



## The Children's Health Insurance Program (CHIP): The Fundamentals

BACKGROUND  
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*OVERVIEW — This background paper provides a brief overview of the fundamental elements of the Children's Health Insurance Program (CHIP). CHIP, which served more than 7 million children in federal fiscal year 2008, is a jointly funded federal-state partnership that was originally enacted in 1997 as a complement to the Medicaid program. CHIP is designed to provide health insurance coverage for children in families who earn too much to qualify for Medicaid but cannot afford to purchase private insurance coverage. The program was reauthorized in the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, which included several changes and additions to the structure of CHIP. This document provides a brief discussion of the rules governing eligibility, benefits, and financing. It also outlines the new sources of funding that are available for reaching out to children who might be eligible for CHIP or Medicaid but have not enrolled, and for establishing quality and performance measurement standards for the program.*

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**Contents**

CHIP: THE BASICS ..... 3

    Table 1: CHIP National Allotment Levels  
 (FY 2009 — FY 2013) ..... 3

PROGRAM DESIGN AND ADMINISTRATION ..... 3

ELIGIBILITY ..... 4

    Additional Populations..... 5

BENEFITS ..... 6

COST SHARING..... 7

FINANCING ..... 8

    The Enhanced Match ..... 8

CHIPRA 2009: FINANCING CHANGES..... 9

REACHING OUT TO UNINSURED FAMILIES..... 10

ENSURING QUALITY AND ACCESS TO CARE..... 11

DOCUMENTATION OF U.S. CITIZENSHIP..... 12

ENDNOTES ..... 12

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## CHIP: THE BASICS

The Children’s Health Insurance Program (CHIP), Title XXI of the Social Security Act, is jointly funded by the federal government and the states and administered at the state level. The federal Centers for Medicare & Medicaid Services (part of the U.S. Department of Health and Human Services) distributes the federal CHIP funds and provides oversight and guidance to the states.

The program was initially created as part of the Balanced Budget Act (BBA) of 1997 (P.L. 105-33) and was previously known as SCHIP—the State Children’s Health Insurance Program. On February 4, 2009, President Barack Obama signed into law the Children’s Health Insurance Program Reauthorization Act (CHIPRA) of 2009 (P.L. 111-3). CHIPRA provides nearly \$69 billion in federal funding for CHIP, Medicaid, and other related programs over the next four and a half years (Table 1).<sup>1</sup>

CHIP is designed to provide access to health insurance coverage for children in families who earn too much income to qualify for Medicaid<sup>2</sup> but cannot afford to purchase private health insurance coverage. States have considerable flexibility to establish income eligibility rules for CHIP, but children enrolling in the program must be otherwise uninsured.

CHIP served more than 73 million children in fiscal year 2008.<sup>3</sup> The Congressional Budget Office estimates that, by 2013, states will be able to provide CHIP-funded coverage to an additional 4.1 million children who would otherwise be uninsured. The vast majority of these additional uninsured children (83 percent) are estimated to be currently eligible for CHIP or Medicaid coverage but not enrolled.<sup>4</sup>

Funding for the CHIP program is divided among the states in the form of capped federal allotments. Each state has access to a share of the national CHIP funding allocation each year. These allotments are provided to the states on a matching basis where the states are responsible for an average of 25 percent of CHIP expenditures and the federal government finances the remaining 75 percent. (See “Financing” discussion, page 8.)

## PROGRAM DESIGN AND ADMINISTRATION

The creation of CHIP in the BBA of 1997 reflected a bipartisan agreement to permit states to develop an alternative to Medicaid and

**TABLE 1**  
CHIP National Allotment Levels  
(FY 2009 — FY 2013)

| FISCAL YEAR  | ALLOTMENT<br>(\$ billion) |
|--------------|---------------------------|
| 2009         | \$10.562                  |
| 2010         | \$12.520                  |
| 2011         | \$13.459                  |
| 2012         | \$14.982                  |
| 2013         | \$17.406                  |
| <b>TOTAL</b> | <b>\$68.929</b>           |

experiment with providing health insurance coverage that more closely resembled what might be available in the commercial health insurance market. The 1997 statute provided new flexibility for states to design benefit packages and establish cost-sharing and eligibility rules that differ from those permitted under Medicaid.

