

shall be responsible for assisting in reducing delays, increasing transparency and understanding of the status of requests, and assisting in the resolution of disputes.”

“(b) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of enactment of this Act.”

(i) CRITICAL INFRASTRUCTURE INFORMATION.—Strike section 12 of the bill.

NOTICE OF HEARING

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. BINGAMAN. Mr. President, I would like to announce for the information of the Senate and the public that a hearing has been scheduled before the Committee on Energy and Natural Resources, Subcommittee on Public Lands and Forests.

The hearing will be held on September 20, 2007, at 2:30 p.m. in room SD-366 of the Dirksen Senate Office Building.

The purpose of the hearing is to receive testimony on several bills, including: S. 1377, to direct the Secretary of the Interior to convey to the City of Henderson, Nevada, certain Federal land located in the City, and for other purposes; S. 1433, to amend the Alaska National Interest Lands Conservation Act to provide competitive status to certain Federal employees in the State of Alaska; S. 1608 and H.R. 815, to provide for the conveyance of certain land in Clark County, Nevada, for use by the Nevada National Guard S. 1740, to amend the Act of February 22, 1889, and the Act of July 2, 1862, to provide for the management of public land trust funds in the State of North Dakota; S. 1802, to adjust the boundaries of the Frank Church River of No Return Wilderness in the State of Idaho; S. 1803, to authorize the exchange of certain land located in the State of Idaho, and for other purposes; S. 1939, to provide for the conveyance of certain land in the Santa Fe National Forest, New Mexico; and S. 1940, to reauthorize the Rio Puerco Watershed Management Program, and for other purposes.

Because of the limited time available for the hearing, witnesses may testify by invitation only. However, those wishing to submit written testimony for the hearing record should send it to the Committee on Energy and Natural Resources, United States Senate, Washington, DC 20510-6150, or by email to rachel_pasternack@energy.senate.gov.

For further information, please contact David Brooks or Rachel Pasternack.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON ARMED SERVICES

Mr. DORGAN. Mr. President, I ask unanimous consent that the Committee on Armed Services be authorized to meet during the session of the Senate on Friday, August 3, 2007, at 8 a.m. in executive session to receive informa-

tion relating to the treatment of detainees.

The PRESIDING OFFICER. Without objection, it is so ordered.

SMALL BUSINESS TAX RELIEF ACT OF 2007

On Thursday, August 2, 2007, the Senate passed H.R. 976, as amended, as follows:

H.R. 976

Resolved, That the bill from the House of Representatives (H.R. 976) entitled “An Act to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes.”, do pass with the following amendments:

Strike out all after the enacting clause and insert:

SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECURITY ACT; REFERENCES; TABLE OF CONTENTS.

(a) *SHORT TITLE*.—This Act may be cited as the “Children’s Health Insurance Program Reauthorization Act of 2007”.

(b) *AMENDMENTS TO SOCIAL SECURITY ACT*.—Except as otherwise specifically provided, whenever in this Act an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

(c) *REFERENCES TO MEDICAID; CHIP; SECRETARY*.—In this Act:

(1) *CHIP*.—The term “CHIP” means the State Children’s Health Insurance Program established under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.).

(2) *MEDICAID*.—The term “Medicaid” means the program for medical assistance established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(3) *SECRETARY*.—The term “Secretary” means the Secretary of Health and Human Services.

(d) *TABLE OF CONTENTS*.—The table of contents for this Act is as follows:

Sec. 1. Short title; amendments to Social Security Act; references; table of contents.

TITLE I—FINANCING OF CHIP

Sec. 101. Extension of CHIP.

Sec. 102. Allotments for the 50 States and the District of Columbia.

Sec. 103. One-time appropriation.

Sec. 104. Improving funding for the territories under CHIP and Medicaid.

Sec. 105. Incentive bonuses for States.

Sec. 106. Phase-out of coverage for nonpregnant childless adults under CHIP; conditions for coverage of parents.

Sec. 107. State option to cover low-income pregnant women under CHIP through a State plan amendment.

Sec. 108. CHIP Contingency fund.

Sec. 109. Two-year availability of allotments; expenditures counted against oldest allotments.

Sec. 110. Limitation on matching rate for States that propose to cover children with effective family income that exceeds 300 percent of the poverty line.

Sec. 111. Option for qualifying States to receive the enhanced portion of the CHIP matching rate for Medicaid coverage of certain children.

TITLE II—OUTREACH AND ENROLLMENT

Sec. 201. Grants for outreach and enrollment.

Sec. 202. Increased outreach and enrollment of Indians.

Sec. 203. Demonstration program to permit States to rely on findings by an Express Lane agency to determine components of a child’s eligibility for Medicaid or CHIP.

Sec. 204. Authorization of certain information disclosures to simplify health coverage determinations.

TITLE III—REDUCING BARRIERS TO ENROLLMENT

Sec. 301. Verification of declaration of citizenship or nationality for purposes of eligibility for Medicaid and CHIP.

Sec. 302. Reducing administrative barriers to enrollment.

TITLE IV—REDUCING BARRIERS TO PROVIDING PREMIUM ASSISTANCE

Subtitle A—Additional State Option for Providing Premium Assistance

Sec. 401. Additional State option for providing premium assistance.

Sec. 402. Outreach, education, and enrollment assistance.

Subtitle B—Coordinating Premium Assistance With Private Coverage

Sec. 411. Special enrollment period under group health plans in case of termination of Medicaid or CHIP coverage or eligibility for assistance in purchase of employment-based coverage; coordination of coverage.

TITLE V—STRENGTHENING QUALITY OF CARE AND HEALTH OUTCOMES OF CHILDREN

Sec. 501. Child health quality improvement activities for children enrolled in Medicaid or CHIP.

Sec. 502. Improved information regarding access to coverage under CHIP.

Sec. 503. Application of certain managed care quality safeguards to CHIP.

TITLE VI—MISCELLANEOUS

Sec. 601. Technical correction regarding current State authority under Medicaid.

Sec. 602. Payment error rate measurement (“PERM”).

Sec. 603. Elimination of counting Medicaid child presumptive eligibility costs against title XXI allotment.

Sec. 604. Improving data collection.

Sec. 605. Deficit Reduction Act technical corrections.

Sec. 606. Elimination of confusing program references.

Sec. 607. Mental health parity in CHIP plans.

Sec. 608. Dental health grants.

Sec. 609. Application of prospective payment system for services provided by Federally-qualified health centers and rural health clinics.

Sec. 610. Support for injured servicemembers.

Sec. 611. Military family job protection.

Sec. 612. Sense of Senate regarding access to affordable and meaningful health insurance coverage.

Sec. 613. Demonstration projects relating to diabetes prevention.

Sec. 614. Outreach regarding health insurance options available to children.

TITLE VII—REVENUE PROVISIONS

Sec. 701. Increase in excise tax rate on tobacco products.

Sec. 702. Administrative improvements.

Sec. 703. Time for payment of corporate estimated taxes.

TITLE VIII—EFFECTIVE DATE

Sec. 801. Effective date.

TITLE I—FINANCING OF CHIP

SEC. 101. EXTENSION OF CHIP.

Section 2104(a) (42 U.S.C. 1397dd(a)) is amended—

(1) in paragraph (9), by striking “and” at the end;

(2) in paragraph (10), by striking the period at the end and inserting a semicolon; and

(3) by adding at the end the following new paragraphs:

“(11) for fiscal year 2008, \$9,125,000,000;
 “(12) for fiscal year 2009, \$10,675,000,000;
 “(13) for fiscal year 2010, \$11,850,000,000;
 “(14) for fiscal year 2011, \$13,750,000,000; and
 “(15) for fiscal year 2012, for purposes of making 2 semi-annual allotments—

“(A) \$1,750,000,000 for the period beginning on October 1, 2011, and ending on March 31, 2012, and

“(B) \$1,750,000,000 for the period beginning on April 1, 2012, and ending on September 30, 2012.”

SEC. 102. ALLOTMENTS FOR THE 50 STATES AND THE DISTRICT OF COLUMBIA.

(a) IN GENERAL.—Section 2104 (42 U.S.C. 1397dd) is amended by adding at the end the following new subsection:

“(i) DETERMINATION OF ALLOTMENTS FOR THE 50 STATES AND THE DISTRICT OF COLUMBIA FOR FISCAL YEARS 2008 THROUGH 2012.—

“(I) COMPUTATION OF ALLOTMENT.—

“(A) IN GENERAL.—Subject to the succeeding paragraphs of this subsection, the Secretary shall for each of fiscal years 2008 through 2012 allot to each subsection (b) State from the available national allotment an amount equal to 110 percent of—

“(i) in the case of fiscal year 2008, the highest of the amounts determined under paragraph (2);

“(ii) in the case of each of fiscal years 2009 through 2011, the Federal share of the expenditures determined under subparagraph (B) for the fiscal year; and

“(iii) beginning with fiscal year 2012, subject to subparagraph (E), each semi-annual allotment determined under subparagraph (D).

“(B) PROJECTED STATE EXPENDITURES FOR THE FISCAL YEAR.—For purposes of subparagraphs (A)(ii) and (D), the expenditures determined under this subparagraph for a fiscal year are the projected expenditures under the State child health plan for the fiscal year (as certified by the State and submitted to the Secretary by not later than August 31 of the preceding fiscal year).

“(C) AVAILABLE NATIONAL ALLOTMENT.—For purposes of this subsection, the term ‘available national allotment’ means, with respect to any fiscal year, the amount available for allotment under subsection (a) for the fiscal year, reduced by the amount of the allotments made for the fiscal year under subsection (c). Subject to paragraph (3)(B), the available national allotment with respect to the amount available under subsection (a)(15)(A) for fiscal year 2012 shall be increased by the amount of the appropriation for the period beginning on October 1 and ending on March 31 of such fiscal year under section 103 of the Children’s Health Insurance Program Reauthorization Act of 2007.

“(D) SEMI-ANNUAL ALLOTMENTS.—For purposes of subparagraph (A)(iii), the semi-annual allotments determined under this paragraph with respect to a fiscal year are as follows:

“(i) For the period beginning on October 1 and ending on March 31 of the fiscal year, the Federal share of the portion of the expenditures determined under subparagraph (B) for the fiscal year which are allocable to such period.

“(ii) For the period beginning on April 1 and ending on September 30 of the fiscal year, the Federal share of the portion of the expenditures determined under subparagraph (B) for the fiscal year which are allocable to such period.

“(E) AVAILABILITY.—Each semi-annual allotment made under subparagraph (A)(iii) shall remain available for expenditure under this title for periods after the period specified in subparagraph (D) for purposes of determining the allotment in the same manner as the allotment would have been available for expenditure if made for an entire fiscal year.

“(2) SPECIAL RULE FOR FISCAL YEAR 2008.—

“(A) IN GENERAL.—For purposes of paragraph (1)(A)(i), the amounts determined under this paragraph for fiscal year 2008 are as follows:

“(i) The total Federal payments to the State under this title for fiscal year 2007, multiplied by

the annual adjustment determined under subparagraph (B) for fiscal year 2008.

“(ii) The Federal share of the amount allotted to the State for fiscal year 2007 under subsection (b), multiplied by the annual adjustment determined under subparagraph (B) for fiscal year 2008.

“(iii) Only in the case of—

“(I) a State that received a payment, redistribution, or allotment under any of paragraphs (1), (2), or (4) of subsection (h), the amount of the projected total Federal payments to the State under this title for fiscal year 2007, as determined on the basis of the November 2006 estimates certified by the State to the Secretary;

“(II) a State whose projected total Federal payments to the State under this title for fiscal year 2007, as determined on the basis of the May 2006 estimates certified by the State to the Secretary, were at least \$95,000,000 but not more than \$96,000,000 higher than the projected total Federal payments to the State under this title for fiscal year 2007 on the basis of the November 2006 estimates, the amount of the projected total Federal payments to the State under this title for fiscal year 2007 on the basis of the May 2006 estimates; or

“(III) a State whose projected total Federal payments under this title for fiscal year 2007, as determined on the basis of the November 2006 estimates certified by the State to the Secretary, exceeded all amounts available to the State for expenditure for fiscal year 2007 (including any amounts paid, allotted, or redistributed to the State in prior fiscal years), the amount of the projected total Federal payments to the State under this title for fiscal year 2007, as determined on the basis of the November 2006 estimates certified by the State to the Secretary, multiplied by the annual adjustment determined under subparagraph (B) for fiscal year 2008.

“(iv) The projected total Federal payments to the State under this title for fiscal year 2008, as determined on the basis of the August 2007 projections certified by the State to the Secretary by not later than September 30, 2007.

“(B) ANNUAL ADJUSTMENT FOR HEALTH CARE COST GROWTH AND CHILD POPULATION GROWTH.—The annual adjustment determined under this subparagraph for a fiscal year with respect to a State is equal to the product of the amounts determined under clauses (i) and (ii):

“(i) PER CAPITA HEALTH CARE GROWTH.—1 plus the percentage increase (if any) in the projected nominal per capita amount of National Health Expenditures for the calendar year that begins during the fiscal year involved over the preceding calendar year, as most recently published by the Secretary.

“(ii) CHILD POPULATION GROWTH.—1.01 plus the percentage change in the population of children under 19 years of age in the State from July 1 of the fiscal year preceding the fiscal year involved to July 1 of the fiscal year involved, as determined by the Secretary based on the most timely and accurate published estimates of the Bureau of the Census.

“(C) DEFINITION.—For purposes of subparagraph (B), the term ‘fiscal year involved’ means the fiscal year for which an allotment under this subsection is being determined.

“(D) PRORATION RULE.—If, after the application of this paragraph without regard to this subparagraph, the sum of the State allotments determined under this paragraph for fiscal year 2008 exceeds the available national allotment for fiscal year 2008, the Secretary shall reduce each such allotment on a proportional basis.

“(3) ALTERNATIVE ALLOTMENTS FOR FISCAL YEARS 2009 THROUGH 2012.—

“(A) IN GENERAL.—If the sum of the State allotments determined under paragraph (1)(A)(ii) for any of fiscal years 2009 through 2011 exceeds the available national allotment for the fiscal year, the Secretary shall allot to each subsection (b) State from the available national allotment for the fiscal year an amount equal to the product of—

“(i) the available national allotment for the fiscal year; and

“(ii) the percentage equal to the sum of the State allotment factors for the fiscal year determined under paragraph (4) with respect to the State.

“(B) SPECIAL RULES BEGINNING IN FISCAL YEAR 2012.—Beginning in fiscal year 2012—

“(i) this paragraph shall be applied separately with respect to each of the periods described in clauses (i) and (ii) of paragraph (1)(D) and the available national allotment for each such period shall be the amount appropriated for such period (rather than the amount appropriated for the entire fiscal year), reduced by the amount of the allotments made for the fiscal year under subsection (c) for each such period, and

“(ii) if—

“(I) the sum of the State allotments determined under paragraph (1)(A)(iii) for either such period exceeds the amount of such available national allotment for such period, the Secretary shall make the allotment for each State for such period in the same manner as under subparagraph (A), and

“(II) the amount of such available national allotment for either such period exceeds the sum of the State allotments determined under paragraph (1)(A)(iii) for such period, the Secretary shall increase the allotment for each State for such period by the amount that bears the same ratio to such excess as the State’s allotment determined under paragraph (1)(A)(iii) for such period (without regard to this subparagraph) bears to the sum of such allotments for all States.

