

**Children's Health Insurance
Program Reauthorization Act
(CHIPRA) 10-State Evaluation,
Telephone Interviews with
State CHIP Program
Administrators**

**Supporting Statement Part A:
Justification for the Study**

August 6, 2012

CONTENTS

BACKGROUND.....	1
A. Justification.....	2
1. Need and Legal Basis.....	2
2. Information Users.....	4
3. Improved Information Technology.....	5
4. Duplication of Similar Information.....	5
5. Small Businesses.....	6
6. Less Frequent Collection.....	6
7. Special Circumstances.....	6
8. Federal Register Notice/Outside Consultation.....	6
9. Payment/Gift to Respondents.....	7
10. Confidentiality.....	7
12. Burden Estimate (Total Hours & Wages).....	7
13. Capital Costs (Maintenance of Capital Costs).....	8
14. Cost to Federal Government.....	8
15. Program or Burden Changes.....	8
16. Publication and Tabulation Dates.....	8
17. Expiration Date.....	10
18. Certification Statement.....	10
REFERENCES.....	11

ATTACHMENT A: CHIPRA AUTHORIZING LEGISLATION

ATTACHMENT B1: DISCUSSION GUIDE, TELEPHONE INTERVIEWS WITH STATE CHIP PROGRAM ADMINISTRATORS

ATTACHMENT B2: FACT SHEET TEMPLATE

ATTACHMENT C: 60—DAY FEDERAL REGISTER NOTICE

ATTACHMENT D1: ADVANCE LETTER TO STATE OFFICIALS

ATTACHMENT D2: CONSENT FORM FOR STATE OFFICIALS

TABLES

1	Estimated Annualized Burden Hours.....	8
2	Estimated Annualized Cost to Respondents for the Hours Burden.....	8

BACKGROUND

The Children's Health Insurance Program Reauthorization Act (CHIPRA) 10-State Evaluation will provide the federal government with new and detailed insights into how the Children's Health Insurance Program (CHIP) has evolved since its early years, what impacts on children's coverage and access to care have occurred, and what new issues have arisen as a result of policy changes related to CHIPRA and the Patient Protection and Affordable Care Act (Affordable Care Act) of 2010 (PL 111-148). The evaluation will address numerous key questions regarding the structure and impact of CHIP and Medicaid programs for children, including (1) to what extent CHIP has reduced uninsurance among children, and how this has been impacted by expansions to the program to cover more children with family incomes above 200 percent of the federal poverty level; (2) how enrollment and disenrollment trends have changed over time in CHIP, and what economic and policy factors appear to be driving those trends (such as reductions in access to employer coverage as a result of the economic downturn); and (3) what outreach, enrollment, and retention policies are most successful at increasing enrollment and retention in Medicaid and CHIP, particularly for children of racial and ethnic minorities and children with special health care needs. To answer these and other questions, the Assistant Secretary for Planning and Evaluation (ASPE) will draw on three new primary data collection efforts, including a survey of selected CHIP enrollees and disenrollees in 10 States (and Medicaid enrollees and disenrollees in 3 of these states), qualitative case studies in the 10 States, and telephone interviews with State CHIP program administrators in all 50 States and the District of Columbia.

- Clearance for the survey of enrollees and disenrollees and the case studies (reference number 201110-0990-006) was obtained on December 12, 2011 and assigned the OMB control number of 0990-0384.
- At this time ASPE is seeking clearance for the telephone interviews with State program administrators in all 50 States and the District of Columbia. This collection will take place only once.

Telephone Interviews with State CHIP Program Administrators.

To supplement an intensive assessment of program experiences in 10 case study States, ASPE will conduct telephone interviews with CHIP program administrators in all 50 States and the District of Columbia. These roughly one-hour interviews, which will be conducted by telephone, will complement other aspects of the qualitative analysis by providing a larger context within which to interpret findings from the case studies and the survey of enrollees and disenrollees. It will focus largely on understanding changes in CHIP since the first evaluation of the program ended in 2005, preparations for implementing the Affordable Care Act, and State views on the future of CHIP.

CHIP OMB Supporting Statement Part A, Telephone Interviews with State CHIP Program Administrators

Going beyond facts and basic descriptive information, it will gather insights about the rationale behind State decisions and about issues requiring attention in the future. To some extent, the interviews will also provide context for the case studies and shed light on how those findings might be generalized to the nation as a whole.

