**. CHIPRA does not include an option for states to cover children and pregnant women who are legal immigrants and who are currently barred from coverage until they have been in the United States for five years.

- **Undocumented Immigrants**. The bill includes language that restates current law that no federal funding will be allocated to immigrants who are not in the country legally.

- **Children of State Employees**. CHIPRA does not include an option for states to cover the children of state employees. Currently, such children are barred from coverage unless the state makes little or no contribution to the cost of dependent coverage for state employees.

Coverage Of Adults

- **Pregnant Women.** The bill gives states the option to cover pregnant women with SCHIP funds by submitting a state plan amendment; no waiver will be required. To use the option, states must cover pregnant women up to at least 185 percent of the federal poverty level in Medicaid (or higher if the state already covers pregnant women in Medicaid at a higher income level). The bill retains existing authority for states to cover pregnant women through the "unborn child" option.

- **Parents**. CHIPRA prohibits HHS from approving any new waivers to cover parents with SCHIP funds. Coverage of parents in the 11 states that already have such waivers can continue without change for a two-year transition period (during federal fiscal years 2008 and 2009; expiring waivers can be renewed through 2009). In 2010 and beyond, the bill moves the funding for these parent waivers out of SCHIP and establishes separate capped allotments to finance the federal share of the cost of coverage. If a state meets specified benchmarks in covering children, it can receive the SCHIP enhanced matching rate for parent coverage in fiscal year 2010 and a modified enhanced matching rate in fiscal year 2011 and future years. (The modified rate is mid-way between the SCHIP matching rate and the Medicaid matching rate.) If the benchmarks, which become more stringent in 2010 and 2011, are not met, states are limited to receiving the regular Medicaid matching rate.

- **Childless Adults.** CHIPRA restates the existing ban on new waivers that allow SCHIP funds to be used for childless adults, and it ends federal financial participation out of SCHIP for the four existing childless adult waivers after a one-year transition (fiscal year 2008; expiring waivers may be renewed through the end of fiscal year 2008). In fiscal year 2009, the four states can receive matching payments at the Medicaid rate, but only for specific individuals who were enrolled in the waiver at some point in the prior year. Federal funding is provided outside of SCHIP through a temporary, separate allotment. In 2010 and beyond, the bill provides a process that states may use to request a Medicaid waiver to cover these "grandfathered" childless adults; HHS is permitted—but not required—to approve the waivers.

[9] The August 17, 2007 directive imposes new conditions on states that offer SCHIP coverage to children with family incomes above 250 percent of the federal poverty level. Analysis shows that 23 states would be impacted by the restrictions, resulting in a loss of coverage for thousands of children. See http://ccf.georgetown.edu/pdfs/cmsdirective.pdf.

Premium Assistance

- **Coordination between Public and Private Coverage.** The bill allows states to operate premium assistance programs for families through Medicaid and SCHIP that are cost-effective and ensure that children retain access to the full Medicaid and SCHIP benefits package. CHIPRA also includes changes to other federal laws designed to improve coordination between public and private coverage, including making the gaining or loss of eligibility for Medicaid or SCHIP a "qualifying event" for the purposes of eligibility for employer-sponsored coverage; requiring employers to share information about their benefits package with states so that states can assess cost-effectiveness and the need for "wraparound" services; and requiring employers to notify families of their potential eligibility for premium assistance. The General Accountability Office (GAO) will also conduct a study on premium assistance.

- **A New "Buy-in" Option.** CHIPRA gives states the option to establish a purchasing pool for employers with fewer than 250 employees and at least one employee who is SCHIP-eligible or has an SCHIP-eligible child. The purchasing pool will offer at least two SCHIP benchmark or benchmark-equivalent products. States can provide SCHIP-funded subsidies for premium costs for those eligible for SCHIP, but a state is not permitted to use SCHIP funds to pay for the administrative costs of establishing such a pool.