The law gave the states three options for designing their CHIP programs: (i) expand the existing Medicaid program, (ii) create a separate child health insurance program, or (iii) use a combination of the two approaches. Most states began by expanding their existing Medicaid programs, but over time more and more states have elected to design separate programs that operate in combination with the Medicaid program. Today, the majority of states are using the combination approach.<sup>5</sup>

States vary in how they administer CHIP. Many states continue to run the CHIP program out of their health and human services agencies (where the Medicaid program is typically housed), but a number of states have elected to place the program in a completely separate agency, such as the Department of Insurance in Pennsylvania or a not-for-profit organization in New Hampshire known as the Healthy Kids Corporation.

## ELIGIBILITY

CHIP is designed to serve low-income, uninsured children in families who make too much to qualify for Medicaid but do not have private insurance coverage, either because their employer does not offer health coverage or because the family could not afford to purchase private coverage. States have a great deal of flexibility in setting eligibility rules for their CHIP programs, but the CHIP matching rate is only available for coverage of children with family incomes below 300 percent of the federal poverty level (FPL) (\$54,930 for a family of three in 2009). This condition was added as part of the CHIPRA legislation. States may expand CHIP coverage to families with incomes above this level but will only receive the Medicaid matching rate for coverage of the children at higher income levels.<sup>6</sup> (For more explanation of the enhanced match for CHIP, see the text box on page 8).

Forty-four states have expanded Medicaid/CHIP up to 200 percent of the FPL or above, and 12 of those states have expanded eligibility to at least 300 percent of the FPL.<sup>7</sup>

Children who are otherwise eligible for Medicaid or have other insurance coverage are generally not eligible for CHIP. States must take steps to ensure that applicants who appear to be Medicaid eligible are enrolled in Medicaid<sup>8</sup> and that the program is not substituting for coverage that is available through private sources (a phenomenon known as “crowd out”).

### Additional Populations

- **Adults** are generally not eligible for CHIP; however, in the early years of the program, several states were granted a “waiver” of federal rules, which permitted them to receive enhanced matching funds for coverage of parents of children enrolled in CHIP, pregnant women, and, in some cases, adults without children. However, coverage of adults without children was subsequently prohibited by the Deficit Reduction Act of 2005. CHIPRA specified that no new waivers covering parents will be permitted and that existing CHIP-funded parent coverage waivers will be phased out over the next two years (by September 30, 2011). At that point, the states with parent coverage waivers in operation will have the opportunity, with CMS approval, to continue to receive federal matching funds for covering parents through a separate fund.<sup>9</sup> Federal CHIP funding for the states that are currently covering adults without children will be phased out by December 31, 2009. At that point, states that receive approval from CMS will have the opportunity to convert coverage for the childless adult population previously funded by CHIP into Medicaid coverage.<sup>10</sup>
- States have the option to provide CHIP-funded coverage for **pregnant women** through a state plan amendment, provided they meet certain conditions. For example, states must be covering children in families with incomes up to at least 200 percent of the FPL (\$36,620 for a family of three in 2009) in CHIP and pregnant women in Medicaid with incomes up to at least 185 percent of the FPL. The CHIPRA legislation formally established this option for states, no longer requiring them to apply for a special waiver of program rules to use CHIP funds to cover pregnant women. Starting in 2009, states will be able to submit a state plan amendment, indicating their intention to extend eligibility to these higher-income pregnant women.<sup>11</sup>
- **Legal immigrants** are now eligible for coverage under CHIP, at state option. The CHIPRA legislation repealed a prohibition on federal funding for Medicaid and CHIP coverage for legal immigrant children and pregnant women for the first five years

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*States have the option to provide CHIP-funded coverage for pregnant women through a state plan amendment.*

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they were in the country.<sup>12</sup> Beginning in 2009, states may enroll lawfully residing immigrant children and pregnant women and can receive federal CHIP funding for that coverage. Since the prohibition was put into place in 1996, 18 states had decided to provide coverage to legal immigrant children using state-only funds; these states will now be able to receive federal matching funds for this population.

## BENEFITS

As noted above, states have the option of expanding Medicaid or creating a separate CHIP program. The benefits and cost-sharing requirements depend on the program design the state chooses.