The research questions that will be addressed by the interviews with State CHIP program administrators include:

- How do key design features of State CHIP programs vary across States? What design changes have States made, and why?
- What role has CHIPRA played in influencing State CHIP programs? What CHIPRA provisions have States found to be most significant? What are the more important accomplishments and challenges stemming from the legislation.
- How has the economic downturn affected States? What is the current State budget picture?
- How has the Affordable Care Act affected State programs, and what future changes are expected?
- In what ways are States preparing for implementation of national health care reform?
- How do CHIP plans, providers, benefit packages and delivery system features compare with Medicaid and private coverage, especially coverage available through State health insurance exchanges? How is this changing with implementation of the Affordable Care Act?
- How adequate are provider networks in meeting the needs of enrollees?
- What concerns do States have about continuity of care for children transitioning between CHIP, Medicaid and Health Insurance Exchange plans? How are States planning to promote continuity of care and coordination across these programs? What policies are already in place? What improvements could be made?
- What lessons from CHIP are most applicable to health reform?
- What assistance do States need in preparing for implementation of the Affordable Care Act?

A. Justification

1. Need and Legal Basis

CHIP was enacted in 1997 to help close coverage gaps for low-income children whose families could not afford private coverage for them but had incomes too high to qualify for Medicaid. Since that time, CHIP has grown to cover more than 5 million children—the largest expansion of public health insurance coverage for children since Medicaid.

CHIP was reauthorized for an additional four and a half years through the Children's Health Insurance Program Reauthorization Act (CHIPRA) (PL 111-3). CHIPRA provided States with new tools to address shortfalls both in enrollment and in access to and quality of care. A number of provisions were

designed to expand eligibility for public coverage among children and increase takeup of public coverage among uninsured children already eligible for Medicaid and CHIP (Georgetown Center for Children and Families 2009).¹ CHIPRA authorized new outreach and enrollment grants, as well as bonus payments to States that both adopted five of eight enrollment/retention strategies and exceeded target enrollment numbers. States also received new options to use Express Lane Eligibility strategies to facilitate eligibility determination, enrollment, and retention, and for meeting citizen documentation requirements. CHIPRA allowed States to use federal dollars to cover legal immigrant children who had been in the United States less than five years (previously, coverage for such children had to be financed exclusively with State funds), provided higher federal matching rates for translation and interpreter services and additional federal allotments to States to cover the costs of expanding eligibility and enrolling more eligible children. Other provisions were designed to improve access to and quality of care for the children served by Medicaid and CHIP (HHS 2010).

The CHIP program today. Since the enactment of CHIPRA in early 2009, a number of States have introduced policy changes to their Medicaid and CHIP programs: 15 have expanded eligibility to higher-income children; 17 have sought approval to introduce improvements in their enrollment and retention processes; as of April 2011, 7 States have received approval to take advantage of the new Express Lane option for Medicaid (Alabama, Georgia, Iowa, Louisiana, Maryland, New Jersey, and Oregon), and four States (Georgia, Iowa, New Jersey and Oregon) also received approval to do this for CHIP; and 19 States have begun using federal funds to cover legal immigrant children and/or pregnant women who had been in the country less than five years (HHS 2010; Families USA 2010). An initial \$40 million in outreach grants was awarded to 42 States and the District of Columbia, and an additional \$10 million was awarded for targeting Native American children.

CHIP in the future. CHIP's evolution is occurring within a rapidly changing health care environment. The Affordable Care Act introduces comprehensive health reforms, including an expansion of Medicaid to adults and children up to 133 percent of the FPL; a maintenance of effort (MOE) requirement through 2019 on State Medicaid and CHIP coverage for children; new subsidies for coverage for families with incomes up to 400 percent of the FPL; the creation of State health insurance exchanges and reforms to health insurance markets; the development of streamlined enrollment systems; and the introduction of coverage mandates for both individuals

¹ These provisions include (1) adopting 12-month continuous eligibility for all children, (2) eliminating the asset test for children, (3) eliminating in-person interview requirements at application and renewal, (4) using joint applications and supplemental forms and the same application and renewal verification process for the two programs, (5) allowing for administrative or paperless verification at renewal through the use of prepopulated forms or ex parte determinations, (6) exercising the option to use presumptive eligibility when evaluating children's eligibility for coverage, (7) exercising the new option in the law to use Express Lane Eligibility procedures; and (8) exercising the new options in the law regarding premium assistance.