Benefits

- **Dental Coverage.** CHIPRA requires SCHIP plans, starting October 1, 2008, to include coverage of dental services. A state can meet this requirement by providing coverage that is equivalent to benchmark dental benefit standards, as outlined in the bill. The bill also requires HHS to implement strategies for increasing access to dental services, including the creation of online provider lists and education materials.

- **Mental Health Parity.** The bill does not require mental health services in SCHIP. However, it requires that if a state provides mental health or substance abuse services through SCHIP that the financial requirements and treatment limitations for those benefits not be more restrictive than those for medical and surgical benefits.

- **EPSDT Services in Medicaid**. CHIPRA makes a technical fix to the Deficit Reduction Act of 2005 to clarify that Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services must be provided as part of benchmark benefit packages for children under Medicaid.

Child Health Quality

- **Funding for Child Health Quality**. CHIPRA provides $225 million over the next five years for child health quality improvements in accordance with the measures outlined below.

- **Quality Initiative for Children**. Under a new quality initiative for children created by the bill, HHS will develop, test, and disseminate a set of child health measures that address the quality and stability of children's coverage.

- **State Reporting.** The bill requires states to submit a child health quality report to HHS each year, as well as to provide information in their SCHIP annual reports on eligibility rules, effectiveness in simplifying application and renewal procedures, and children's access to care under SCHIP. States will receive enhanced administrative funding in Medicaid for collecting and reporting on child health measures. The bill also provides $5 million to improve "MSIS,"

the data system used by states to report on enrollment and eligibility in SCHIP and Medicaid.

- **Demonstration Grants.** CHIPRA establish a demonstration project. HHS will provide grants to up to 10 states and child health providers to use and test child health quality measures and to promote the use of health information technology for children. The bill also includes $25 million in demonstration funding to combat obesity.

- **Studies.** Under CHIPRA, the Institute of Medicine will conduct a study on pediatric health and health quality measures. The GAO will also issue a report on children's access to care under SCHIP and Medicaid and recommendations for improving such access.

- **Model Electronic Health Record**. The bill requires HHS to establish a program to encourage the development of a model electronic health record format for children in Medicaid and SCHIP.

- **Managed Care Standards Applied to SCHIP**. The bill applies Medicaid managed care standards to SCHIP.

Other Provisions

- **Treatment of States with Significant Medicaid Expansions Pre-SCHIP.** The states that expanded Medicaid coverage for children prior to the enactment of SCHIP are given more flexibility under the bill to use SCHIP funds for these Medicaid expansions. It allows these states to use their SCHIP allotments[10], beginning in fiscal year 2008, to draw down an enhanced matching rate for children in Medicaid with family incomes above 133 percent of the federal poverty level.

- **Moratorium on Rehabilitation and School-Based Service Restrictions**. CHIPRA prohibits HHS from taking any action, until May 28, 2008, that would restrict Medicaid coverage or payments for rehabilitation or school-based administration, transportation or medical services. This measure is in response to HHS's recent efforts to restrict how states use and pay for Medicaid rehabilitation services and how schools receive reimbursements through Medicaid administrative funds for such things as transportation and outreach and enrollment activities.

- **Miscellaneous**. The bill also:
  1) Provides $20 million to the Census Bureau to improve the state-specific estimates of uninsured children available under the Current Population Survey and to explore using the American Community Survey for such estimates;
  2) Requires a new federal evaluation of SCHIP in 2010;
  3) Makes changes to the "PERM" regulations (i.e., the regulations which require states to report on errors in claim payments and eligibility determinations);
  4) Grants families a 30-day premium payment grace period under SCHIP before termination of a child's coverage;
  5) Applies Medicaid's payment system for Federal Qualified Health Centers and Rural Health Clinics to SCHIP; and
  6) Fixes a technical problem with financing for Medicaid's existing presumptive eligibility option.

[10] In light of this provision, qualifying states may submit new projections of their expected use of SCHIP funds for purposes of establishing the size of their fiscal year 2008 allotments.