“(4) WEIGHTED FACTORS.—

“(A) FACTORS DESCRIBED.—For purposes of paragraph (3), the factors described in this subparagraph are the following:

“(i) PROJECTED STATE EXPENDITURES FOR THE FISCAL YEAR.—The ratio of the projected expenditures under the State child health plan for the fiscal year (as certified by the State to the Secretary by not later than August 31 of the preceding fiscal year) to the sum of the projected expenditures under all such plans for all subsection (b) States for the fiscal year, multiplied by the applicable percentage weight assigned under subparagraph (B).

“(ii) NUMBER OF LOW-INCOME CHILDREN IN THE STATE.—The ratio of the number of low-income children in the State, as determined on the basis of the most timely and accurate published estimates of the Bureau of the Census, to the sum of the number of low-income children so determined for all subsection (b) States for such fiscal year, multiplied by the applicable percentage weight assigned under subparagraph (B).

“(iii) PROJECTED STATE EXPENDITURES FOR THE PRECEDING FISCAL YEAR.—The ratio of the projected expenditures under the State child health plan for the preceding fiscal year (as determined on the basis of the projections certified by the State to the Secretary for November of the fiscal year), to the sum of the projected expenditures under all such plans for all subsection (b) States for such preceding fiscal year (as so determined), multiplied by the applicable percentage weight assigned under subparagraph (B).

“(iv) ACTUAL STATE EXPENDITURES FOR THE SECOND PRECEDING FISCAL YEAR.—The ratio of the actual expenditures under the State child health plan for the second preceding fiscal year, as determined by the Secretary on the basis of expenditure data reported by States on CMS Form 64 or CMS Form 21, to such sum of the actual expenditures under all such plans for all subsection (b) States for such second preceding fiscal year, multiplied by the applicable percentage weight assigned under subparagraph (B).

“(B) ASSIGNMENT OF WEIGHTS.—For each of fiscal years 2009 through 2012, the applicable weights assigned under this subparagraph are the following:

“(i) With respect to the factor described in subparagraph (A)(i), a weight of 75 percent for each such fiscal year.

“(ii) With respect to the factor described in subparagraph (A)(ii), a weight of 12½ percent for each such fiscal year.

“(iii) With respect to the factor described in subparagraph (A)(iii), a weight of 7½ percent for each such fiscal year.

“(iv) With respect to the factor described in subparagraph (A)(iv), a weight of 5 percent for each such fiscal year.

“(5) DEMONSTRATION OF NEED FOR INCREASED ALLOTMENT BASED ON PROJECTED STATE EXPENDITURES EXCEEDING 10 PERCENT OF THE PRECEDING FISCAL YEAR ALLOTMENT.—

“(A) IN GENERAL.—If the projected expenditures under the State child health plan described in paragraph (1)(B) for any of fiscal years 2009 through 2012 are at least 10 percent more than the allotment determined for the State for the preceding fiscal year (determined without regard to paragraph (2)(D) or paragraph (3)), and, during the preceding fiscal year, the State did not receive approval for a State plan amendment or waiver to expand coverage under the State child health plan or did not receive a CHIP contingency fund payment under subsection (k)—

“(i) the State shall submit to the Secretary, by not later than August 31 of the preceding fiscal year, information relating to the factors that contributed to the need for the increase in the State’s allotment for the fiscal year, as well as any other additional information that the Secretary may require for the State to demonstrate the need for the increase in the State’s allotment for the fiscal year;

“(ii) the Secretary shall—

“(I) review the information submitted under clause (i);

“(II) notify the State in writing within 60 days after receipt of the information that—

“(aa) the projected expenditures under the State child health plan are approved or disapproved (and if disapproved, the reasons for disapproval); or

“(bb) specified additional information is needed; and

“(III) if the Secretary disapproved the projected expenditures or determined additional information is needed, provide the State with a reasonable opportunity to submit additional information to demonstrate the need for the increase in the State’s allotment for the fiscal year.

“(B) PROVISIONAL AND FINAL ALLOTMENT.—In the case of a State described in subparagraph (A) for which the Secretary has not determined by September 30 of a fiscal year whether the State has demonstrated the need for the increase in the State’s allotment for the succeeding fiscal year, the Secretary shall provide the State with a provisional allotment for the fiscal year equal to 110 percent of the allotment determined for the State under this subsection for the preceding fiscal year (determined without regard to paragraph (2)(D) or paragraph (3)), and may, not later than November 30 of the fiscal year, adjust the State’s allotment (and the allotments of other subsection (b) States), as necessary (and, if applicable, subject to paragraph (3)), on the basis of information submitted by the State in accordance with subparagraph (A).

“(6) SPECIAL RULES.—

“(A) DEADLINE AND DATA FOR DETERMINING FISCAL YEAR 2008 ALLOTMENTS.—In computing the amounts under paragraph (2)(A) and subsection (c)(5)(A) that determine the allotments to subsection (b) States and territories for fiscal year 2008, the Secretary shall use the most recent data available to the Secretary before the start of that fiscal year. The Secretary may adjust such amounts and allotments, as necessary, on the basis of the expenditure data for the prior year reported by States on CMS Form 64 or CMS Form 21 not later than November 30, 2007, but in no case shall the Secretary adjust the allotments provided under paragraph (2)(A) or subsection (c)(5)(A) for fiscal year 2008 after December 31, 2007.

“(B) INCLUSION OF CERTAIN EXPENDITURES.—

“(i) PROJECTED EXPENDITURES OF QUALIFYING STATES.—Payments made or projected to be made to a qualifying State described in paragraph (2) of section 2105(g) for expenditures described in paragraph (1)(B)(ii) or (4)(B) of that section shall be included for purposes of determining the projected expenditures described in paragraph (1)(B) with respect to the allotments determined for each of fiscal years 2009 through 2012 and for purposes of determining the amounts described in clauses (i) and (iv) of paragraph (2)(A) with respect to the allotments determined for fiscal year 2008.

“(ii) PROJECTED EXPENDITURES UNDER BLOCK GRANT SET-ASIDES FOR NONPREGNANT CHILDLESS ADULTS AND PARENTS.—Payments projected to be made to a State under subsection (a) or (b) of section 2111 shall be included for purposes of determining the projected expenditures described in paragraph (1)(B) with respect to the allotments determined for each of fiscal years 2009 through 2012 (to the extent such payments are permitted under such section), including for purposes of allocating such expenditures for purposes of clauses (i) and (ii) of paragraph (1)(D).

“(7) SUBSECTION (b) STATE.—In this subsection, the term ‘subsection (b) State’ means 1 of the 50 States or the District of Columbia.”

(b) CONFORMING AMENDMENTS.—Section 2104 (42 U.S.C. 1397dd) is amended—

(1) in subsection (a), by striking “subsection (d)” and inserting “subsections (d), (h), and (i)”; and

(2) in subsection (b)(1), by striking “subsection (d)” and inserting “subsections (d), (h), and (i)”; and

(3) in subsection (c)(1), by striking “subsection (d)” and inserting “subsections (d), (h), and (i)”.

SEC. 103. ONE-TIME APPROPRIATION.

There is appropriated to the Secretary, out of any money in the Treasury not otherwise appropriated, \$12,500,000,000 to accompany the allotment made for the period beginning on October 1, 2011, and ending on March 31, 2012, under section 2104(a)(15)(A) of the Social Security Act (42 U.S.C. 1397dd(a)(15)(A)) (as added by section 101), to remain available until expended. Such amount shall be used to provide allotments to States under subsections (c)(5) and (i) of section 2104 of the Social Security Act (42 U.S.C. 1397dd) for the first 6 months of fiscal year 2012 in the same manner as allotments are provided under subsection (a)(15)(A) of such section and subject to the same terms and conditions as apply to the allotments provided from such subsection (a)(15)(A).

SEC. 104. IMPROVING FUNDING FOR THE TERRITORIES UNDER CHIP AND MEDICAID.

(a) UPDATE OF CHIP ALLOTMENTS.—Section 2104(c) (42 U.S.C. 1397dd(c)) is amended—

(1) in paragraph (1), by inserting “and paragraphs (5) and (6)” after “and (i)”; and

(2) by adding at the end the following new paragraphs:

“(5) ANNUAL ALLOTMENTS FOR TERRITORIES BEGINNING WITH FISCAL YEAR 2008.—Of the total allotment amount appropriated under subsection (a) for a fiscal year beginning with fiscal year 2008, the Secretary shall allot to each of the commonwealths and territories described in paragraph (3) the following:

“(A) FISCAL YEAR 2008.—For fiscal year 2008, the highest amount of Federal payments to the commonwealth or territory under this title for any fiscal year occurring during the period of fiscal years 1998 through 2007, multiplied by the annual adjustment determined under subsection (i)(2)(B) for fiscal year 2008, except that clause (ii) thereof shall be applied by substituting ‘the United States’ for ‘the State’.

“(B) FISCAL YEARS 2009 THROUGH 2012.—

“(i) IN GENERAL.—For each of fiscal years 2009 through 2012, except as provided in clause (ii), the amount determined under this paragraph

for the preceding fiscal year multiplied by the annual adjustment determined under subsection (i)(2)(B) for the fiscal year, except that clause (ii) thereof shall be applied by substituting ‘the United States’ for ‘the State’.

“(ii) SPECIAL RULE FOR FISCAL YEAR 2012.—In the case of fiscal year 2012—

“(I) 89 percent of the amount allocated to the commonwealth or territory for such fiscal year (without regard to this subclause) shall be allocated for the period beginning on October 1, 2011, and ending on March 31, 2012, and

“(II) 11 percent of such amount shall be allocated for the period beginning on April 1, 2012, and ending on September 30, 2012.”

(b) REMOVAL OF FEDERAL MATCHING PAYMENTS FOR DATA REPORTING SYSTEMS FROM THE OVERALL LIMIT ON PAYMENTS TO TERRITORIES UNDER TITLE XIX.—Section 1108(g) (42 U.S.C. 1308(g)) is amended by adding at the end the following new paragraph:

“(4) EXCLUSION OF CERTAIN EXPENDITURES FROM PAYMENT LIMITS.—With respect to fiscal years beginning with fiscal year 2008, if Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa qualify for a payment under subparagraph (A)(i), (B), or (F) of section 1903(a)(3) for a calendar quarter of such fiscal year, the payment shall not be taken into account in applying subsection (f) (as increased in accordance with paragraphs (1), (2), and (3) of this subsection) to such commonwealth or territory for such fiscal year.”

(c) GAO STUDY AND REPORT.—Not later than September 30, 2009, the Comptroller General of the United States shall submit a report to the appropriate committees of Congress regarding Federal funding under Medicaid and CHIP for Puerto Rico, the United States Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands. The report shall include the following:

(1) An analysis of all relevant factors with respect to—

(A) eligible Medicaid and CHIP populations in such commonwealths and territories;

(B) historical and projected spending needs of such commonwealths and territories and the ability of capped funding streams to respond to those spending needs;

(C) the extent to which Federal poverty guidelines are used by such commonwealths and territories to determine Medicaid and CHIP eligibility; and

(D) the extent to which such commonwealths and territories participate in data collection and reporting related to Medicaid and CHIP, including an analysis of territory participation in the Current Population Survey versus the American Community Survey.

(2) Recommendations for improving Federal funding under Medicaid and CHIP for such commonwealths and territories.

SEC. 105. INCENTIVE BONUSES FOR STATES.

(a) IN GENERAL.—Section 2104 (42 U.S.C. 1397dd), as amended by section 102, is amended by adding at the end the following new subsection:

“(j) INCENTIVE BONUSES.—

“(1) ESTABLISHMENT OF INCENTIVE POOL FROM UNOBLIGATED NATIONAL ALLOTMENT AND UNEXPENDED STATE ALLOTMENTS.—

“(A) IN GENERAL.—There is hereby established in the Treasury of the United States a fund which shall be known as the ‘CHIP Incentive Bonuses Pool’ (in this subsection referred to as the ‘Incentive Pool’). Amounts in the Incentive Pool are authorized to be appropriated for payments under this subsection and shall remain available until expended.

“(B) DEPOSITS THROUGH INITIAL APPROPRIATION AND TRANSFERS OF FUNDS.—

“(i) INITIAL APPROPRIATION.—There is appropriated to the Incentive Pool, out of any money in the Treasury not otherwise appropriated, \$3,000,000,000 for fiscal year 2008.

“(ii) TRANSFERS.—Notwithstanding any other provision of law, the following amounts are

hereby appropriated or transferred to, deposited in, and made available for expenditure from the Incentive Pool on the following dates:

“(I) UNEXPENDED FISCAL YEAR 2006 AND 2007 ALLOTMENTS.—On December 31, 2007, the sum for all States of the excess (if any) for each State of—

“(aa) the aggregate allotments provided for the State under subsection (b) or (c) for fiscal years 2006 and 2007 that are not expended by September 30, 2007, over

“(bb) an amount equal to 50 percent of the allotment provided for the State under subsection (c) or (i) for fiscal year 2008 (as determined in accordance with subsection (i)(6)).

“(II) UNOBLIGATED NATIONAL ALLOTMENT.—

“(aa) FISCAL YEARS 2008 THROUGH 2011.—On December 31 of fiscal year 2008, and on December 31 of each succeeding fiscal year through fiscal year 2011, the portion, if any, of the amount appropriated under subsection (a) for such fiscal year that is unobligated for allotment to a State under subsection (c) or (i) for such fiscal year or set aside under subsection (a)(3) or (b)(2) of section 2111 for such fiscal year.

“(bb) FIRST HALF OF FISCAL YEAR 2012.—On December 31 of fiscal year 2012, the portion, if any, of the sum of the amounts appropriated under subsection (a)(15)(A) and under section 103 of the Children’s Health Insurance Program Reauthorization Act of 2007 for the period beginning on October 1, 2011, and ending on March 31, 2012, that is unobligated for allotment to a State under subsection (c) or (i) for such fiscal year or set aside under subsection (b)(2) of section 2111 for such fiscal year.

“(cc) SECOND HALF OF FISCAL YEAR 2012.—On June 30 of fiscal year 2012, the portion, if any, of the amount appropriated under subsection (a)(15)(B) for the period beginning on April 1, 2012, and ending on September 30, 2012, that is unobligated for allotment to a State under subsection (c) or (i) for such fiscal year or set aside under subsection (b)(2) of section 2111 for such fiscal year.

“(III) PERCENTAGE OF STATE ALLOTMENTS THAT ARE UNEXPENDED BY THE END OF THE FIRST YEAR OF AVAILABILITY BEGINNING WITH THE FISCAL YEAR 2009 ALLOTMENTS.—On October 1 of each of fiscal years 2009 through 2012, the sum for all States for such fiscal year (the ‘current fiscal year’) of the excess (if any) for each State of—

“(aa) the allotment made for the State under subsection (b), (c), or (i) for the fiscal year preceding the current fiscal year (reduced by any amounts set aside under section 2111(a)(3)) that is not expended by the end of such preceding fiscal year, over

“(bb) an amount equal to the applicable percentage (for the fiscal year) of the allotment made for the State under subsection (b), (c), or (i) (as so reduced) for such preceding fiscal year.

For purposes of item (bb), the applicable percentage is 20 percent for fiscal year 2009, and 10 percent for each of fiscal years 2010, 2011, and 2012.