(including children) and employers. The Affordable Care Act also provides two additional years of federal funding for CHIP (extending it through 2015) and increases federal CHIP matching rates by as much as 23 percentage points in 2015 and beyond. Starting in January 2014, more parents below 133 percent of the FPL will become eligible for Medicaid, and children in that income group who are enrolled in CHIP will be transitioned to Medicaid. The MOE requirements under the Affordable Care Act limit the ability of States to change eligibility and enrollment procedures for Medicaid and CHIP but may lead to cuts in provider payment rates for the next few years. Also, despite the MOE requirement on CHIP and Medicaid coverage for children through 2019, it is not clear how long States will be able to continue their CHIP programs beyond 2015 unless additional federal allotments are provided. With no additional federal funding for CHIP after 2015, many children enrolled in separate CHIP programs will likely be shifted into health insurance exchanges or employer-sponsored insurance (ESI) plans.

Authorizing legislation and mandate for the current evaluation. It is within this context of the gap in children's health care needs that Congress authorized an updated evaluation of CHIP to explore how the program has evolved since its inception and its role in covering low-income children. Findings from the evaluation are to be submitted in a report to Congress. The authorizing legislation for the evaluation is contained in Section 603 of the CHIPRA legislation (see Attachment A). Congress stipulated that the evaluation include 10 States that (1) use diverse approaches to providing child health assistance, (2) represent various geographic areas (including a mixture of urban and rural areas), and (3) each contain a significant portion of uncovered children. Findings from the evaluation are to be submitted in a report to Congress. In September 2010 a contract was awarded to Mathematica Policy Research (Mathematica) and its subcontractor, The Urban Institute, to conduct the evaluation, which is being overseen by The Office of the Assistant Secretary for Planning and Evaluation (ASPE).

Coming five years after completion of the first evaluation, the current evaluation will provide new and detailed insights into how the program has evolved since its early years, what impacts on children's coverage and access to care have occurred, and what new issues have arisen as a result of policy changes related to CHIPRA and the Affordable Care Act. Building on prior evaluations focused on the early years of CHIP, it will explore how States have grappled with important implementation challenges as the program matured and their experiences in enrolling, retaining, and delivering care to children in low-income families. It will place particular emphasis on understanding enrollee experiences in getting care and the types of services received, as well as how CHIP compares with other public and private coverage. Using a mixture of quantitative and qualitative research methods, the evaluation will document how CHIP programs have developed, where they stand today, and where they may be headed in the future. It will draw on new primary data collection efforts modeled after the previous evaluation, including surveys of enrollees and disenrollees in CHIP (10 States) and

Medicaid (3 States), site visits and focus groups in the 10 survey States, and key informant interviews with CHIP program administrators in every State. To analyze States' progress in enrolling and retaining children and to document effective policies and practices, the evaluation will also make use of various secondary data sources, including annual reports, other program data States submit to the Centers for Medicare & Medicaid Services (CMS), and administrative data files from State eligibility and enrollment systems. It also will tap data from other national surveys to understand how CHIP and Medicaid are perceived by low-income families with uninsured children who may be eligible and to gauge the extent to which CHIP is reducing the share of low-income children who are uninsured.

2. Information Users

ASPE will use the data collected and analyzed in the CHIPRA 10-State Evaluation to evaluate the CHIP program and its contributions to closing the health care coverage gap for low-income children whose families do not qualify for Medicaid, but cannot afford private coverage for them. Data from the interviews with CHIP State program administrators will be combined with information from the survey of enrollees and disenrollees, the case studies (site visits and focus groups), and other national datasets to inform the evaluation findings on a broad range of research questions.