States creating Medicaid expansion programs must provide the full Medicaid benefit package, including the set of services known as Early and Periodic Screening, Diagnostic, and Treatment (EPS-DT).<sup>13</sup> For separate CHIP programs, states may choose among four benefit options:

- **Benchmark coverage** can be the coverage that is offered under the BlueCross/BlueShield plan for federal employees, a coverage plan that is offered to state employees, or a coverage plan that is offered by a health maintenance organization (HMO) and has the largest commercial enrollment in the state.
- **Benchmark-equivalent coverage** must include basic services (inpatient and outpatient hospital, physician, medical and surgical, laboratory and x-ray, and well-baby/well-child care, including immunizations) and have at least the aggregate actuarial value of one of the benchmark benefit packages.
- **The benefit package** that Florida, New York, and Pennsylvania were using in their state-based programs before the enactment of SCHIP in 1997.<sup>14</sup>
- **Secretary-approved coverage** in which states may propose an alternative benefit package and request approval from the Secretary of Health and Human Services.

States are now required to provide **dental coverage** for all children enrolled in CHIP (it was previously an optional benefit).<sup>15</sup> The dental coverage must meet one of three benchmark dental benefit standards, which closely mirror the broader CHIP benchmark benefit options noted above. The law also includes provisions to ensure access to dental services at federally qualified health centers, or FQHCs, and

encourages expanded dental education and outreach to help more families learn about the benefits of oral health care.

Finally, states have the option to provide dental-only supplemental coverage for children who would be otherwise income-eligible for CHIP but have private health insurance coverage that does not include dental benefits, or the cost of dental coverage is too high.

## COST SHARING

The rules surrounding cost sharing (the use of premiums, copayments, deductibles, and enrollment fees) for CHIP also depend on a state's program design.<sup>16</sup> States with Medicaid expansion programs are required to follow the Medicaid cost-sharing rules for children, which historically have been limited to small, or “nominal” amounts. Most children are generally exempt from cost sharing in Medicaid.<sup>17</sup> Preventive services are exempt from cost sharing for all CHIP families, regardless of income.

For states that have separate CHIP programs, premiums and enrollment fees, as well as copayments, may be imposed, but the maximum amount of cost sharing that can be charged depends on the child's family income:

- For families with **incomes at or below 150 percent of the FPL**, premiums may not exceed the levels permitted in the Medicaid regulations. Families may be charged service-related cost sharing that must be limited to (i) nominal amounts as defined by Medicaid regulations for those with incomes below 100 percent of the FPL, and (ii) slightly higher amounts as defined in the CHIP regulations for families with incomes between 100 and 150 percent of the FPL. States may not impose more than one type of cost-sharing charge on a service, and copayments must be based on the total cost of services furnished during an office visit, generally limited to \$5 per visit.
- For families with **incomes above 150 percent of the FPL**, the total amount of cost-sharing charges are not as limited but may not exceed 5 percent of the family's total income for the length of a child's eligibility period in the state. In addition, states must inform families of their cost-sharing maximum amount and provide a mechanism for families to stop making payments once the cost-sharing limits have been reached.

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*Preventive services are exempt from cost sharing for all CHIP families regardless of income.*

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## FINANCING

The BBA of 1997 made nearly \$40 billion in federal funds available over ten years to assist states in providing health care services to uninsured, low-income children. As noted above, CHIPRA reauthorized the program and increased the federal funding level for CHIP to \$68.9 billion between April 1, 2009, and September 30, 2013 (See Table 1, page 3).<sup>18</sup>

The statute provides a capped amount of federal CHIP funds to be made available to states. A formula determines the share of the federal appropriation that is allocated to each state, and states must provide matching funds to receive the federal CHIP funds. Unlike Medicaid, CHIP is not an entitlement program. Medicaid's open-ended entitlement specifies that all eligible individuals must be able to enroll in coverage and federal and state matching funds must be made available, regardless of overall program costs.<sup>19</sup> In contrast, once a state's federal CHIP allotment has been spent, the state must use its own funds if it wishes to continue financing CHIP coverage through a separate program.<sup>20</sup>

### THE ENHANCED MATCH

As with Medicaid, federal funding for CHIP is provided to states through a matching formula called the federal medical assistance percentage, or FMAP. As an incentive for states to establish CHIP programs and access the associated federal funds, the BBA of 1997 "enhanced" the federal Medicaid matching rate for spending on children enrolled in CHIP. Depending on the per capita income in the state, the formula results in a CHIP matching rate that is between 65 and 83 percent—generally 30 percent higher than each state's Medicaid FMAP. (The law sets a maximum CHIP matching rate of 85 percent.) For example, wealthier states like California, Minnesota, Maryland, and New York that have a 50 percent matching rate for Medicaid have a 65 percent enhanced matching rate for CHIP, and states with lower per capita incomes, such as Mississippi, New Mexico, and South Carolina, receive higher matching rates. On average, states contribute about 25 percent of the funding for CHIP while the federal government contributes about 75 percent.