“(IV) REMAINDER OF STATE ALLOTMENTS THAT ARE UNEXPENDED BY THE END OF THE PERIOD OF AVAILABILITY BEGINNING WITH THE FISCAL YEAR 2006 ALLOTMENTS.—On October 1 of each of fiscal years 2009 through 2012, the total amount of allotments made to States under subsection (b), (c), or (i) for the second preceding fiscal year (third preceding fiscal year in the case of the fiscal year 2006 allotments) and remaining after the application of subclause (III) that are not expended by September 30 of the preceding fiscal year.

“(V) UNEXPENDED TRANSITIONAL COVERAGE BLOCK GRANT FOR NONPREGNANT CHILDLESS ADULTS.—On October 1, 2009, any amounts set aside under section 2111(a)(3) that are not expended by September 30, 2009.

“(VI) EXCESS CHIP CONTINGENCY FUNDS.—

“(aa) AMOUNTS IN EXCESS OF THE AGGREGATE CAP.—On October 1 of each of fiscal years 2010 through 2012, any amount in excess of the aggregate cap applicable to the CHIP Contingency Fund for the fiscal year under subsection (k)(2)(B).

“(bb) UNEXPENDED CHIP CONTINGENCY FUND PAYMENTS.—On October 1 of each of fiscal years 2010 through 2012, any portion of a CHIP Contingency Fund payment made to a State that remains unexpended at the end of the period for which the payment is available for expenditure under subsection (e)(3).

“(VII) EXTENSION OF AVAILABILITY FOR PORTION OF UNEXPENDED STATE ALLOTMENTS.—The portion of the allotment made to a State for a fiscal year that is not transferred to the Incentive Pool under subclause (I) or (III) shall remain available for expenditure by the State only during the fiscal year in which such transfer occurs, in accordance with subclause (IV) and subsection (e)(4).

“(C) INVESTMENT OF FUND.—The Secretary of the Treasury shall invest, in interest bearing securities of the United States, such currently available portions of the Incentive Pool as are not immediately required for payments from the Pool. The income derived from these investments constitutes a part of the Incentive Pool.

“(2) PAYMENTS TO STATES INCREASING ENROLLMENT.—

“(A) IN GENERAL.—Subject to paragraph (3)(D), with respect to each of fiscal years 2009 through 2012, the Secretary shall make payments to States from the Incentive Pool determined under subparagraph (B).

“(B) DETERMINATION OF PAYMENTS.—If, for any coverage period ending in a fiscal year ending after September 30, 2008, the average monthly enrollment of children in the State plan under title XIX exceeds the baseline monthly average for such period, the payment made for the fiscal year shall be equal to the applicable amount determined under subparagraph (C).

“(C) APPLICABLE AMOUNT.—For purposes of subparagraph (B), the applicable amount is the product determined in accordance with the following:

“(i) If such excess with respect to the number of individuals who are enrolled in the State plan under title XIX does not exceed 2 percent, the product of \$75 and the number of such individuals included in such excess.

“(ii) If such excess with respect to the number of individuals who are enrolled in the State plan under title XIX exceeds 2, but does not exceed 5 percent, the product of \$300 and the number of such individuals included in such excess, less the amount of such excess calculated in clause (i).

“(iii) If such excess with respect to the number of individuals who are enrolled in the State plan under title XIX exceeds 5 percent, the product of \$625 and the number of such individuals included in such excess, less the sum of the amount of such excess calculated in clauses (i) and (ii).

“(D) INDEXING OF DOLLAR AMOUNTS.—For each coverage period ending in a fiscal year ending after September 30, 2009, the dollar amounts specified in subparagraph (C) shall be increased by the percentage increase (if any) in the projected nominal per capita amount of National Health Expenditures for the calendar year beginning on January 1 of the coverage period over the preceding coverage period, as most recently published by the Secretary before the beginning of the coverage period involved.

“(3) RULES RELATING TO ENROLLMENT INCREASES.—For purposes of paragraph (2)(B)—

“(A) BASELINE MONTHLY AVERAGE.—Except as provided in subparagraph (C), the baseline monthly average for any fiscal year for a State is equal to—

“(i) the baseline monthly average for the preceding fiscal year; multiplied by

“(ii) the sum of 1 plus the sum of—

“(I) 0.01; and

“(II) the percentage increase in the population of low-income children in the State from the preceding fiscal year to the fiscal year involved, as determined by the Secretary based on the most timely and accurate published estimates of the Bureau of the Census before the beginning of the fiscal year involved.

“(B) COVERAGE PERIOD.—Except as provided in subparagraph (C), the coverage period for any fiscal year consists of the last 2 quarters of the preceding fiscal year and the first 2 quarters of the fiscal year.

“(C) SPECIAL RULES FOR FISCAL YEAR 2009.—With respect to fiscal year 2009—

“(i) the coverage period for that fiscal year shall be based on the first 2 quarters of fiscal year 2009; and

“(ii) the baseline monthly average shall be—
“(I) the average monthly enrollment of low-income children enrolled in the State’s plan under title XIX for the first 2 quarters of fiscal year 2007 (as determined over a 6-month period on the basis of the most recent information reported through the Medicaid Statistical Information System (MSIS)); multiplied by
“(II) the sum of 1 plus the sum of—

“(aa) 0.02; and

“(bb) the percentage increase in the population of low-income children in the State from fiscal year 2007 to fiscal year 2009, as determined by the Secretary based on the most timely and accurate published estimates of the Bureau of the Census before the beginning of the fiscal year involved.

“(D) ADDITIONAL REQUIREMENT FOR ELIGIBILITY FOR PAYMENT.—For purposes of subparagraphs (B) and (C), the average monthly enrollment shall be determined without regard to children who do not meet the income eligibility criteria in effect on July 19, 2007, for enrollment under the State plan under title XIX or under a waiver of such plan.

“(4) TIME OF PAYMENT.—Payments under paragraph (2) for any fiscal year shall be made during the last quarter of such year.

“(5) USE OF PAYMENTS.—Payments made to a State from the Incentive Pool shall be used for any purpose that the State determines is likely to reduce the percentage of low-income children in the State without health insurance.

“(6) PRORATION RULE.—If the amount available for payment from the Incentive Pool is less than the total amount of payments to be made for such fiscal year, the Secretary shall reduce the payments described in paragraph (2) on a proportional basis.

“(7) REFERENCES.—With respect to a State plan under title XIX, any references to a child in this subsection shall include a reference to any individual provided medical assistance under the plan who has not attained age 19 (or, if a State has so elected under such State plan, age 20 or 21).”

(b) REDISTRIBUTION OF UNEXPENDED FISCAL YEAR 2005 ALLOTMENTS.—Notwithstanding section 2104(f) of the Social Security Act (42 U.S.C. 1397dd(f)), with respect to fiscal year 2008, the Secretary shall provide for a redistribution under such section from the allotments for fiscal year 2005 under subsection (b) and (c) of such section that are not expended by the end of fiscal year 2007, to each State described in clause (iii) of section 2104(i)(2)(A) of the Social Security Act, as added by section 102(a), of an amount that bears the same ratio to such unexpended fiscal year 2005 allotments as the ratio of the fiscal year 2007 allotment determined for each such State under subsection (b) of section 2104 of such Act for fiscal year 2007 (without regard to any amounts paid, allotted, or redistributed to the State under section 2104 for any preceding fiscal year) bears to the total amount of the fiscal year 2007 allotments for all such States (as so determined).

(c) CONFORMING AMENDMENT ELIMINATING RULES FOR REDISTRIBUTION OF UNEXPENDED ALLOTMENTS FOR FISCAL YEARS AFTER 2005.—Effective January 1, 2008, section 2104(f) (42 U.S.C. 1397dd(f)) is amended to read as follows:

“(f) UNALLOCATED PORTION OF NATIONAL ALLOTMENT AND UNUSED ALLOTMENTS.—For provisions relating to the distribution of portions of the unallocated national allotment under subsection (a) for fiscal years beginning with fiscal year 2008, and unexpended allotments for fiscal years beginning with fiscal year 2006, see subsection (j).”.

(d) ADDITIONAL FUNDING FOR THE SECRETARY TO IMPROVE TIMELINESS OF DATA REPORTING AND ANALYSIS FOR PURPOSES OF DETERMINING ENROLLMENT INCREASES UNDER MEDICAID AND CHIP.—

(1) APPROPRIATION.—There is appropriated, out of any money in the Treasury not otherwise appropriated, \$5,000,000 to the Secretary for fiscal year 2008 for the purpose of improving the timeliness of the data reported and analyzed from the Medicaid Statistical Information System (MSIS) for purposes of carrying out section 2104(j)(2)(B) of the Social Security Act (as added by subsection (a)) and to provide guidance to States with respect to any new reporting requirements related to such improvements. Amounts appropriated under this paragraph shall remain available until expended.

(2) REQUIREMENTS.—The improvements made by the Secretary under paragraph (1) shall be designed and implemented (including with respect to any necessary guidance for States) so that, beginning no later than October 1, 2008, data regarding the enrollment of low-income children (as defined in section 2110(c)(4) of the Social Security Act (42 U.S.C. 1397jj(c)(4)) of a State enrolled in the State plan under Medicaid or the State child health plan under CHIP with respect to a fiscal year shall be collected and analyzed by the Secretary within 6 months of submission.

SEC. 106. PHASE-OUT OF COVERAGE FOR NON-PREGNANT CHILDLESS ADULTS UNDER CHIP; CONDITIONS FOR COVERAGE OF PARENTS.

(a) PHASE-OUT RULES.—

(1) IN GENERAL.—Title XXI (42 U.S.C. 1397aa et seq.) is amended by adding at the end the following new section:

“SEC. 2111. PHASE-OUT OF COVERAGE FOR NON-PREGNANT CHILDLESS ADULTS; CONDITIONS FOR COVERAGE OF PARENTS.

“(a) TERMINATION OF COVERAGE FOR NON-PREGNANT CHILDLESS ADULTS.—

“(1) NO NEW CHIP WAIVERS; AUTOMATIC EXTENSIONS AT STATE OPTION THROUGH FISCAL YEAR 2008.—Notwithstanding section 1115 or any other provision of this title, except as provided in this subsection—

“(A) the Secretary shall not on or after the date of the enactment of the Children’s Health Insurance Program Reauthorization Act of 2007, approve or renew a waiver, experimental, pilot, or demonstration project that would allow funds made available under this title to be used to provide child health assistance or other health benefits coverage to a nonpregnant childless adult; and

“(B) notwithstanding the terms and conditions of an applicable existing waiver, the provisions of paragraphs (2) and (3) shall apply for purposes of any fiscal year beginning on or after October 1, 2008, in determining the period to which the waiver applies, the individuals eligible to be covered by the waiver, and the amount of the Federal payment under this title.

“(2) TERMINATION OF CHIP COVERAGE UNDER APPLICABLE EXISTING WAIVERS AT THE END OF FISCAL YEAR 2008.—

“(A) IN GENERAL.—No funds shall be available under this title for child health assistance or other health benefits coverage that is provided to a nonpregnant childless adult under an applicable existing waiver after September 30, 2008.

“(B) EXTENSION UPON STATE REQUEST.—If an applicable existing waiver described in subparagraph (A) would otherwise expire before October 1, 2008, and the State requests an extension of such waiver, the Secretary shall grant such an extension, but only through September 30, 2008.

“(C) APPLICATION OF ENHANCED FMAP.—The enhanced FMAP determined under section 2105(b) shall apply to expenditures under an applicable existing waiver for the provision of child health assistance or other health benefits coverage to a nonpregnant childless adult during fiscal year 2008.

“(3) OPTIONAL 1-YEAR TRANSITIONAL COVERAGE BLOCK GRANT FUNDED FROM STATE ALLOTMENT.—Subject to paragraph (4)(B), each State for which coverage under an applicable existing waiver is terminated under paragraph (2)(A) may elect to provide nonpregnant childless adults who were provided child health assistance or health benefits coverage under the applicable existing waiver at any time during fiscal year 2008 with such assistance or coverage during fiscal year 2009, as if the authority to provide such assistance or coverage under an applicable existing waiver was extended through that fiscal year, but subject to the following terms and conditions:

“(A) BLOCK GRANT SET ASIDE FROM STATE ALLOTMENT.—The Secretary shall set aside for the State an amount equal to the Federal share of the State’s projected expenditures under the applicable existing waiver for providing child health assistance or health benefits coverage to all nonpregnant childless adults under such waiver for fiscal year 2008 (as certified by the State and submitted to the Secretary by not later than August 31, 2008, and without regard to whether any such individual lost coverage during fiscal year 2008 and was later provided child health assistance or other health benefits coverage under the waiver in that fiscal year), increased by the annual adjustment for fiscal year 2009 determined under section 2104(i)(2)(B)(i). The Secretary may adjust the amount set aside under the preceding sentence, as necessary, on the basis of the expenditure data for fiscal year 2008 reported by States on CMS Form 64 or CMS Form 21 not later than November 30, 2008, but in no case shall the Secretary adjust such amount after December 31, 2008.

“(B) NO COVERAGE FOR NONPREGNANT CHILDLESS ADULTS WHO WERE NOT COVERED DURING FISCAL YEAR 2008.—

“(i) FMAP APPLIED TO EXPENDITURES.—The Secretary shall pay the State for each quarter of fiscal year 2009, from the amount set aside under subparagraph (A), an amount equal to the Federal medical assistance percentage (as determined under section 1905(b) without regard to clause (4) of such section) of expenditures in the quarter for providing child health assistance or other health benefits coverage to a nonpregnant childless adult but only if such adult was enrolled in the State program under this title during fiscal year 2008 (without regard to whether the individual lost coverage during fiscal year 2008 and was reenrolled in that fiscal year or in fiscal year 2009).

“(ii) FEDERAL PAYMENTS LIMITED TO AMOUNT OF BLOCK GRANT SET-ASIDE.—No payments shall be made to a State for expenditures described in this subparagraph after the total amount set aside under subparagraph (A) for fiscal year 2009 has been paid to the State.

“(4) STATE OPTION TO APPLY FOR MEDICAID WAIVER TO CONTINUE COVERAGE FOR NONPREGNANT CHILDLESS ADULTS.—

“(A) IN GENERAL.—Each State for which coverage under an applicable existing waiver is terminated under paragraph (2)(A) may submit, not later than June 30, 2009, an application to the Secretary for a waiver under section 1115 of the State plan under title XIX to provide medical assistance to a nonpregnant childless adult whose coverage is so terminated (in this subsection referred to as ‘Medicaid nonpregnant childless adults waiver’).

“(B) DEADLINE FOR APPROVAL.—The Secretary shall make a decision to approve or deny an application for a Medicaid nonpregnant childless adults waiver submitted under subparagraph (A) within 90 days of the date of the

submission of the application. If no decision has been made by the Secretary as of September 30, 2009, on the application of a State for a Medicaid nonpregnant childless adults waiver that was submitted to the Secretary by June 30, 2009, the application shall be deemed approved.