In the telephone interviews with State CHIP program administrators ASPE will collect information from CHIP program directors in each of the 50 States plus the District of Columbia. The purpose of the discussions with State CHIP program administrators is to collect information on how CHIP programs have evolved since the previous national evaluation concluded in 2005, especially in response to CHIPRA, and how CHIP programs are preparing for and are likely to change because of the Affordable Care Act. The passage of health reform legislation in early 2010 substantially changed the context for this evaluation. ASPE now must gather information to help inform the role CHIP will play in an environment with broader Medicaid enrollment and a mandate for coverage supported by State-based exchanges for purchasing private insurance and facilitating enrollment in public coverage. The telephone interviews with State CHIP program administrators will provide information critical to understanding the role of CHIP in current delivery systems for children and informing decisions about the future of CHIP following implementation of the Affordable Care Act. The interviews will collect information on how CHIP programs responded to various provisions in the CHIPRA legislation, how CHIP is being integrated into and coordinated with State health insurance exchanges and other insurance affordability programs, and how CHIP programs are expected to change as a result of the Affordable Care Act.

- The discussion guide for the telephone interviews with State CHIP program administrators is contained in Attachment B1.

The telephone interviews are scheduled to take place in January and February of 2013, after the national and State elections in Fall 2012 so that States will have a better understanding of their strategies related to health reform implementation. We will conduct a one-hour telephone interview with each State's CHIP program director. In States with combination programs (with both a Medicaid expansion and a separate CHIP component), we plan to have both the CHIP and Medicaid directors present during a single group interview. Two-person teams will conduct each interview. Prior to each interview, we will prepare a fact sheet to be used as a tool to confirm factual information already known about each State's CHIP program (a template for this fact sheet is contained in Attachment B2). We will send this fact sheet to State CHIP program administrators in advance of interviews for their review and feedback. This will save time during the interview by reducing the number of factual questions we ask, while ensuring we have the correct contextual information for each State.

3. Improved Information Technology

Overall, CHIPRA 10-State Evaluation will comply fully with the Government Paperwork Elimination Act (Public Law 105-277, Title XVII) by employing technology efficiently to reduce burden on respondents, particularly with our enrollee and disenrollee survey. The information collection for the telephone interviews with State CHIP program administrators will not involve the use of information technology but will be conducted via telephone as an effort to reduce the burden on respondents.

4. Duplication of Similar Information

This information collection from CHIP program administrators in each State is unique in that there are no other information collections focused on the role of and outlook for CHIP following the enactment of the Affordable Care Act. Other surveys gather information about CHIP program design features that are relevant to the proposed survey, and ASPE will use information from these surveys and other background documents to characterize basic features of each State's CHIP program prior to conducting the interviews. This will ensure that there is no duplication of information; we will only ask program administrators for information that is not already available through other sources. These basic program features will be summarized in a fact sheet for each State (a template for these fact sheets is included in Attachment B2). In preparing the fact sheets ASPE will draw on information from the following sources to ensure no duplication of information:

- The Kaiser Family Foundation's 50-State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost Sharing Practices in Medicaid and CHIP (2010-2011 and 2011-2012 versions)
- The CHIP Annual Reporting Template (CARTS) for 2011

- The Kaiser Family Foundation/HMA Medicaid Budget Survey for FY 2011/2012
- The ASPE-sponsored survey of State Medicaid and CHIP program administrators for the evaluation of Express Lane Eligibility.

We will also draw on information collected through the case studies for the CHIPRA 10-State evaluation, for the 10 States included in that component. Although there is a section on Affordable Care Act preparations in the case study protocol for interviews with State program officials, the telephone interviews with CHIP program administrators in every State will cover additional topics and provide information for a later time period that is most relevant to understanding State plans and expectations related to implementation of the Affordable Care Act. In addition, the telephone interviews will obtain information from every State and the District of Columbia. The case studies are being conducted from February through August 2012 in the following 10 States: Alabama, California, Florida, Louisiana, Michigan, New York, Ohio, Texas, Utah, and Virginia.

5. Small Businesses

No small businesses or entities will be impacted.

6. Less Frequent Collection

The telephone interviews with State CHIP program administrators will take place only once. ASPE collected data for the initial CHIP evaluation in 2002 - 2003 and has not collected data about the program since that time. If the current data collection does not take place, ASPE will not be able to meet its obligation to Congress to provide new and detailed insights into how the CHIP program has evolved since its early years, what impacts on children's coverage and access to care have occurred, and what new issues have arisen as a result of policy changes related to CHIPRA and the Affordable Care Act.

There are no technical or legal obstacles to reducing respondent burden.

7. Special Circumstances

This request fully complies with the general information collection guidelines of 5 CFR 1320.5(d)(2). No special circumstances apply.