## CHIPRA 2009: FINANCING CHANGES

The CHIP reauthorization process yielded some significant changes to the formula that is used to determine each state's annual CHIP allotment, as well as how any unspent CHIP funds will be treated at the end of each federal fiscal year, as discussed below.

- **Allotments** — In 2009, the CHIP allotment formula will be used to distribute available CHIP funds among the states primarily based on their existing CHIP spending levels. The allotments will be increased annually, to account for health care inflation and growth in the population of children in the state and to allow for enrollment increases and coverage expansions. In addition, the states' CHIP allotments will be "rebased" or recalculated every two years to reflect states' actual use of CHIP funds, from all sources, over time. This formula is designed to make CHIP funding levels more predictable for state budgetary purposes as well as to provide more room for states to pursue and sustain eligibility and/or benefits expansions. Further, the CHIPRA legislation explicitly allows states that receive federal approval to expand CHIP coverage during the year to receive allotment increases (in 2010 and 2012 only) as long as requests are submitted in advance.<sup>21</sup>
- **Child Enrollment Contingency Fund** — The Child Enrollment Contingency Fund is a second mechanism designed to promote more predictable funding levels. This fund is financed through a separate appropriation and is set at 20 percent of the national allotment amount each year (for example, \$2.1 billion for FY 2009). The contingency fund will provide states with a source of supplemental CHIP funding in the event they experience a shortfall<sup>22</sup> (assuming they have met a specified target enrollment level). States that use the contingency fund will have the next year's allotment increased by the amount accessed from the contingency fund.<sup>23</sup>
- **Redistribution of unused CHIP funds** — The initial CHIP legislation included a process for redistributing any unspent or excess CHIP funds to states that had exhausted their allotments. A state had to expend all of its allotment to be eligible for redistribution in a given fiscal year. If the money was not spent by the end of the three-year period of availability, the statute required the funds to revert to the federal government. Over the years, states became increasingly reliant on redistributed funds from other states in order to meet their program obligations. The initial allotment formula did not correspond well with states' enrollment patterns. As a result, Congress acted six times over the ten-year authorization

period to give states more time to spend SCHIP funds or to keep their programs from having a shortfall.

The CHIPRA legislation made several adjustments designed to move states away from reliance on the redistribution process and toward more predictable budgeting. As described above, the allotment formula has been significantly modified to better reflect states' spending patterns, and the statute specifically outlines the process and timeline for redistributing CHIP funds to shortfall states. In addition, the statute reduces the period of availability of the CHIP allotments from three years to two years. This is intended to enable the CHIP funding to be more evenly distributed among the states. In addition, any unspent CHIP funds will be continuously recirculated back into the program in the form of Medicaid performance bonuses (discussed below) rather than reverting to the federal Treasury.

## REACHING OUT TO UNINSURED FAMILIES

An estimated 6 million uninsured children in the United States are likely to be eligible for Medicaid or CHIP coverage but have not enrolled in the programs. Toward that end, the CHIPRA legislation included three major areas of focus designed to bolster states' ability to enroll more children in health coverage:

- Over the next four and half years, \$100 million will be made available to develop **outreach** and marketing campaigns designed to identify and enroll eligible children in Medicaid and CHIP. Of that amount, \$10 million will be dedicated to a national enrollment campaign; \$90 million will be distributed in the form of grants to state and local governments and other eligible organizations (such as health centers, hospitals, other programs that serve children, and schools and community-based groups) to conduct outreach efforts. \$10 million of the \$90 million is to be awarded to Indian Health Service providers and other organizations serving American Indians.
- States will have the opportunity to receive **performance bonuses** for successfully increasing Medicaid enrollment as a result of outreach activities and for simplifying program enrollment and renewal procedures. States that increase enrollment above a target level will receive a federal payment for each additional eligible child enrolled (in part to help defray the costs of covering more children). The performance bonuses will vary, as they will be based on the average cost of covering a child in a given state

and the extent to which the state's Medicaid enrollment exceeds the target levels.<sup>24</sup>

- The CHIPRA legislation also specifically endorses tools like **Express Lane Eligibility**, which allows states to rely on income and other eligibility findings from other public programs and information collected through other databases to determine children's eligibility for CHIP and Medicaid. These types of data system matches are expected to make it significantly easier and more efficient for states and families to enroll children in coverage.