“(C) STANDARD FOR BUDGET NEUTRALITY.—The budget neutrality requirement applicable with respect to expenditures for medical assistance under a Medicaid nonpregnant childless adults waiver shall—

“(i) in the case of fiscal year 2010, allow expenditures for medical assistance under title XIX for all such adults to not exceed the total amount of payments made to the State under paragraph (3)(B) for fiscal year 2009, increased by the percentage increase (if any) in the projected nominal per capita amount of National Health Expenditures for calendar year 2010 over calendar year 2009, as most recently published by the Secretary; and

“(ii) in the case of any succeeding fiscal year, allow such expenditures to not exceed the amount in effect under this subparagraph for the preceding fiscal year, increased by the percentage increase (if any) in the projected nominal per capita amount of National Health Expenditures for the calendar year that begins during the fiscal year involved over the preceding calendar year, as most recently published by the Secretary.

“(b) RULES AND CONDITIONS FOR COVERAGE OF PARENTS OF TARGETED LOW-INCOME CHILDREN.—

“(1) TWO-YEAR TRANSITION PERIOD; AUTOMATIC EXTENSION AT STATE OPTION THROUGH FISCAL YEAR 2009.—

“(A) NO NEW CHIP WAIVERS.—Notwithstanding section 1115 or any other provision of this title, except as provided in this subsection—

“(i) the Secretary shall not on or after the date of the enactment of the Children’s Health Insurance Program Reauthorization Act of 2007 approve or renew a waiver, experimental, pilot, or demonstration project that would allow funds made available under this title to be used to provide child health assistance or other health benefits coverage to a parent of a targeted low-income child; and

“(ii) notwithstanding the terms and conditions of an applicable existing waiver, the provisions of paragraphs (2) and (3) shall apply for purposes of any fiscal year beginning on or after October 1, 2009, in determining the period to which the waiver applies, the individuals eligible to be covered by the waiver, and the amount of the Federal payment under this title.

“(B) EXTENSION UPON STATE REQUEST.—If an applicable existing waiver described in subparagraph (A) would otherwise expire before October 1, 2009, and the State requests an extension of such waiver, the Secretary shall grant such an extension, but only, subject to paragraph (2)(A), through September 30, 2009.

“(C) APPLICATION OF ENHANCED FMAP.—The enhanced FMAP determined under section 2105(b) shall apply to expenditures under an applicable existing waiver for the provision of child health assistance or other health benefits coverage to a parent of a targeted low-income child during fiscal years 2008 and 2009.

“(2) RULES FOR FISCAL YEARS 2010 THROUGH 2012.—

“(A) PAYMENTS FOR COVERAGE LIMITED TO BLOCK GRANT FUNDED FROM STATE ALLOTMENT.—Any State that provides child health assistance or health benefits coverage under an applicable existing waiver for a parent of a targeted low-income child may elect to continue to provide such assistance or coverage through fiscal year 2010, 2011, or 2012, subject to the same terms and conditions that applied under the applicable existing waiver, unless otherwise modified in subparagraph (B).

“(B) TERMS AND CONDITIONS.—

“(i) BLOCK GRANT SET ASIDE FROM STATE ALLOTMENT.—If the State makes an election under subparagraph (A), the Secretary shall set aside

for the State for each such fiscal year an amount equal to the Federal share of 110 percent of the State's projected expenditures under the applicable existing waiver for providing child health assistance or health benefits coverage to all parents of targeted low-income children enrolled under such waiver for the fiscal year (as certified by the State and submitted to the Secretary by not later than August 31 of the preceding fiscal year). In the case of fiscal year 2012, the set aside for any State shall be computed separately for each period described in clauses (i) and (ii) of subsection (i)(1)(D) and any increase or reduction in the allotment for either such period under subsection (i)(3)(B)(ii) shall be allocated on a pro rata basis to such set aside.

“(ii) PAYMENTS FROM BLOCK GRANT.—The Secretary shall pay the State from the amount set aside under clause (i) for the fiscal year, an amount for each quarter of such fiscal year equal to the applicable percentage determined under clause (iii) or (iv) for expenditures in the quarter for providing child health assistance or other health benefits coverage to a parent of a targeted low-income child.

“(iii) ENHANCED FMAP ONLY IN FISCAL YEAR 2010 FOR STATES WITH SIGNIFICANT CHILD OUTREACH OR THAT ACHIEVE CHILD COVERAGE BENCHMARKS; FMAP FOR ANY OTHER STATES.—For purposes of clause (ii), the applicable percentage for any quarter of fiscal year 2010 is equal to—

“(I) the enhanced FMAP determined under section 2105(b) in the case of a State that meets the outreach or coverage benchmarks described in any of subparagraphs (A), (B), or (C) of paragraph (3) for fiscal year 2009; or

“(II) the Federal medical assistance percentage (as determined under section 1905(b) without regard to clause (4) of such section) in the case of any other State.

“(iv) AMOUNT OF FEDERAL MATCHING PAYMENT IN 2011 OR 2012.—For purposes of clause (ii), the applicable percentage for any quarter of fiscal year 2011 or 2012 is equal to—

“(I) the REMAP percentage if—

“(aa) the applicable percentage for the State under clause (iii) was the enhanced FMAP for fiscal year 2009; and

“(bb) the State met either of the coverage benchmarks described in subparagraph (B) or (C) of paragraph (3) for the preceding fiscal year; or

“(II) the Federal medical assistance percentage (as so determined) in the case of any State to which subclause (I) does not apply.

For purposes of subclause (I), the REMAP percentage is the percentage which is the sum of such Federal medical assistance percentage and a number of percentage points equal to one-half of the difference between such Federal medical assistance percentage and such enhanced FMAP.

“(v) NO FEDERAL PAYMENTS OTHER THAN FROM BLOCK GRANT SET ASIDE.—No payments shall be made to a State for expenditures described in clause (ii) after the total amount set aside under clause (i) for a fiscal year has been paid to the State.

“(vi) NO INCREASE IN INCOME ELIGIBILITY LEVEL FOR PARENTS.—No payments shall be made to a State from the amount set aside under clause (i) for a fiscal year for expenditures for providing child health assistance or health benefits coverage to a parent of a targeted low-income child whose family income exceeds the income eligibility level applied under the applicable existing waiver to parents of targeted low-income children on the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2007.

“(3) OUTREACH OR COVERAGE BENCHMARKS.—For purposes of paragraph (2), the outreach or coverage benchmarks described in this paragraph are as follows:

“(A) SIGNIFICANT CHILD OUTREACH CAMPAIGN.—The State—

“(i) was awarded a grant under section 2113 for fiscal year 2009;

“(ii) implemented 1 or more of the process measures described in section 2104(j)(3)(A)(i) for such fiscal year; or

“(iii) has submitted a specific plan for outreach for such fiscal year.

“(B) HIGH-PERFORMING STATE.—The State, on the basis of the most timely and accurate published estimates of the Bureau of the Census, ranks in the lowest 1/3 of States in terms of the State's percentage of low-income children without health insurance.

“(C) STATE INCREASING ENROLLMENT OF LOW-INCOME CHILDREN.—The State qualified for a payment from the Incentive Fund under clause (ii) or (iii) of paragraph (2)(C) of section 2104(j) for the most recent coverage period applicable under such section.

“(4) RULES OF CONSTRUCTION.—Nothing in this subsection shall be construed as prohibiting a State from submitting an application to the Secretary for a waiver under section 1115 of the State plan under title XIX to provide medical assistance to a parent of a targeted low-income child that was provided child health assistance or health benefits coverage under an applicable existing waiver.

“(C) APPLICABLE EXISTING WAIVER.—For purposes of this section—

“(1) IN GENERAL.—The term ‘applicable existing waiver’ means a waiver, experimental, pilot, or demonstration project under section 1115, grandfathered under section 6102(c)(3) of the Deficit Reduction Act of 2005, or otherwise conducted under authority that—

“(A) would allow funds made available under this title to be used to provide child health assistance or other health benefits coverage to—

“(i) a parent of a targeted low-income child;

“(ii) a nonpregnant childless adult; or

“(iii) individuals described in both clauses (i) and (ii); and

“(B) was in effect during fiscal year 2007.

“(2) DEFINITIONS.—

“(A) PARENT.—The term ‘parent’ includes a caretaker relative (as such term is used in carrying out section 1931) and a legal guardian.

“(B) NONPREGNANT CHILDLESS ADULT.—The term ‘nonpregnant childless adult’ has the meaning given such term by section 2107(f).”

(2) CONFORMING AMENDMENTS.—

(A) Section 2107(f) (42 U.S.C. 1397gg(f)) is amended—

(i) by striking “, the Secretary” and inserting “.”;

(ii) by striking “.”;

(iii) by striking the second sentence; and

(iv) by adding at the end the following new paragraph:

“(2) The Secretary may not approve, extend, renew, or amend a waiver, experimental, pilot, or demonstration project with respect to a State after the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2007 that would waive or modify the requirements of section 2111.”

(B) Section 6102(c) of the Deficit Reduction Act of 2005 (Public Law 109-171; 120 Stat. 131) is amended by striking “Nothing” and inserting “Subject to section 2111 of the Social Security Act, as added by section 106(a)(1) of the Children's Health Insurance Program Reauthorization Act of 2007, nothing”.

(b) GAO STUDY AND REPORT.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study of whether—

(A) the coverage of a parent, a caretaker relative (as such term is used in carrying out section 1931), or a legal guardian of a targeted low-income child under a State health plan under title XXI of the Social Security Act increases the enrollment of, or the quality of care for, children, and

(B) such parents, relatives, and legal guardians who enroll in such a plan are more likely to enroll their children in such a plan or in a State plan under title XIX of such Act.

(2) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Comptroller General shall report the results of the study to the appropriate committees of Congress, including recommendations (if any) for changes in legislation.

SEC. 107. STATE OPTION TO COVER LOW-INCOME PREGNANT WOMEN UNDER CHIP THROUGH A STATE PLAN AMENDMENT.

(a) IN GENERAL.—Title XXI (42 U.S.C. 1397aa et seq.), as amended by section 106(a), is amended by adding at the end the following new section:

“SEC. 2112. OPTIONAL COVERAGE OF TARGETED LOW-INCOME PREGNANT WOMEN THROUGH A STATE PLAN AMENDMENT.

“(a) IN GENERAL.—Subject to the succeeding provisions of this section, a State may elect through an amendment to its State child health plan under section 2102 to provide pregnancy-related assistance under such plan for targeted low-income pregnant women.

“(b) CONDITIONS.—A State may only elect the option under subsection (a) if the following conditions are satisfied:

“(1) MEDICAID INCOME ELIGIBILITY LEVEL FOR PREGNANT WOMEN OF AT LEAST 185 PERCENT OF POVERTY.—The State has established an income eligibility level for pregnant women under subsection (a)(10)(A)(i)(III), (a)(10)(A)(i)(IV), or (1)(1)(A) of section 1902 that is at least 185 percent of the income official poverty line.

“(2) NO CHIP INCOME ELIGIBILITY LEVEL FOR PREGNANT WOMEN LOWER THAN THE STATE'S MEDICAID LEVEL.—The State does not apply an effective income level for pregnant women under the State plan amendment that is lower than the effective income level (expressed as a percent of the poverty line and considering applicable income disregards) specified under subsection (a)(10)(A)(i)(III), (a)(10)(A)(i)(IV), or (1)(1)(A) of section 1902, on the date of enactment of this paragraph to be eligible for medical assistance as a pregnant woman.

“(3) NO COVERAGE FOR HIGHER INCOME PREGNANT WOMEN WITHOUT COVERING LOWER INCOME PREGNANT WOMEN.—The State does not provide coverage for pregnant women with higher family income without covering pregnant women with a lower family income.

“(4) APPLICATION OF REQUIREMENTS FOR COVERAGE OF TARGETED LOW-INCOME CHILDREN.—The State provides pregnancy-related assistance for targeted low-income pregnant women in the same manner, and subject to the same requirements, as the State provides child health assistance for targeted low-income children under the State child health plan, and in addition to providing child health assistance for such women.

“(5) NO PREEXISTING CONDITION EXCLUSION OR WAITING PERIOD.—The State does not apply any exclusion of benefits for pregnancy-related assistance based on any preexisting condition or any waiting period (including any waiting period imposed to carry out section 2102(b)(3)(C)) for receipt of such assistance.

“(6) APPLICATION OF COST-SHARING PROTECTION.—The State provides pregnancy-related assistance to a targeted low-income woman consistent with the cost-sharing protections under section 2103(e) and applies the limitation on total annual aggregate cost sharing imposed under paragraph (3)(B) of such section to the family of such a woman.

“(c) OPTION TO PROVIDE PRESUMPTIVE ELIGIBILITY.—A State that elects the option under subsection (a) and satisfies the conditions described in subsection (b) may elect to apply section 1920 (relating to presumptive eligibility for pregnant women) to the State child health plan in the same manner as such section applies to the State plan under title XIX.

“(d) DEFINITIONS.—For purposes of this section:

“(1) PREGNANCY-RELATED ASSISTANCE.—The term ‘pregnancy-related assistance’ has the meaning given the term ‘child health assistance’ in section 2110(a) and includes any medical assistance that the State would provide for a pregnant woman under the State plan under title XIX during pregnancy and the period described in paragraph (2)(A).

“(2) TARGETED LOW-INCOME PREGNANT WOMAN.—The term ‘targeted low-income pregnant woman’ means a woman—

“(A) during pregnancy and through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends;

“(B) whose family income does not exceed the income eligibility level established under the State child health plan under this title for a targeted low-income child; and

“(C) who satisfies the requirements of paragraphs (1)(A), (1)(C), (2), and (3) of section 2110(b) in the same manner as a child applying for child health assistance would have to satisfy such requirements.

“(e) AUTOMATIC ENROLLMENT FOR CHILDREN BORN TO WOMEN RECEIVING PREGNANCY-RELATED ASSISTANCE.—If a child is born to a targeted low-income pregnant woman who was receiving pregnancy-related assistance under this section on the date of the child’s birth, the child shall be deemed to have applied for child health assistance under the State child health plan and to have been found eligible for such assistance under such plan or to have applied for medical assistance under title XIX and to have been found eligible for such assistance under such title, as appropriate, on the date of such birth and to remain eligible for such assistance until the child attains 1 year of age. During the period in which a child is deemed under the preceding sentence to be eligible for child health or medical assistance, the child health or medical assistance eligibility identification number of the mother shall also serve as the identification number of the child, and all claims shall be submitted and paid under such number (unless the State issues a separate identification number for the child before such period expires).

“(f) STATES PROVIDING ASSISTANCE THROUGH OTHER OPTIONS.—

“(1) CONTINUATION OF OTHER OPTIONS FOR PROVIDING ASSISTANCE.—The option to provide assistance in accordance with the preceding subsections of this section shall not limit any other option for a State to provide—

“(A) child health assistance through the application of sections 457.10, 457.350(b)(2), 457.622(c)(5), and 457.626(a)(3) of title 42, Code of Federal Regulations (as in effect after the final rule adopted by the Secretary and set forth at 67 Fed. Reg. 61956-61974 (October 2, 2002)), or

“(B) pregnancy-related services through the application of any waiver authority (as in effect on June 1, 2007).

“(2) CLARIFICATION OF AUTHORITY TO PROVIDE POSTPARTUM SERVICES.—Any State that provides child health assistance under any authority described in paragraph (1) may continue to provide such assistance, as well as postpartum services, through the end of the month in which the 60-day period (beginning on the last day of the pregnancy) ends, in the same manner as such assistance and postpartum services would be provided if provided under the State plan under title XIX, but only if the mother would otherwise satisfy the eligibility requirements that apply under the State child health plan (other than with respect to age) during such period.