TABLE 2: CHIPRA's Projected Fiscal Year (FY) 2008 Allotments and Other Available Funds

(In Millions)

STATE	Projected FY2008 allotment under CHIPRA	Funds available from FY2006 and FY2007 allotments*	Total available federal SCHIP funds in FY2008 under CHIPRA
Alabama	$123.8	$44.8	**$168.6**
Alaska	$35.6		**$35.6**
Arizona	$153.7	$35.5	**$189.2**
Arkansas	$128.9	$53.0	**$181.9**
California	$1,396.2	$94.6	**$1,490.8**
Colorado	$84.9	$102.4	**$187.3**
Connecticut	$47.0	$74.4	**$121.4**
Delaware	$13.1	$17.3	**$30.4**
DC	$13.8	$18.0	**$31.8**
Florida	$352.9	$448.6	**$801.5**
Georgia	$407.5		**$407.5**
Hawaii	$22.3	$13.9	**$36.2**
Idaho	$34.2	$36.8	**$71.0**
Illinois	$682.0		**$682.0**
Indiana	$110.3	$118.4	**$228.7**
Iowa	$76.1		**$76.1**
Kansas	$56.6	$18.4	**$75.0**
Kentucky	$92.9	$65.3	**$158.2**
Louisiana	$144.1	$43.0	**$187.1**
Maine	$38.6		**$38.6**
Maryland	$178.8		**$178.8**
Massachusetts	$302.6		**$302.9**
Michigan	$211.2	$36.1	**$247.3**
Minnesota	$99.3		**$99.3**
Mississippi	$142.2		**$142.2**
Missouri	$138.9	$4.4	**$147.8**
Montana	$26.7	$14.0	**$40.7**
Nebraska	$39.8		**$39.8**
Nevada	$62.8	$89.6	**$152.4**
New Hampshire	$14.7	$14.9	**$29.6**
New Jersey	$367.4		**$367.4**
New Mexico	$116.5	$78.2	**$194.7**
New York	$453.3	$437.3	**$890.6**
North Carolina	$316.3	$9.0	**$333.9**
North Dakota	$14.8	$0.7	**$15.5**
Ohio	$251.7	$59.0	**$310.7**
Oklahoma	$136.8	$32.0	**$168.8**
Oregon	$115.7	$61.0	**$176.7**
Pennsylvania	$253.1	$154.4	**$407.5**
Rhode Island	$89.5		**$89.5**
South Carolina	$133.0	$117.2	**$250.2**

STATE	Projected FY2008 allotment under CHIPRA	Funds available from FY2006 and FY2007 allotments*	Total available federal SCHIP funds in FY2008
South Dakota	$15.3	$2.8	**$18.1**
Tennessee	$115.4	$177.9	**$293.3**
Texas	$880.3	$1,012.7	**$1,893.0**
Utah	$61.7	$34.8	**$96.5**
Vermont	$6.8	$9.8	**$16.6**
Virginia	$137.1	$65.9	**$203.0**
Washington	$94.2	$144.6	**$238.8**
West Virginia	$45.4	$23.3	**$68.7**
Wisconsin	$123.3		**$123.3**
Wyoming	$10.0	$9.8	**$19.8**
State Total	**$8,969.1**	**$3,773.8**	**$12,742.9**

*Reflects a state's unspent allotments from fiscal years 2006 and 2007 that are available for use in fiscal year 2008.
Source: Congressional Research Service and Centers for Medicaid and Medicaid Services analyses, September 2007.

Acknowledgements

This analysis was funded by the Robert Wood Johnson Foundation. It was developed by the Center for Children and Families (CCF). CCF is an independent, nonpartisan research and policy center based at Georgetown University's Health Policy Institute whose mission is to expand and improve health coverage for America's children and families.

The report was written by Cindy Mann, Joan Alker, Jocelyn Guyer and Dawn Horner of CCF. The authors thank the Robert Wood Johnson Foundation and the Center on Budget and Policy Priorities for their input on the report.

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