8. Federal Register Notice/Outside Consultation

The 60-day Federal Register Notice was published in the Federal Register on June 5, 2012, volume 77, number 108, p. 33220. See Attachment C.

Public comments. There were no public comments submitted during the 60-day notice time period.

Consultation Outside the Agency. Input on the discussion guide for the telephone interviews with State CHIP program administrators was obtained through meetings and discussions with several staff at the Center for Medicare and Medicaid Services (CMS) held in December 2011, February 2012 and March 2012. In addition to staff at ASPE (Andrew Bindman, Rose Chu, Nancy DeLew, Richard Kronick, Kenneth Finegold, Wilma Robinson, and Benjamin Sommers) the following individuals from CMS contributed input on the survey instrument:

- Jennifer Ryan, Deputy Director, Children and Adults Health Programs Group
- Linda Nablo, Director, Division of Children's Health Insurance Programs, Children and Adults Health Programs Group
- Amy Lutzky, Project Officer, Division of Children's Health Insurance Programs, Children and Adults Health Programs Group
- Stacey Green, Technical Director, Division of Children's Health Insurance Programs, Children and Adults Health Programs Group

9. Payment/Gift to Respondents

The telephone interviews will be conducted with State CHIP program administrators (in States with combination programs, this will include the administrator of the separate CHIP component as well as the administrator of the Medicaid Expansion CHIP component) and will not involve payment or other compensation. States are being compensated for their efforts to provide data for the survey of enrollees and disenrollees, which was described in the materials submitted previously for that information collection component.

10. Confidentiality

Mathematica has embedded protections for privacy and confidentiality in the study design. The information collection will fully comply with all respects of the Privacy Act. Electronic files containing information obtained through the survey will be stored on a secure network with appropriate safeguards to prevent any unauthorized access. Handwritten and hardcopies of interview notes will be kept in locked file cabinets when not in use. Individuals and agencies will be advised of the privacy of their replies under Section 934(c) of the Public Health Service Act, 42 USC 299c-3(c). State program officials will be told in an advance letter and again during the interview that data they provide will be treated in a confidential manner, unless otherwise compelled by law. They also will be informed that participation is voluntary. Attachment D1 contains a copy of a letter that will be sent to each State program official prior to setting up the interview, and Attachment D2 contains consent form text that will be included in an email invitation to State CHIP program administrators.

12. Burden Estimate (Total Hours & Wages)

ASPE estimates the following burden hours based on the budgeted length of the interviews.

Table 1. Estimated Annualized Burden Hours

Type of Respondent	Form	Number of Respondents	Number of Responses per Respondent	Average Burden Per Response (in hours)	Total Burden Hours
State CHIP Program Administrators	Telephone interviews, Discussion Guide (see attachment B1)	77 ^a	1	1	77

^a This includes one respondent per State in the 25 States with only a separate CHIP program or a Medicaid expansion program, and two respondents per State in the 26 States with combination programs.

ASPE used the Department of Labor website to determine the annualized cost to respondents and displays these figures in Table 2 below. We calculated the CHIP personnel as \$43.96, BLS’s median hourly wage for management occupations.

Table 2. Estimated Annualized Cost to Respondents for the Hours Burden

Type of Respondent	Total Burden Hours	Hourly Wage Rate	Total Respondent Costs
State CHIP Program Administrators	77	\$43.96	\$3,121.16

13. Capital Costs (Maintenance of Capital Costs)

There is no capital and start up cost to respondents associated with this data collection.

14. Cost to Federal Government

The evaluation is taking place over a three year period. The total cost to the government of all components of the evaluation is \$9,076,450. ASPE determined the annualized cost to be \$3,025,483 per year by dividing the total funded amount by three years. The total evaluation cost was based on the contractor’s budget that calculated wages and hours for all staff, all mailing costs, telephone charges, and overhead costs per contract year.

In addition to the evaluation costs, there are personnel costs for several Federal employees involved in the oversight and analysis of information collection that amount to an annualized cost of \$36,600 for Federal labor. The total annualized cost for the evaluation is therefore the sum of the annual contracted evaluation cost (\$3,025,483) and the annual Federal labor cost (\$36,600), or a total of \$3,062,083 per year.

15. Program or Burden Changes

This is a new data collection.