“(3) NO INFERENCE.—Nothing in this subsection shall be construed—

“(A) to infer congressional intent regarding the legality or illegality of the content of the sections specified in paragraph (1)(A); or

“(B) to modify the authority to provide pregnancy-related services under a waiver specified in paragraph (1)(B).”.

(b) ADDITIONAL CONFORMING AMENDMENTS.—

(1) NO COST SHARING FOR PREGNANCY-RELATED BENEFITS.—Section 2103(e)(2) (42 U.S.C. 1397cc(e)(2)) is amended—

(A) in the heading, by inserting “OR PREGNANCY-RELATED ASSISTANCE” after “PREVENTIVE SERVICES”; and

(B) by inserting before the period at the end the following: “or for pregnancy-related assistance”.

(2) NO WAITING PERIOD.—Section 2102(b)(1)(B) (42 U.S.C. 1397bb(b)(1)(B)) is amended—

(A) in clause (i), by striking “, and” at the end and inserting a semicolon;

(B) in clause (ii), by striking the period at the end and inserting “; and”; and

(C) by adding at the end the following new clause:

“(iii) may not apply a waiting period (including a waiting period to carry out paragraph (3)(C)) in the case of a targeted low-income pregnant woman provided pregnancy-related assistance under section 2112.”.

SEC. 108. CHIP CONTINGENCY FUND.

Section 2104 (42 U.S.C. 1397dd), as amended by section 105, is amended by adding at the end the following new subsection:

“(k) CHIP CONTINGENCY FUND.—

“(1) ESTABLISHMENT.—There is hereby established in the Treasury of the United States a fund which shall be known as the ‘CHIP Contingency Fund’ (in this subsection referred to as the ‘Fund’). Amounts in the Fund are authorized to be appropriated for payments under this subsection.

“(2) DEPOSITS INTO FUND.—

“(A) INITIAL AND SUBSEQUENT APPROPRIATIONS.—Subject to subparagraphs (B) and (E), out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated to the Fund—

“(i) for fiscal year 2009, an amount equal to 12.5 percent of the available national allotment under subsection (i)(1)(C) for the fiscal year; and

“(ii) for each of fiscal years 2010 through 2012, such sums as are necessary for making payments to eligible States for such fiscal year, but not in excess of the aggregate cap described in subparagraph (B).

“(B) AGGREGATE CAP.—Subject to subparagraph (E), the total amount available for payment from the Fund for each of fiscal years 2009 through 2012 (taking into account deposits made under subparagraph (C)), shall not exceed 12.5 percent of the available national allotment under subsection (i)(1)(C) for the fiscal year.

“(C) INVESTMENT OF FUND.—The Secretary of the Treasury shall invest, in interest bearing securities of the United States, such currently available portions of the Fund as are not immediately required for payments from the Fund. The income derived from these investments constitutes a part of the Fund.

“(D) TRANSFER OF EXCESS FUNDS TO THE INCENTIVE FUND.—The Secretary of the Treasury shall transfer to, and deposit in, the CHIP Incentive Bonuses Pool established under subsection (j) any amounts in excess of the aggregate cap described in subparagraph (B) for a fiscal year.

“(E) SPECIAL RULES FOR AMOUNTS SET ASIDE FOR PARENTS AND CHILDLESS ADULTS.—For purposes of subparagraphs (A) and (B)—

“(i) the available national allotment under subsection (i)(1)(C) shall be reduced by any amount set aside under section 2111(a)(3) for block grant payments for transitional coverage for childless adults; and

“(ii) the Secretary shall establish a separate account in the Fund for the portion of any amount appropriated to the Fund for any fiscal year which is allocable to the portion of the available national allotment under subsection (i)(1)(C) which is set aside for the fiscal year under section 2111(b)(2)(B)(i) for coverage of parents of low-income children.

The Secretary shall include in the account established under clause (ii) any income derived

under subparagraph (C) which is allocable to amounts in such account.

“(3) CHIP CONTINGENCY FUND PAYMENTS.—

“(A) PAYMENTS.—

“(i) IN GENERAL.—Subject to clauses (ii) and (iii) and the succeeding subparagraphs of this paragraph, the Secretary shall pay from the Fund to a State that is an eligible State for a month of a fiscal year a CHIP contingency fund payment equal to the Federal share of the shortfall determined under subparagraph (D). In the case of an eligible State under subparagraph (D)(i), the Secretary shall not make the payment under this subparagraph until the State makes, and submits to the Secretary, a projection of the amount of the shortfall.

“(ii) SEPARATE DETERMINATIONS OF SHORTFALLS.—The Secretary shall separately compute the shortfall under subparagraph (D) for expenditures for eligible individuals other than nonpregnant childless adults and parents with respect to whom amounts are set aside under section 2111, for expenditures for such childless adults, and for expenditures for such parents.

“(iii) PAYMENTS.—

“(I) NONPREGNANT CHILDLESS ADULTS.—No payments shall be made from the Fund for nonpregnant childless adults with respect to whom amounts are set aside under section 2111(a)(3).

“(II) PARENTS.—Any payments with respect to any shortfall for parents who are paid from amounts set aside under section 2111(b)(2)(B)(i) shall be made only from the account established under paragraph (2)(E)(ii) and not from any other amounts in the Fund. No other payments may be made from such account.

“(iv) SPECIAL RULES.—Subparagraphs (B) and (C) shall be applied separately with respect to shortfalls described in clause (ii).

“(B) USE OF FUNDS.—Amounts paid to an eligible State from the Fund shall be used only to eliminate the Federal share of a shortfall in the State’s allotment under subsection (i) for a fiscal year.

“(C) PRORATION RULE.—If the amounts available for payment from the Fund for a fiscal year are less than the total amount of payments determined under subparagraph (A) for the fiscal year, the amount to be paid under such subparagraph to each eligible State shall be reduced proportionally.

“(D) ELIGIBLE STATE.—

“(i) IN GENERAL.—A State is an eligible State for a month if the State is a subsection (b) State (as defined in subsection (i)(7)), the State requests access to the Fund for the month, and it is described in clause (ii) or (iii).

“(ii) SHORTFALL OF FEDERAL ALLOTMENT FUNDING OF NOT MORE THAN 5 PERCENT.—The Secretary estimates, on the basis of the most recent data available to the Secretary or requested from the State by the Secretary, that the State’s allotment for the fiscal year is at least 95 percent, but less than 100 percent, of the projected expenditures under the State child health plan for the State for the fiscal year determined under subsection (i) (without regard to incentive bonuses or payments for which the State is eligible for under subsection (j)(2) for the fiscal year).

“(iii) SHORTFALL OF FEDERAL ALLOTMENT FUNDING OF MORE THAN 5 PERCENT CAUSED BY SPECIFIC EVENTS.—The Secretary estimates, on the basis of the most recent data available to the Secretary or requested from the State by the Secretary, that the State’s allotment for the fiscal year is less than 95 percent of the projected expenditures under the State child health plan for the State for the fiscal year determined under subsection (i) (without regard to incentive bonuses or payments for which the State is eligible for under subsection (j)(2) for the fiscal year) and that such shortfall is attributable to 1 or more of the following events:

“(I) STAFFORD ACT OR PUBLIC HEALTH EMERGENCY.—The State has—

“(aa) 1 or more parishes or counties for which a major disaster has been declared in accordance with section 401 of the Robert T. Stafford

Disaster Relief and Emergency Assistance Act (42 U.S.C. 5170) and which the President has determined warrants individual and public assistance from the Federal Government under such Act; or

“(bb) a public health emergency declared by the Secretary under section 319 of the Public Health Service Act.

“(II) STATE ECONOMIC DOWNTURN.—The State unemployment rate is at least 5.5 percent during any 3-month period during the fiscal year and such rate is at least 120 percent of the State unemployment rate for the same period as averaged over the last 3 fiscal years.

“(III) EVENT RESULTING IN RISE IN PERCENTAGE OF LOW-INCOME CHILDREN WITHOUT HEALTH INSURANCE.—The State experienced a recent event that resulted in an increase in the percentage of low-income children in the State without health insurance (as determined on the basis of the most timely and accurate published estimates of the Bureau of the Census) that was outside the control of the State and warrants granting the State access to the Fund (as determined by the Secretary).

“(E) PAYMENTS MADE TO ALL ELIGIBLE STATES ON A MONTHLY BASIS; AUTHORITY FOR PRO RATA PAYMENTS.—The Secretary shall make monthly payments from the Fund to all States that are determined to be eligible States with respect to a month. If the sum of the payments to be made from the Fund for a month exceed the amount in the Fund, the Secretary shall reduce each such payment on a proportional basis.

“(F) PAYMENTS LIMITED TO FISCAL YEAR OF ELIGIBILITY DETERMINATION UNLESS NEW ELIGIBILITY BASIS DETERMINED.—No State shall receive a CHIP contingency fund payment under this section for a month beginning after September 30 of the fiscal year in which the State is determined to be an eligible State under this subsection, except that in the case of an event described in subclause (I) or (III) of subparagraph (D)(iii) that occurred after July 1 of the fiscal year, any such payment with respect to such event shall remain available until September 30 of the subsequent fiscal year. Nothing in the preceding sentence shall be construed as prohibiting a State from being determined to be an eligible State under this subsection for any fiscal year occurring after a fiscal year in which such a determination is made.

“(G) EXEMPTION FROM DETERMINATION OF PERCENTAGE OF ALLOTMENT RETAINED AFTER FIRST YEAR OF AVAILABILITY.—In no event shall payments made to a State under this subsection be treated as part of the allotment determined for a State for a fiscal year under subsection (i) for purposes of subsection (j)(1)(B)(ii)(III).

“(H) APPLICATION OF ALLOTMENT REPORTING RULES.—Rules applicable to States for purposes of receiving payments from an allotment determined under subsection (c) or (i) shall apply in the same manner to an eligible State for purposes of receiving a CHIP contingency fund payment under this subsection.

“(4) ANNUAL REPORTS.—The Secretary shall annually report to the Congress on the amounts in the Fund, the specific events that caused States to apply for payments from the Fund, and the payments made from the Fund.”.

SEC. 109. TWO-YEAR AVAILABILITY OF ALLOTMENTS; EXPENDITURES COUNTED AGAINST OLDEST ALLOTMENTS.

Section 2104(e) (42 U.S.C. 1397dd(e)) is amended to read as follows:

“(e) AVAILABILITY OF AMOUNTS ALLOTTED.—

“(1) IN GENERAL.—Except as provided in subsection (j)(1)(B)(ii)(III), amounts allotted to a State pursuant to this section—

“(A) for each of fiscal years 1998 through 2006, shall remain available for expenditure by the State through the end of the second succeeding fiscal year; and

“(B) for each of fiscal years 2007 through 2012, shall remain available for expenditure by the State only through the end of the succeeding fiscal year for which such amounts are allotted.

“(2) INCENTIVE BONUSES.—Incentive bonuses paid to a State under subsection (j)(2) for a fiscal year shall remain available for expenditure by the State without limitation.

“(3) CHIP CONTINGENCY FUND PAYMENTS.—Except as provided in paragraph (3)(F) of subsection (k), CHIP Contingency Fund payments made to a State under such subsection for a month of a fiscal year shall remain available for expenditure by the State through the end of the fiscal year.

“(4) RULE FOR COUNTING EXPENDITURES AGAINST CHIP CONTINGENCY FUND PAYMENTS, FISCAL YEAR ALLOTMENTS, AND INCENTIVE BONUSES.—

“(A) IN GENERAL.—Expenditures under the State child health plan made on or after October 1, 2007, shall be counted against—

“(i) first, any CHIP Contingency Fund payment made to the State under subsection (k) for the earliest month of the earliest fiscal year for which the payment remains available for expenditure; and

“(ii) second, amounts allotted to the State for the earliest fiscal year for which amounts remain available for expenditure.

“(B) INCENTIVE BONUSES.—A State may elect, but is not required, to count expenditures under the State child health plan against any incentive bonuses paid to the State under subsection (j)(2) for a fiscal year.

“(C) BLOCK GRANT SET-ASIDES.—Expenditures for coverage of—

“(i) nonpregnant childless adults for fiscal year 2009 shall be counted only against the amount set aside for such coverage under section 2111(a)(3); and

“(ii) parents of targeted low-income children for each of fiscal years 2010 through 2012, shall be counted only against the amount set aside for such coverage under section 2111(b)(2)(B)(i).”.

SEC. 110. LIMITATION ON MATCHING RATE FOR STATES THAT PROPOSE TO COVER CHILDREN WITH EFFECTIVE FAMILY INCOME THAT EXCEEDS 300 PERCENT OF THE POVERTY LINE.

(a) FMAP APPLIED TO EXPENDITURES.—Section 2105(c) (42 U.S.C. 1397ee(c)) is amended by adding at the end the following new paragraph:

“(8) LIMITATION ON MATCHING RATE FOR EXPENDITURES FOR CHILD HEALTH ASSISTANCE PROVIDED TO CHILDREN WHOSE EFFECTIVE FAMILY INCOME EXCEEDS 300 PERCENT OF THE POVERTY LINE.—

“(A) FMAP APPLIED TO EXPENDITURES.—Except as provided in subparagraph (B), for fiscal years beginning with fiscal year 2008, the Federal medical assistance percentage (as determined under section 1905(b) without regard to clause (4) of such section) shall be substituted for the enhanced FMAP under subsection (a)(1) with respect to any expenditures for providing child health assistance or health benefits coverage for a targeted low-income child whose effective family income would exceed 300 percent of the poverty line but for the application of a general exclusion of a block of income that is not determined by type of expense or type of income.

“(B) EXCEPTION.—Subparagraph (A) shall not apply to any State that, on the date of enactment of the Children’s Health Insurance Program Reauthorization Act of 2007, has an approved State plan amendment or waiver to provide, or has enacted a State law to submit a State plan amendment to provide, expenditures described in such subparagraph under the State child health plan.”.

(b) CONFORMING AMENDMENT.—Section 2105(a)(1) (42 U.S.C. 1397dd(a)(1)) is amended, in the matter preceding subparagraph (A), by inserting “or subsection (c)(8)” after “subparagraph (B)”.

SEC. 111. OPTION FOR QUALIFYING STATES TO RECEIVE THE ENHANCED PORTION OF THE CHIP MATCHING RATE FOR MEDICAID COVERAGE OF CERTAIN CHILDREN.

Section 2105(g) (42 U.S.C. 1397ee(g)) is amended—

(1) in paragraph (1)(A), by inserting “subject to paragraph (4),” after “Notwithstanding any other provision of law;” and

(2) by adding at the end the following new paragraph:

“(4) OPTION FOR ALLOTMENTS FOR FISCAL YEARS 2008 THROUGH 2012.—

“(A) PAYMENT OF ENHANCED PORTION OF MATCHING RATE FOR CERTAIN EXPENDITURES.—In the case of expenditures described in subparagraph (B), a qualifying State (as defined in paragraph (2)) may elect to be paid from the State’s allotment made under section 2104 for any of fiscal years 2008 through 2012 (insofar as the allotment is available to the State under subsections (e) and (i) of such section) an amount each quarter equal to the additional amount that would have been paid to the State under title XIX with respect to such expenditures if the enhanced FMAP (as determined under subsection (b)) had been substituted for the Federal medical assistance percentage (as defined in section 1905(b)).