## ENSURING QUALITY AND ACCESS TO CARE

Congress made a significant commitment to developing quality and performance measures in CHIP; CHIPRA dedicated \$225 million from fiscal years 2009 through 2013 for quality improvement and measurement activities. The legislation also includes a timeline for implementing the new federal and state quality initiatives.

- **By January 1, 2010**, the Secretary of HHS will produce a set of core child health quality measures designed to assess the stability and effectiveness of health coverage provided in Medicaid and CHIP. These measures will provide information both on the duration of children's enrollment in coverage and on access and effectiveness of a range of services and treatments. These measures will offer both state-level and national data on the quality of care for children.
- **By January 1, 2011**, the Secretary will provide a report to Congress on the status of its quality improvement efforts in Medicaid and CHIP nationally and at the state level. Such a report will be provided to Congress every three years thereafter.
- HHS will establish a program **by January 1, 2011**, to improve on the Medicaid and CHIP quality measures that are developed over time, and to expand on and increase existing pediatric measures used by private health care providers. The Secretary will publish recommended changes to the core set of measures each year (beginning in 2013), to be influenced by developments in evidence-based practices, and award grants to develop and test new pediatric quality measures.
- **No later than September 30, 2011**, states are required to submit a child health quality report to the Secretary of HHS to be made publicly available. Reports will be provided annually thereafter.

## DOCUMENTATION OF U.S. CITIZENSHIP

CHIPRA of 2009 extended to CHIP the requirement in Medicaid that children, parents, and pregnant women who declare that they are U.S. citizens or nationals must provide formal documentation of their status in order to enroll in the programs. This new requirement primarily affects citizen children and adults, as noncitizen applicants have always been required to provide documentation of their immigration status in order to be determined eligible for Medicaid or CHIP coverage.<sup>25</sup>

The legislation gives states a new way to comply with the requirement, allowing states to submit (electronically, if possible) the names and social security numbers of applicants to the Social Security Administration (SSA). SSA will conduct a data match to confirm the citizenship status of the applicants, or determine that additional documentation is needed. States will be expected to provide Medicaid or CHIP (as appropriate) coverage to the child during any reconciliation period. The legislation also clarified that newborns who automatically receive Medicaid coverage based on their mother's eligibility will not be required to have their citizenship documented when their eligibility comes up for renewal on their first birthday.

## ENDNOTES

1. It should be noted that the FY 2013 allotment is equal to \$2.85 billion for the first half of the fiscal year and \$2.85 billion for the second half. A one-time appropriation of \$11.06 billion will be added on to these amounts to make up the total FY 2013 allotment. The statute also calls for the establishment of a "contingency fund" that amounts to 20 percent of the national CHIP allotment each year (funded through a separate appropriation), so the amount of federal funds that are available to states for administering CHIP is actually higher.
2. For information on Medicaid see, "Medicaid," National Health Policy Forum, The Basics, January 15, 2009; available at [www.nhpf.org/library/details.cfm/2546](http://www.nhpf.org/library/details.cfm/2546).
3. Centers for Medicare & Medicaid Services, "FY 2008 Number of Children Ever Enrolled Year – SCHIP by Program Type"; available at <http://www.cms.hhs.gov/NationalCHIPPolicy/downloads/FY2008StateTotalTable012309FINAL.pdf>.
4. Congressional Budget Office, "H.R. 2, The Children's Health Insurance Program Reauthorization Act of 2009," February 11, 2009; available at [www.cbo.gov/ftpdocs/99xx/doc9985/hr2paygo.pdf](http://www.cbo.gov/ftpdocs/99xx/doc9985/hr2paygo.pdf).
5. For a current accounting of state program types, see [www.cms.hhs.gov/NationalCHIPPolicy/downloads/FY2008StateTotalTable012309FINAL.pdf](http://www.cms.hhs.gov/NationalCHIPPolicy/downloads/FY2008StateTotalTable012309FINAL.pdf).