16. Publication and Tabulation Dates

While the CHIPRA 10-State evaluation consists of more than a dozen tasks, it is more easily thought of as a set of five coordinated components with findings that will be integrated to address a large number of overlapping research questions:

1. The most ambitious component involves the design, administration, and analysis of data from a major **survey of CHIP enrollees and disenrollees** being conducted in 10 carefully chosen States. Administered to the parents or guardians of children with current or recent CHIP coverage, the study will address questions that cannot be examined satisfactorily from existing data. The survey will provide a critical source of information on the demographic and socioeconomic characteristics of CHIP children and their families; perceptions of and experiences with application and renewal processes; the health status and health care needs of CHIP enrollees; enrollee experiences with accessing health care; and satisfaction with the program. A complementary **survey of Medicaid enrollees**, administered in 3 of the 10 CHIP survey States, will extend findings on these and other questions to the children and families enrolled in Medicaid.
2. A second major component involves the design, execution, and analysis of qualitative data from **CHIP case studies** in the same 10 States selected for the survey. Featuring **site visits** to various State and local stakeholders (such as program administrators, providers, and child advocates) and **focus groups** with families of CHIP-enrolled children, these studies likewise will address many questions that cannot be explored well through existing data. Examples include understanding perceptions of CHIP in the selected States, the barriers eligible families may experience when enrolling in the program or accessing health care, the extent to which CHIPRA has changed the programs' design or administration, and the likely ramifications of health care reform.
3. The last component to feature primary data is **telephone interviews with State CHIP program administrators** in all 50 States and the District of Columbia; this component also involves the design, execution, and analysis of data. Reprising a similar study conducted as part of the original CHIP evaluation, the interviews with State CHIP program administrators will focus on how CHIP programs have evolved since the program was first introduced and in response to legislation reauthorizing the program, on State experiences implementing provisions of the Affordable Care Act,

and the outlook for CHIP in a reformed health care landscape. Findings from this census survey will provide context for many of the questions examined through the case studies, helping us to interpret findings in a national perspective.

4. The fourth component makes use of **State program data**—CHIP annual reports and related data submitted by States, as well as administrative data from State eligibility and enrollment systems—to analyze enrollment and retention trends and dynamics and identify program features and other factors influencing these outcomes. We will explore enrollment and retention trends, including transitions between CHIP and other coverage and trends in churning out of and into the program. Using information from the case studies and other program documents, we will investigate how State-specific factors, such as innovative outreach practices and enrollment and retention policies, affect the rates and patterns observed in these data.
5. Drawing on data from several **national surveys** (the National Survey of Children’s Health module of the State and Local Area Integrated Telephone Survey [SLAITS], the Current Population Survey (CPS), and the AmericaACS), we will estimate program participation rates, explore how low-income families with uninsured children perceive CHIP and Medicaid, and determine the implications of health reform provisions for the larger population of families with uninsured children.

Each of these components will yield findings that will be captured in **source-specific reports** released over the course of the evaluation. Despite their seeming independence, however, the design and execution of the different components will be closely coordinated. For example, we have coordinated instrument development for the stakeholder interviews conducted as part of the case studies with the discussion guide for the telephone interviews with State CHIP program administrators in every State to ensure that we address common research questions as completely and consistently as possible. Likewise, we have coordinated the instrument development for the CHIP survey with the moderator guides for the focus groups. Moreover, the findings from the source-specific reports will be synthesized into two major reports. The first is a **2011 evaluation report** that will include findings from the analysis of State program reports and other secondary data. This report was submitted to Congress in December 2011. A more comprehensive **2013 evaluation report** will integrate findings and lessons from all of the study components to address the full range of research questions effectively. Submission of this report to Congress is schedule for Fall 2013.

17.Expiration Date

The OMB number and expiration date will be displayed on the survey instrument and any documents shared with survey respondents.

18.Certification Statement

No exceptions are being sought.

REFERENCES

Families USA. "Express Lane Eligibility: What Is It and How Does It Work?" October 2010. Available at [http://www.familiesusa.org/assets/pdfs/Express-Lane-Eligibility.pdf]. Accessed October 27, 2010.

Georgetown Center for Children and Families. "The Children's Health Insurance Program Reauthorization Act of 2009." Washington, DC: Georgetown Health Policy Institute, March 2009.

U.S. Department of Health and Human Services. "Children's Health Insurance Program Reauthorization Act: One Year Later, Connecting Kids to Coverage." Washington, DC: HHS, 2010.