“(B) EXPENDITURES DESCRIBED.—For purposes of subparagraph (A), the expenditures described in this subparagraph are expenditures made after the date of the enactment of this paragraph and during the period in which funds are available to the qualifying State for use under subparagraph (A), for the provision of medical assistance to individuals residing in the State who are eligible for medical assistance under the State plan under title XIX or under a waiver of such plan and who have not attained age 19 (or, if a State has so elected under the State plan under title XIX, age 20 or 21), and whose family income equals or exceeds 133 percent of the poverty line but does not exceed the Medicaid applicable income level.”.

TITLE II—OUTREACH AND ENROLLMENT

SEC. 201. GRANTS FOR OUTREACH AND ENROLLMENT.

(a) GRANTS.—Title XXI (42 U.S.C. 1397aa et seq.), as amended by section 107, is amended by adding at the end the following:

“SEC. 2113. GRANTS TO IMPROVE OUTREACH AND ENROLLMENT.

“(a) OUTREACH AND ENROLLMENT GRANTS; NATIONAL CAMPAIGN.—

“(1) IN GENERAL.—From the amounts appropriated under subsection (g), subject to paragraph (2), the Secretary shall award grants to eligible entities during the period of fiscal years 2008 through 2012 to conduct outreach and enrollment efforts that are designed to increase the enrollment and participation of eligible children under this title and title XIX.

“(2) TEN PERCENT SET ASIDE FOR NATIONAL ENROLLMENT CAMPAIGN.—An amount equal to 10 percent of such amounts shall be used by the Secretary for expenditures during such period to carry out a national enrollment campaign in accordance with subsection (h).

“(b) PRIORITY FOR AWARD OF GRANTS.—

“(1) IN GENERAL.—In awarding grants under subsection (a), the Secretary shall give priority to eligible entities that—

“(A) propose to target geographic areas with high rates of—

“(i) eligible but unenrolled children, including such children who reside in rural areas; or

“(ii) racial and ethnic minorities and health disparity populations, including those proposals that address cultural and linguistic barriers to enrollment; and

“(B) submit the most demonstrable evidence required under paragraphs (1) and (2) of subsection (c).

“(2) TEN PERCENT SET ASIDE FOR OUTREACH TO INDIAN CHILDREN.—An amount equal to 10 percent of the funds appropriated under subsection (g) shall be used by the Secretary to award grants to Indian Health Service providers and urban Indian organizations receiving funds under title V of the Indian Health Care Improvement Act (25 U.S.C. 1651 et seq.) for outreach to, and enrollment of, children who are Indians.

“(c) APPLICATION.—An eligible entity that desires to receive a grant under subsection (a) shall submit an application to the Secretary in such form and manner, and containing such information, as the Secretary may decide. Such application shall include—

“(1) evidence demonstrating that the entity includes members who have access to, and credibility with, ethnic or low-income populations in the communities in which activities funded under the grant are to be conducted;

“(2) evidence demonstrating that the entity has the ability to address barriers to enrollment, such as lack of awareness of eligibility, stigma concerns and punitive fears associated with receipt of benefits, and other cultural barriers to applying for and receiving child health assistance or medical assistance;

“(3) specific quality or outcomes performance measures to evaluate the effectiveness of activities funded by a grant awarded under this section; and

“(4) an assurance that the eligible entity shall—

“(A) conduct an assessment of the effectiveness of such activities against the performance measures;

“(B) cooperate with the collection and reporting of enrollment data and other information in order for the Secretary to conduct such assessments; and

“(C) in the case of an eligible entity that is not the State, provide the State with enrollment data and other information as necessary for the State to make necessary projections of eligible children and pregnant women.

“(d) DISSEMINATION OF ENROLLMENT DATA AND INFORMATION DETERMINED FROM EFFECTIVENESS ASSESSMENTS; ANNUAL REPORT.—The Secretary shall—

“(1) make publicly available the enrollment data and information collected and reported in accordance with subsection (c)(4)(B); and

“(2) submit an annual report to Congress on the outreach and enrollment activities conducted with funds appropriated under this section.

“(e) MAINTENANCE OF EFFORT FOR STATES AWARDED GRANTS; NO STATE MATCH REQUIRED.—In the case of a State that is awarded a grant under this section—

“(1) the State share of funds expended for outreach and enrollment activities under the State child health plan shall not be less than the State share of such funds expended in the fiscal year preceding the first fiscal year for which the grant is awarded; and

“(2) no State matching funds shall be required for the State to receive a grant under this section.

“(f) DEFINITIONS.—In this section:

“(1) ELIGIBLE ENTITY.—The term ‘eligible entity’ means any of the following:

“(A) A State with an approved child health plan under this title.

“(B) A local government.

“(C) An Indian tribe or tribal consortium, a tribal organization, an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act (25 U.S.C. 1651 et seq.), or an Indian Health Service provider.

“(D) A Federal health safety net organization.

“(E) A national, State, local, or community-based public or nonprofit private organization, including organizations that use community health workers or community-based doula programs.

“(F) A faith-based organization or consortia, to the extent that a grant awarded to such an entity is consistent with the requirements of section 1955 of the Public Health Service Act (42 U.S.C. 300z-65) relating to a grant award to nongovernmental entities.

“(G) An elementary or secondary school.

“(2) FEDERAL HEALTH SAFETY NET ORGANIZATION.—The term ‘Federal health safety net organization’ means—

“(A) a Federally-qualified health center (as defined in section 1905(l)(2)(B));

“(B) a hospital defined as a disproportionate share hospital for purposes of section 1923;

“(C) a covered entity described in section 340B(a)(4) of the Public Health Service Act (42 U.S.C. 256b(a)(4)); and

“(D) any other entity or consortium that serves children under a federally funded program, including the special supplemental nutrition program for women, infants, and children (WIC) established under section 17 of the Child Nutrition Act of 1966 (42 U.S.C. 1786), the Head Start and Early Head Start programs under the Head Start Act (42 U.S.C. 9801 et seq.), the school lunch program established under the Richard B. Russell National School Lunch Act, and an elementary or secondary school.

“(3) INDIANS; INDIAN TRIBE; TRIBAL ORGANIZATION; URBAN INDIAN ORGANIZATION.—The terms ‘Indian’, ‘Indian tribe’, ‘tribal organization’, and ‘urban Indian organization’ have the meanings given such terms in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

“(4) COMMUNITY HEALTH WORKER.—The term ‘community health worker’ means an individual who promotes health or nutrition within the community in which the individual resides—

“(A) by serving as a liaison between communities and health care agencies;

“(B) by providing guidance and social assistance to community residents;

“(C) by enhancing community residents’ ability to effectively communicate with health care providers;

“(D) by providing culturally and linguistically appropriate health or nutrition education;

“(E) by advocating for individual and community health or nutrition needs; and

“(F) by providing referral and followup services.

“(g) APPROPRIATION.—There is appropriated, out of any money in the Treasury not otherwise appropriated, \$100,000,000 for the period of fiscal years 2008 through 2012, to remain available until expended, for the purpose of awarding grants under this section. Amounts appropriated and paid under the authority of this section shall be in addition to amounts appropriated under section 2104 and paid to States in accordance with section 2105, including with respect to expenditures for outreach activities in accordance with subsections (a)(1)(D)(ii) and (c)(2)(C) of that section.

“(h) NATIONAL ENROLLMENT CAMPAIGN.—From the amounts made available under subsection (a)(2), the Secretary shall develop and implement a national enrollment campaign to improve the enrollment of underserved child populations in the programs established under this title and title XIX. Such campaign may include—

“(1) the establishment of partnerships with the Secretary of Education and the Secretary of Agriculture to develop national campaigns to link the eligibility and enrollment systems for the assistance programs each Secretary administers that often serve the same children;

“(2) the integration of information about the programs established under this title and title XIX in public health awareness campaigns administered by the Secretary;

“(3) increased financial and technical support for enrollment hotlines maintained by the Secretary to ensure that all States participate in such hotlines;

“(4) the establishment of joint public awareness outreach initiatives with the Secretary of Education and the Secretary of Labor regarding the importance of health insurance to building strong communities and the economy;

“(5) the development of special outreach materials for Native Americans or for individuals with limited English proficiency; and

“(6) such other outreach initiatives as the Secretary determines would increase public

awareness of the programs under this title and title XIX.”.

(b) ENHANCED ADMINISTRATIVE FUNDING FOR TRANSLATION OR INTERPRETATION SERVICES UNDER CHIP.—Section 2105(a)(1) (42 U.S.C. 1397ee(a)(1)), as amended by section 603, is amended—

(1) in the matter preceding subparagraph (A), by inserting “(or, in the case of expenditures described in subparagraph (D)(iv), the higher of 75 percent or the sum of the enhanced FMAP plus 5 percentage points)” after “enhanced FMAP”; and

(2) in subparagraph (D)—

(A) in clause (iii), by striking “and” at the end;

(B) by redesignating clause (iv) as clause (v); and

(C) by inserting after clause (iii) the following new clause:

“(iv) for translation or interpretation services in connection with the enrollment and use of services under this title by individuals for whom English is not their primary language (as found necessary by the Secretary for the proper and efficient administration of the State plan); and”.

(c) NONAPPLICATION OF ADMINISTRATIVE EXPENDITURES CAP.—Section 2105(c)(2) (42 U.S.C. 1397ee(c)(2)) is amended by adding at the end the following:

“(C) NONAPPLICATION TO CERTAIN EXPENDITURES.—The limitation under subparagraph (A) shall not apply with respect to the following expenditures:

“(i) EXPENDITURES FUNDED UNDER SECTION 2113.—Expenditures for outreach and enrollment activities funded under a grant awarded to the State under section 2113.”.

SEC. 202. INCREASED OUTREACH AND ENROLLMENT OF INDIANS.

(a) IN GENERAL.—Section 1139 (42 U.S.C. 1320b-9) is amended to read as follows:

“**SEC. 1139. IMPROVED ACCESS TO, AND DELIVERY OF, HEALTH CARE FOR INDIANS UNDER TITLES XIX AND XXI.**

“(a) AGREEMENTS WITH STATES FOR MEDICAID AND CHIP OUTREACH ON OR NEAR RESERVATIONS TO INCREASE THE ENROLLMENT OF INDIANS IN THOSE PROGRAMS.—

“(1) IN GENERAL.—In order to improve the access of Indians residing on or near a reservation to obtain benefits under the Medicaid and State children’s health insurance programs established under titles XIX and XXI, the Secretary shall encourage the State to take steps to provide for enrollment on or near the reservation. Such steps may include outreach efforts such as the outstationing of eligibility workers, entering into agreements with the Indian Health Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations to provide outreach, education regarding eligibility and benefits, enrollment, and translation services when such services are appropriate.

“(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed as affecting arrangements entered into between States and the Indian Health Service, Indian Tribes, Tribal Organizations, or Urban Indian Organizations for such Service, Tribes, or Organizations to conduct administrative activities under such titles.

“(b) REQUIREMENT TO FACILITATE COOPERATION.—The Secretary, acting through the Centers for Medicare & Medicaid Services, shall take such steps as are necessary to facilitate cooperation with, and agreements between, States and the Indian Health Service, Indian Tribes, Tribal Organizations, or Urban Indian Organizations with respect to the provision of health care items and services to Indians under the programs established under title XIX or XXI.

“(c) DEFINITION OF INDIAN; INDIAN TRIBE; INDIAN HEALTH PROGRAM; TRIBAL ORGANIZATION; URBAN INDIAN ORGANIZATION.—In this section, the terms ‘Indian’, ‘Indian Tribe’, ‘Indian Health Program’, ‘Tribal Organization’, and ‘Urban Indian Organization’ have the meanings

given those terms in section 4 of the Indian Health Care Improvement Act.”.

(b) NONAPPLICATION OF 10 PERCENT LIMIT ON OUTREACH AND CERTAIN OTHER EXPENDITURES.—Section 2105(c)(2)(C) (42 U.S.C. 1397ee(c)(2)(C)), as added by section 201(c), is amended by adding at the end the following new clause:

“(ii) EXPENDITURES TO INCREASE OUTREACH TO, AND THE ENROLLMENT OF, INDIAN CHILDREN UNDER THIS TITLE AND TITLE XIX.—Expenditures for outreach activities to families of Indian children likely to be eligible for child health assistance under the plan or medical assistance under the State plan under title XIX (or under a waiver of such plan), to inform such families of the availability of, and to assist them in enrolling their children in, such plans, including such activities conducted under grants, contracts, or agreements entered into under section 1139(a).”.

SEC. 203. DEMONSTRATION PROGRAM TO PERMIT STATES TO RELY ON FINDINGS BY AN EXPRESS LANE AGENCY TO DETERMINE COMPONENTS OF A CHILD'S ELIGIBILITY FOR MEDICAID OR CHIP.

(a) REQUIREMENT TO CONDUCT DEMONSTRATION PROGRAM.—

(1) IN GENERAL.—The Secretary shall establish a 3-year demonstration program under which up to 10 States shall be authorized to rely on a finding made within the preceding 12 months by an Express Lane agency to determine whether a child has met 1 or more of the eligibility requirements, such as income, assets or resources, citizenship status, or other criteria, necessary to determine the child's initial eligibility, eligibility redetermination, or renewal of eligibility, for medical assistance under the State Medicaid plan or child health assistance under the State CHIP plan. A State selected to participate in the demonstration program—

(A) shall not be required to direct a child (or a child's family) to submit information or documentation previously submitted by the child or family to an Express Lane agency that the State relies on for its Medicaid or CHIP eligibility determination; and

(B) may rely on information from an Express Lane agency when evaluating a child's eligibility for medical assistance under the State Medicaid plan or child health assistance under the State CHIP plan without a separate, independent confirmation of the information at the time of enrollment, redetermination, or renewal.

(2) PAYMENTS TO STATES.—From the amount appropriated under paragraph (1) of subsection (f), after the application of paragraph (2) of that subsection, the Secretary shall pay the States selected to participate in the demonstration program such sums as the Secretary shall determine for expenditures made by the State for systems upgrades and implementation of the demonstration program. In no event shall a payment be made to a State from the amount appropriated under subsection (f) for any expenditures incurred for providing medical assistance or child health assistance to a child enrolled in the State Medicaid plan or the State CHIP plan through reliance on a finding made by an Express Lane agency.

(b) REQUIREMENTS; OPTIONS FOR APPLICATION.—

(1) STATE REQUIREMENTS.—A State selected to participate in the demonstration program established under this section may rely on a finding of an Express Lane agency only if the following conditions are met:

(A) REQUIREMENT TO DETERMINE ELIGIBILITY USING REGULAR PROCEDURES IF CHILD IS FIRST FOUND INELIGIBLE.—If reliance on a finding from an Express Lane agency results in a child not being found eligible for the State Medicaid plan or the State CHIP plan, the State would be required to determine eligibility under such plan using its regular procedures.

(B) NOTICE.—The State shall inform the families (especially those whose children are enrolled

in the State CHIP plan) that they may qualify for lower premium payments or more comprehensive health coverage under the State Medicaid plan if the family's income were directly evaluated for an eligibility determination by the State Medicaid agency, and that, at the family's option, the family may seek an eligibility determination by the State Medicaid agency.

(C) COMPLIANCE WITH DEPARTMENT OF HOMELAND SECURITY PROCEDURES.—The State may rely on an Express Lane agency finding that a child is a qualified alien as long as the Express Lane agency complies with guidance and regulatory procedures issued by the Secretary of Homeland Security for eligibility determinations of qualified aliens (as defined in subsections (b) and (c) of section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641)).