6. New Jersey and New York were granted an exception to this new limitation because they had previously proposed expanding CHIP eligibility to 350 and 400 percent of the FPL, respectively.
7. For a complete listing of Medicaid and CHIP eligibility levels, see Center for Children and Families (CCF), “Eligibility Levels in Medicaid & SCHIP for Children, Pregnant Women and Parents as of January 1, 2009,” Georgetown Health Policy Institute, updated April 7, 2009; available at <http://ccf.georgetown.edu/index/cms-file-system-action?file=statistics/eligibility%20by%20state.pdf>.
8. This is commonly referred to as the “screen and enroll requirement.”
9. These matching funds will be provided to states through a separate capped allotment in 2012 and 2013, provided the states are meeting a specified set of child coverage benchmarks. The actual FMAP rate for these states will be determined at a later point.
10. The statute does not guarantee that states will be able to continue getting matching funds for coverage of childless adults through Medicaid, but it notes that they will have the opportunity to apply for a section 1115 waiver to do so, provided they submit the application by September 30, 2009, and meet applicable standards for budget neutrality.
11. For more details about the conditions for extending coverage to pregnant women, see CCF, “The Children’s Health Insurance Program Reauthorization Act of 2009: Overview and Summary,” Georgetown University Health Policy Institute, February 2009, p. 10; available at <http://ccf.georgetown.edu/index/the-children-s-health-insurance-program-reauthorization-act-of-2009>.
12. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, better known as “welfare reform,” explicitly prohibited legal immigrants who have resided in the United States for less than five years from being eligible for Medicaid or CHIP.
13. The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit is Medicaid’s comprehensive and preventive child health program for individuals under the age of 21. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA 1989) and includes periodic screening, vision, dental, and hearing services. In addition, the statute requires that any medically necessary health care service listed at section 1905(a) of the Social Security Act be provided to children enrolled in Medicaid, even if the service is not available under the state’s Medicaid plan to the rest of the Medicaid population. For more information, see Christie Provost Peters, “EPSDT: Medicaid’s Critical but Controversial Benefits Program for Children,” National Health Policy Forum, Issue Brief No. 819, November 20, 2006, available at [www.nhpf.org/library/details.cfm/2538](http://www.nhpf.org/library/details.cfm/2538). See also the “EPSDT—An Overview” at the Commonwealth Fund Web site, [www.cmwf.org/Content/Publications/Data-Briefs/2005/Sep/EPSDT--An-Overview.aspx](http://www.cmwf.org/Content/Publications/Data-Briefs/2005/Sep/EPSDT--An-Overview.aspx).
14. These states were considered the leaders in expanding children’s coverage in the 1990s and served as models for the development of SCHIP in 1997. As a result, the legislation specifically referenced these three states’ benefits packages as acceptable benchmark benefits packages for other states to adopt.

15. Dental benefits have always been required for children enrolled in Medicaid; this requirement was added as part of the CHIPRA reauthorization bill.
16. For a chart outlining the cost-sharing rules for Medicaid and CHIP, see <http://ccf.georgetown.edu/index/cms-filesystem-action?file=strategy%20center/costsharing%20tables.pdf>.
17. These requirements were modified in the Deficit Reduction Act (DRA) of 2005, which gave states additional flexibility to set cost sharing at higher levels than previously permitted. For children with family incomes above 150 percent of the FPL, the DRA permits premiums and cost sharing that could potentially amount to 20 percent of the cost of a service or prescription. However, to date only a handful of states have elected to use this new authority.
18. The Congressional Budget Office has estimated that only \$58 billion of the \$68.9 billion will be spent by 2013. The spending predictions also include spending for Medicaid enrollment and other activities.
19. For more information on the Medicaid financing structure, see "Medicaid Financing," National Health Policy Forum, The Basics, January 15, 2009; available at [www.nhpf.org/details.cfm/2528](http://www.nhpf.org/details.cfm/2528).
20. States may continue to receive Medicaid matching funds for covering children once the CHIP allotment is exhausted, but the separate program would need to be converted into a Medicaid expansion.
21. For a detailed explanation of the financing changes in CHIPRA 2009, see CCF, "The Children's Health Insurance Program Reauthorization Act of 2009: Overview and Summary," pp. 5-9.
22. A shortfall is defined as having projected expenditures in a fiscal year that will exceed the funding that is available from current, as well as prior year allotments.
23. Assuming sufficient funds are available.
24. For a more complete description of the performance bonuses and the conditions for receiving them, see the CCF, "The Children's Health Insurance Program Reauthorization Act of 2009: Overview and Summary," p. 11.
25. For more information on this topic, see "The Medicaid Citizenship Documentation Requirement," National Health Policy Forum, The Basics, January 15, 2009, available at [www.nhpf.org/library/details.cfm/2575](http://www.nhpf.org/library/details.cfm/2575).