(D) VERIFICATION OF CITIZENSHIP OR NATIONALITY STATUS.—The State shall satisfy the requirements of section 1902(a)(46)(B) or 2105(c)(9) of the Social Security Act, as applicable (and as added by section 301 of this Act) for verifications of citizenship or nationality status.

(E) CODING; APPLICATION TO ENROLLMENT ERROR RATES.—

(i) IN GENERAL.—The State agrees to—

(I) assign such codes as the Secretary shall require to the children who are enrolled in the State Medicaid plan or the State CHIP plan through reliance on a finding made by an Express Lane agency for the duration of the State's participation in the demonstration program;

(II) annually provide the Secretary with a statistically valid sample (that is approved by Secretary) of the children enrolled in such plans through reliance on such a finding by conducting a full Medicaid eligibility review of the children identified for such sample for purposes of determining an eligibility error rate with respect to the enrollment of such children;

(III) submit the error rate determined under subclause (II) to the Secretary;

(IV) if such error rate exceeds 3 percent for either of the first 2 fiscal years in which the State participates in the demonstration program, demonstrate to the satisfaction of the Secretary the specific corrective actions implemented by the State to improve upon such error rate; and

(V) if such error rate exceeds 3 percent for any fiscal year in which the State participates in the demonstration program, a reduction in the amount otherwise payable to the State under section 1903(a) of the Social Security Act (42 Secretary 1396b(a)) for quarters for that fiscal year, equal to the total amount of erroneous excess payments determined for the fiscal year only with respect to the children included in the sample for the fiscal year that are in excess of a 3 percent error rate with respect to such children.

(ii) NO PUNITIVE ACTION BASED ON ERROR RATE.—The Secretary shall not apply the error rate derived from the sample under clause (i) to the entire population of children enrolled in the State Medicaid plan or the State CHIP plan through reliance on a finding made by an Express Lane agency, or to the population of children enrolled in such plans on the basis of the State's regular procedures for determining eligibility, or penalize the State on the basis of such error rate in any manner other than the reduction of payments provided for under clause (i)(V).

(iii) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as relieving a State that participates in the demonstration program established under this section from being subject to a penalty under section 1903(u) of the Social Security Act (42 U.S.C. 1396b(u)) for payments made under the State Medicaid plan with respect to ineligible individuals and families that are determined to exceed the error rate permitted under that section (as determined without regard to the error rate determined under clause (i)(II)).

(2) STATE OPTIONS FOR APPLICATION.—A State selected to participate in the demonstration program may elect to apply any of the following:

(A) SATISFACTION OF CHIP SCREEN AND ENROLL REQUIREMENTS.—If the State relies on a finding of an Express Lane agency for purposes of determining eligibility under the State CHIP plan, the State may meet the screen and enroll requirements imposed under subparagraphs (A) and (B) of section 2102(b)(3) of the Social Security Act (42 U.S.C. 1397bb(b)(3)) by using any of the following:

(i) Establishing a threshold percentage of the poverty line that is 30 percentage points (or such other higher number of percentage points) as the State determines reflects the income methodologies of the program administered by the Express Lane Agency and the State Medicaid plan.

(ii) Providing that a child satisfies all income requirements for eligibility under the State Medicaid plan.

(iii) Providing that a child has a family income that exceeds the Medicaid applicable income level.

(B) PRESUMPTIVE ELIGIBILITY.—The State may provide for presumptive eligibility under the State CHIP plan for a child who, based on an eligibility determination of an income finding from an Express Lane agency, would qualify for child health assistance under the State CHIP plan. During the period of presumptive eligibility, the State may determine the child's eligibility for child health assistance under the State CHIP plan based on telephone contact with family members, access to data available in electronic or paper format, or other means that minimize to the maximum extent feasible the burden on the family.

(C) AUTOMATIC ENROLLMENT.—

(i) IN GENERAL.—The State may initiate and determine eligibility for medical assistance under the State Medicaid plan or for child health assistance under the State CHIP plan without a program application from, or on behalf of, the child based on data obtained from sources other than the child (or the child's family), but a child can only be automatically enrolled in the State Medicaid plan or the State CHIP plan if the child or the family affirmatively consents to being enrolled through affirmation and signature on an Express Lane agency application.

(ii) INFORMATION REQUIREMENT.—A State that elects the option under clause (i) shall have procedures in place to inform the child or the child's family of the services that will be covered under the State Medicaid plan or the State CHIP plan (as applicable), appropriate methods for using such services, premium or other cost sharing charges (if any) that apply, medical support obligations created by the enrollment (if applicable), and the actions the child or the child's family must take to maintain enrollment and renew coverage.

(iii) OPTION TO WAIVE SIGNATURES.—The State may waive any signature requirements for enrollment for a child who consents to, or on whose behalf consent is provided for, enrollment in the State Medicaid plan or the State CHIP plan.

(3) SIGNATURE REQUIREMENTS.—In the case of a State selected to participate in the demonstration program—

(A) no signature under penalty of perjury shall be required on an application form for medical assistance under the State Medicaid plan or child health assistance under the State CHIP plan to attest to any element of the application for which eligibility is based on information received from an Express Lane agency or a source other than an applicant; and

(B) any signature requirement for determination of an application for medical assistance under the State Medicaid plan or child health assistance under the State CHIP plan may be satisfied through an electronic signature.

(4) **RULES OF CONSTRUCTION.**—Nothing in this subsection shall be construed to—

(A) relieve a State of the obligation under section 1902(a)(5) of the Social Security Act (42 U.S.C. 1396a(a)(5)) to determine eligibility for medical assistance under the State Medicaid plan; or

(B) prohibit any State options otherwise permitted under Federal law (without regard to this paragraph or the demonstration program established under this section) that are intended to increase the enrollment of eligible children for medical assistance under the State Medicaid plan or child health assistance under the State CHIP plan, including options related to outreach, enrollment, applications, or the determination or redetermination of eligibility.

(c) **LIMITED WAIVER OF OTHER APPLICABLE REQUIREMENTS.**—

(1) **SOCIAL SECURITY ACT.**—The Secretary shall waive only such requirements of the Social Security Act as the Secretary determines are necessary to carry out the demonstration program established under this section.

(2) **AUTHORIZATION FOR PARTICIPATING STATES TO RECEIVE CERTAIN DATA DIRECTLY RELEVANT TO DETERMINING ELIGIBILITY AND CORRECT AMOUNT OF ASSISTANCE.**—For provisions relating to the authority of States participating in the demonstration program to receive certain data directly, see section 204(c).

(d) **EVALUATION AND REPORT.**—

(1) **EVALUATION.**—The Secretary shall conduct, by grant, contract, or interagency agreement, a comprehensive, independent evaluation of the demonstration program established under this section. Such evaluation shall include an analysis of the effectiveness of the program, and shall include—

(A) obtaining a statistically valid sample of the children who were enrolled in the State Medicaid plan or the State CHIP plan through reliance on a finding made by an Express Lane agency and determining the percentage of children who were erroneously enrolled in such plans;

(B) determining whether enrolling children in such plans through reliance on a finding made by an Express Lane agency improves the ability of a State to identify and enroll low-income, uninsured children who are eligible but not enrolled in such plans;

(C) evaluating the administrative costs or savings related to identifying and enrolling children in such plans through reliance on such findings, and the extent to which such costs differ from the costs that the State otherwise would have incurred to identify and enroll low-income, uninsured children who are eligible but not enrolled in such plans; and

(D) any recommendations for legislative or administrative changes that would improve the effectiveness of enrolling children in such plans through reliance on such findings.

(2) **REPORT TO CONGRESS.**—Not later than September 30, 2012, the Secretary shall submit a report to Congress on the results of the evaluation of the demonstration program established under this section.

(e) **DEFINITIONS.**—In this section:

(1) **CHILD; CHILDREN.**—With respect to a State selected to participate in the demonstration program established under this section, the terms “child” and “children” have the meanings given such terms for purposes of the State plans under titles XIX and XXI of the Social Security Act.

(2) **EXPRESS LANE AGENCY.**—

(A) **IN GENERAL.**—The term “Express Lane agency” means a public agency that—

(i) is determined by the State Medicaid agency or the State CHIP agency (as applicable) to be capable of making the determinations of 1 or more eligibility requirements described in subsection (a)(1);

(ii) is identified in the State Medicaid plan or the State CHIP plan; and

(iii) notifies the child’s family—

(I) of the information which shall be disclosed in accordance with this section;

(II) that the information disclosed will be used solely for purposes of determining eligibility for medical assistance under the State Medicaid plan or for child health assistance under the State CHIP plan; and

(III) that the family may elect to not have the information disclosed for such purposes; and

(iv) enters into, or is subject to, an interagency agreement to limit the disclosure and use of the information disclosed.

(B) **INCLUSION OF SPECIFIC PUBLIC AGENCIES.**—Such term includes the following:

(i) A public agency that determines eligibility for assistance under any of the following:

(I) The temporary assistance for needy families program funded under part A of title IV of the Social Security Act (42 U.S.C. 601 et seq.).

(II) A State program funded under part D of title IV of such Act (42 U.S.C. 651 et seq.).

(III) The State Medicaid plan.

(IV) The State CHIP plan.

(V) The Food Stamp Act of 1977 (7 U.S.C. 2011 et seq.).

(VI) The Head Start Act (42 U.S.C. 9801 et seq.).

(VII) The Richard B. Russell National School Lunch Act (42 U.S.C. 1751 et seq.).

(VIII) The Child Nutrition Act of 1966 (42 U.S.C. 1771 et seq.).

(IX) The Child Care and Development Block Grant Act of 1990 (42 U.S.C. 9858 et seq.).

(X) The Stewart B. McKinney Homeless Assistance Act (42 U.S.C. 11301 et seq.).

(XI) The United States Housing Act of 1937 (42 U.S.C. 1437 et seq.).

(XII) The Native American Housing Assistance and Self-Determination Act of 1996 (25 U.S.C. 4101 et seq.).

(ii) A State-specified governmental agency that has fiscal liability or legal responsibility for the accuracy of the eligibility determination findings relied on by the State.

(iii) A public agency that is subject to an interagency agreement limiting the disclosure and use of the information disclosed for purposes of determining eligibility under the State Medicaid plan or the State CHIP plan.

(C) **EXCLUSIONS.**—Such term does not include an agency that determines eligibility for a program established under the Social Services Block Grant established under title XX of the Social Security Act (42 U.S.C. 1397 et seq.) or a private, for-profit organization.

(D) **RULES OF CONSTRUCTION.**—Nothing in this paragraph shall be construed as—

(i) affecting the authority of a State Medicaid agency to enter into contracts with nonprofit and for-profit agencies to administer the Medicaid application process;

(ii) exempting a State Medicaid agency from complying with the requirements of section 1902(a)(4) of the Social Security Act (relating to merit-based personnel standards for employees of the State Medicaid agency and safeguards against conflicts of interest); or

(iii) authorizing a State Medicaid agency that participates in the demonstration program established under this section to use the Express Lane option to avoid complying with such requirements for purposes of making eligibility determinations under the State Medicaid plan.

(3) **MEDICAID APPLICABLE INCOME LEVEL.**—With respect to a State, the term “Medicaid applicable income level” has the meaning given that term for purposes of such State under section 2110(b)(4) of the Social Security Act (42 U.S.C. 1397jj(4)).

(4) **POVERTY LINE.**—The term “poverty line” has the meaning given that term in section

2110(c)(5) of the Social Security Act (42 U.S.C. 1397jj(c)(5)).

(5) **STATE.**—The term “State” means 1 of the 50 States or the District of Columbia.

(6) **STATE CHIP AGENCY.**—The term “State CHIP agency” means the State agency responsible for administering the State CHIP plan.

(7) **STATE CHIP PLAN.**—The term “State CHIP plan” means the State child health plan established under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.), and includes any waiver of such plan.

(8) **STATE MEDICAID AGENCY.**—The term “State Medicaid agency” means the State agency responsible for administering the State Medicaid plan.

(9) **STATE MEDICAID PLAN.**—The term “State Medicaid plan” means the State plan established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), and includes any waiver of such plan.

(f) **APPROPRIATION.**—

(1) **OPERATIONAL FUNDS.**—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary to carry out the demonstration program established under this section, \$49,000,000 for the period of fiscal years 2008 through 2012.

(2) **EVALUATION FUNDS.**—\$5,000,000 of the funds appropriated under paragraph (1) shall be used to conduct the evaluation required under subsection (d).

(3) **BUDGET AUTHORITY.**—Paragraph (1) constitutes budget authority in advance of appropriations Act and represents the obligation of the Federal Government to provide for the payment to States selected to participate in the demonstration program established under this section of the amounts provided under such paragraph (after the application of paragraph (2)).

SEC. 204. AUTHORIZATION OF CERTAIN INFORMATION DISCLOSURES TO SIMPLIFY HEALTH COVERAGE DETERMINATIONS.

(a) **AUTHORIZATION OF INFORMATION DISCLOSURE.**—Title XIX (42 U.S.C. 1396 et seq.) is amended—

(1) by redesignating section 1939 as section 1940; and

(2) by inserting after section 1938 the following new section:

“**AUTHORIZATION TO RECEIVE PERTINENT INFORMATION**

“**SEC. 1939. (a) IN GENERAL.**—Notwithstanding any other provision of law, a Federal or State agency or private entity in possession of the sources of data directly relevant to eligibility determinations under this title (including eligibility files, information described in paragraph (2) or (3) of section 1137(a), vital records information about births in any State, and information described in sections 453(i) and 1902(a)(25)(I)) is authorized to convey such data or information to the State agency administering the State plan under this title, but only if such conveyance meets the requirements of subsection (b).

“(b) **REQUIREMENTS FOR CONVEYANCE.**—Data or information may be conveyed pursuant to this section only if the following requirements are met:

“(1) The child whose circumstances are described in the data or information (or such child’s parent, guardian, caretaker relative, or authorized representative) has either provided advance consent to disclosure or has not objected to disclosure after receiving advance notice of disclosure and a reasonable opportunity to object.

“(2) Such data or information are used solely for the purposes of—

“(A) identifying children who are eligible or potentially eligible for medical assistance under this title and enrolling (or attempting to enroll) such children in the State plan; and

“(B) verifying the eligibility of children for medical assistance under the State plan.

“(3) An interagency or other agreement, consistent with standards developed by the Secretary—

“(A) prevents the unauthorized use, disclosure, or modification of such data and otherwise meets applicable Federal requirements for safeguarding privacy and data security; and

“(B) requires the State agency administering the State plan to use the data and information obtained under this section to seek to enroll children in the plan.

“(c) CRIMINAL PENALTY.—A person described in subsection (a) who publishes, divulges, discloses, or makes known in any manner, or to any extent, not authorized by Federal law, any information obtained under this section shall be fined not more than \$1,000 or imprisoned not more than 1 year, or both, for each such unauthorized activity.

“(d) RULE OF CONSTRUCTION.—The limitations and requirements that apply to disclosure pursuant to this section shall not be construed to prohibit the conveyance or disclosure of data or information otherwise permitted under Federal law (without regard to this section).”.

(b) CONFORMING AMENDMENT TO TITLE XXI.—Section 2107(e)(1) (42 U.S.C. 1397gg(e)(1)) is amended by adding at the end the following new subparagraph:

“(E) Section 1939 (relating to authorization to receive data directly relevant to eligibility determinations).”.

(c) AUTHORIZATION FOR STATES PARTICIPATING IN THE EXPRESS LANE DEMONSTRATION PROGRAM TO RECEIVE CERTAIN DATA DIRECTLY RELEVANT TO DETERMINING ELIGIBILITY AND CORRECT AMOUNT OF ASSISTANCE.—Only in the case of a State selected to participate in the Express Lane demonstration program established under section 203, the Secretary shall enter into such agreements as are necessary to permit such a State to receive data directly relevant to eligibility determinations and determining the correct amount of benefits under the State CHIP plan or the State Medicaid plan (as such terms are defined in paragraphs (7) and (9) section 203(e)) from the following:

(1) The National Directory of New Hires established under section 453(i) of the Social Security Act (42 U.S.C. 653(i)).

(2) Data regarding enrollment in insurance that may help to facilitate outreach and enrollment under the State Medicaid plan, the State CHIP plan, and such other programs as the Secretary may specify.

TITLE III—REDUCING BARRIERS TO ENROLLMENT

SEC. 301. VERIFICATION OF DECLARATION OF CITIZENSHIP OR NATIONALITY FOR PURPOSES OF ELIGIBILITY FOR MEDICAID AND CHIP.

(a) STATE OPTION TO VERIFY DECLARATION OF CITIZENSHIP OR NATIONALITY FOR PURPOSES OF ELIGIBILITY FOR MEDICAID THROUGH VERIFICATION OF NAME AND SOCIAL SECURITY NUMBER.—

(1) ALTERNATIVE TO DOCUMENTATION REQUIREMENT.—

(A) IN GENERAL.—Section 1902 (42 U.S.C. 1396a) is amended—

(i) in subsection (a)(46)—

(I) by inserting “(A)” after “(46)”;

(II) by adding “and” after the semicolon; and

(III) by adding at the end the following new subparagraph:

“(B) provide, with respect to an individual declaring to be a citizen or national of the United States for purposes of establishing eligibility under this title, that the State shall satisfy the requirements of—

“(i) section 1903(x); or

“(ii) subsection (dd);”;

(ii) by adding at the end the following new subsection:

“(dd)(1) For purposes of subsection (a)(46)(B)(ii), the requirements of this subsection with respect to an individual declaring to be a citizen or national of the United States for purposes of establishing eligibility under this title, are, in lieu of requiring the individual to present satisfactory documentary evidence of citizenship or nationality under section 1903(x) (if the individual is not described in paragraph (2) of that section), as follows:

“(A) The State submits the name and social security number of the individual to the Commissioner of Social Security as part of the plan established under paragraph (2).

“(B) If the State receives notice from the Commissioner of Social Security that the name or social security number of the individual is invalid, the State—

“(i) notifies the individual of such fact;

(ii) provides the individual with a period of 90 days from the date on which the notice required under clause (i) is received by the individual to either present satisfactory documentary evidence of citizenship or nationality (as defined in section 1903(x)(3)) or cure the invalid determination with the Commissioner of Social Security; and

“(iii) disenrolls the individual from the State plan under this title within 30 days after the end of such 90-day period if no such documentary evidence is presented.

“(2)(A) Each State electing to satisfy the requirements of this subsection for purposes of section 1902(a)(46)(B) shall establish a program under which the State submits each month to the Commissioner of Social Security for verification the name and social security number of each individual enrolled in the State plan under this title that month who has attained the age of 1 before the date of the enrollment.

“(B) In establishing the State program under this paragraph, the State may enter into an agreement with the Commissioner of Social Security to provide for the electronic submission and verification of the name and social security number of an individual before the individual is enrolled in the State plan.

“(3)(A) The State agency implementing the plan approved under this title shall, at such times and in such form as the Secretary may specify, provide information on the percentage each month that the invalid names and numbers submitted bears to the total submitted for verification.

“(B) If, for any fiscal year, the average monthly percentage determined under subparagraph (A) is greater than 7 percent—

“(i) the State shall develop and adopt a corrective plan to review its procedures for verifying the identities of individuals seeking to enroll in the State plan under this title and to identify and implement changes in such procedures to improve their accuracy; and

“(ii) pay to the Secretary an amount equal to the amount which bears the same ratio to the total payments under the State plan for the fiscal year for providing medical assistance to individuals who provided invalid information as the number of individuals with invalid information in excess of 7 percent of such total submitted bears to the total number of individuals with invalid information.

“(C) The Secretary may waive, in certain limited cases, all or part of the payment under subparagraph (B)(ii) if the State is unable to reach the allowable error rate despite a good faith effort by such State.

“(D) This paragraph shall not apply to a State for a fiscal year if there is an agreement described in paragraph (2)(B) in effect as of the close of the fiscal year.

“(4) Nothing in this subsection shall affect the rights of any individual under this title to appeal any disenrollment from a State plan.”.

(B) COSTS OF IMPLEMENTING AND MAINTAINING SYSTEM.—Section 1903(a)(3) (42 U.S.C. 1396b(a)(3)) is amended—

(i) by striking “plus” at the end of subparagraph (E) and inserting “and”, and

(ii) by adding at the end the following new subparagraph:

“(F)(i) 90 percent of the sums expended during the quarter as are attributable to the design, development, or installation of such mechanized verification and information retrieval systems as the Secretary determines are necessary to implement section 1902(dd) (including a system described in paragraph (2)(B) thereof), and

“(ii) 75 percent of the sums expended during the quarter as are attributable to the operation of systems to which clause (i) applies, plus”.

(2) LIMITATION ON WAIVER AUTHORITY.—Notwithstanding any provision of section 1115 of the Social Security Act (42 U.S.C. 1315), or any other provision of law, the Secretary may not waive the requirements of section 1902(a)(46)(B) of such Act (42 U.S.C. 1396a(a)(46)(B)) with respect to a State.

(3) CONFORMING AMENDMENTS.—Section 1903 (42 U.S.C. 1396b) is amended—

(A) in subsection (i)(22), by striking “subsection (x)” and inserting “section 1902(a)(46)(B)”; and

(B) in subsection (x)(1), by striking “subsection (i)(22)” and inserting “section 1902(a)(46)(B)(i)”.

(b) CLARIFICATION OF REQUIREMENTS RELATING TO PRESENTATION OF SATISFACTORY DOCUMENTARY EVIDENCE OF CITIZENSHIP OR NATIONALITY.—

(1) ACCEPTANCE OF DOCUMENTARY EVIDENCE ISSUED BY A FEDERALLY RECOGNIZED INDIAN TRIBE.—Section 1903(x)(3)(B) (42 U.S.C. 1396b(x)(3)(B)) is amended—

(A) by redesignating clause (v) as clause (vi); and

(B) by inserting after clause (iv), the following new clause:

“(v)(I) Except as provided in subclause (II), a document issued by a federally recognized Indian tribe evidencing membership or enrollment in, or affiliation with, such tribe (such as a tribal enrollment card or certificate of degree of Indian blood).

“(II) With respect to those federally recognized Indian tribes located within States having an international border whose membership includes individuals who are not citizens of the United States, the Secretary shall, after consulting with such tribes, issue regulations authorizing the presentation of such other forms of documentation (including tribal documentation, if appropriate) that the Secretary determines to be satisfactory documentary evidence of citizenship or nationality for purposes of satisfying the requirement of this subsection.”.

(2) REQUIREMENT TO PROVIDE REASONABLE OPPORTUNITY TO PRESENT SATISFACTORY DOCUMENTARY EVIDENCE.—Section 1903(x) (42 U.S.C. 1396b(x)) is amended by adding at the end the following new paragraph:

“(4) In the case of an individual declaring to be a citizen or national of the United States with respect to whom a State requires the presentation of satisfactory documentary evidence of citizenship or nationality under section 1902(a)(46)(B)(i), the individual shall be provided at least the reasonable opportunity to present satisfactory documentary evidence of citizenship or nationality under this subsection as is provided under clauses (i) and (ii) of

section 1137(d)(4)(A) to an individual for the submittal to the State of evidence indicating a satisfactory immigration status.”

(3) CHILDREN BORN IN THE UNITED STATES TO MOTHERS ELIGIBLE FOR MEDICAID.—

(A) CLARIFICATION OF RULES.—Section 1903(x) (42 U.S.C. 1396b(x)), as amended by paragraph (2), is amended—

(i) in paragraph (2)—

(I) in subparagraph (C), by striking “or” at the end;

(II) by redesignating subparagraph (D) as subparagraph (E); and

(III) by inserting after subparagraph (C) the following new subparagraph:

“(D) pursuant to the application of section 1902(e)(4) (and, in the case of an individual who is eligible for medical assistance on such basis, the individual shall be deemed to have provided satisfactory documentary evidence of citizenship or nationality and shall not be required to provide further documentary evidence on any date that occurs during or after the period in which the individual is eligible for medical assistance on such basis); or”;

(ii) by adding at the end the following new paragraph:

“(5) Nothing in subparagraph (A) or (B) of section 1902(a)(46), the preceding paragraphs of this subsection, or the Deficit Reduction Act of 2005, including section 6036 of such Act, shall be construed as changing the requirement of section 1902(e)(4) that a child born in the United States to an alien mother for whom medical assistance for the delivery of such child is available as treatment of an emergency medical condition pursuant to subsection (v) shall be deemed eligible for medical assistance during the first year of such child’s life.”

(B) STATE REQUIREMENT TO ISSUE SEPARATE IDENTIFICATION NUMBER.—Section 1902(e)(4) (42 U.S.C. 1396a(e)(4)) is amended by adding at the end the following new sentence: “Notwithstanding the preceding sentence, in the case of a child who is born in the United States to an alien mother for whom medical assistance for the delivery of the child is made available pursuant to section 1903(v), the State immediately shall issue a separate identification number for the child upon notification by the facility at which such delivery occurred of the child’s birth.”

(4) TECHNICAL AMENDMENTS.—Section 1903(x)(2) (42 U.S.C. 1396b(x)) is amended—

(A) in subparagraph (B)—

(i) by realigning the left margin of the matter preceding clause (i) 2 ems to the left; and

(ii) by realigning the left margins of clauses (i) and (ii), respectively, 2 ems to the left; and

(B) in subparagraph (C)—

(i) by realigning the left margin of the matter preceding clause (i) 2 ems to the left; and

(ii) by realigning the left margins of clauses (i) and (ii), respectively, 2 ems to the left.

(c) APPLICATION OF DOCUMENTATION SYSTEM TO CHIP.—

(1) IN GENERAL.—Section 2105(c) (42 U.S.C. 1397ee(c)), as amended by section 110(a), is amended by adding at the end the following new paragraph:

“(9) CITIZENSHIP DOCUMENTATION REQUIREMENTS.—

“(A) IN GENERAL.—No payment may be made under this section with respect to an individual who has, or is, declared to be a citizen or national of the United States for purposes of establishing eligibility under this title unless the State meets the requirements of section 1902(a)(46)(B) with respect to the individual.

“(B) ENHANCED PAYMENTS.—Notwithstanding subsection (b), the enhanced FMAP with respect to payments under subsection (a) for expenditures described in clause (i) or (ii) of section 1903(a)(3)(F) necessary to comply with subpara-

graph (A) shall in no event be less than 90 percent and 75 percent, respectively.”

(2) NONAPPLICATION OF ADMINISTRATIVE EXPENDITURES CAP.—Section 2105(c)(2)(C) (42 U.S.C. 1397ee(c)(2)(C)), as amended by section 202(b), is amended by adding at the end the following:

“(iii) EXPENDITURES TO COMPLY WITH CITIZENSHIP OR NATIONALITY VERIFICATION REQUIREMENTS.—Expenditures necessary for the State to comply with paragraph (9)(A).”

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the amendments made by this section shall take effect on October 1, 2008.

(B) TECHNICAL AMENDMENTS.—The amendments made by—

(i) paragraphs (1), (2), and (3) of subsection (b) shall take effect as if included in the enactment of section 6036 of the Deficit Reduction Act of 2005 (Public Law 109–171; 120 Stat. 80); and

(ii) paragraph (4) of subsection (b) shall take effect as if included in the enactment of section 405 of division B of the Tax Relief and Health Care Act of 2006 (Public Law 109–432; 120 Stat. 2996).

(2) RESTORATION OF ELIGIBILITY.—In the case of an individual who, during the period that began on July 1, 2006, and ends on October 1, 2008, was determined to be ineligible for medical assistance under a State Medicaid plan, including any waiver of such plan, solely as a result of the application of subsections (i)(22) and (x) of section 1903 of the Social Security Act (as in effect during such period), but who would have been determined eligible for such assistance if such subsections, as amended by subsection (b), had applied to the individual, a State may deem the individual to be eligible for such assistance as of the date that the individual was determined to be ineligible for such medical assistance on such basis.

(3) SPECIAL TRANSITION RULE FOR INDIANS.—During the period that begins on July 1, 2006, and ends on the effective date of final regulations issued under subclause (II) of section 1903(x)(3)(B)(v) of the Social Security Act (42 U.S.C. 1396b(x)(3)(B)(v)) (as added by subsection (b)(1)(B)), an individual who is a member of a federally-recognized Indian tribe described in subclause (II) of that section who presents a document described in subclause (I) of such section that is issued by such Indian tribe, shall be deemed to have presented satisfactory evidence of citizenship or nationality for purposes of satisfying the requirement of subsection (x) of section 1903 of such Act.

SEC. 302. REDUCING ADMINISTRATIVE BARRIERS TO ENROLLMENT.

Section 2102(b) (42 U.S.C. 1397bb(b)) is amended—

(1) by redesignating paragraph (4) as paragraph (5); and

(2) by inserting after paragraph (3) the following new paragraph:

“(4) REDUCTION OF ADMINISTRATIVE BARRIERS TO ENROLLMENT.—

“(A) IN GENERAL.—Subject to subparagraph (B), the plan shall include a description of the procedures used to reduce administrative barriers to the enrollment of children and pregnant women who are eligible for medical assistance under title XIX or for child health assistance or health benefits coverage under this title. Such procedures shall be established and revised as often as the State determines appropriate to take into account the most recent information available to the State identifying such barriers.

“(B) DEEMED COMPLIANCE IF JOINT APPLICATION AND RENEWAL PROCESS THAT PERMITS APPLICATION OTHER THAN IN PERSON.—A State shall be deemed to comply with subparagraph (A) if the State’s application and renewal forms

and supplemental forms (if any) and information verification process is the same for purposes of establishing and renewing eligibility for children and pregnant women for medical assistance under title XIX and child health assistance under this title, and such process does not require an application to be made in person or a face-to-face interview.”

TITLE IV—REDUCING BARRIERS TO PROVIDING PREMIUM ASSISTANCE

Subtitle A—Additional State Option for Providing Premium Assistance

SEC. 401. ADDITIONAL STATE OPTION FOR PROVIDING PREMIUM ASSISTANCE.

(a) IN GENERAL.—Section 2105(c) (42 U.S.C. 1397ee(c)), as amended by section 301(c), is amended by adding at the end the following:

“(10) STATE OPTION TO OFFER PREMIUM ASSISTANCE.—

“(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph, a State may elect to offer a premium assistance subsidy (as defined in subparagraph (C)) for qualified employer-sponsored coverage (as defined in subparagraph (B)) to all targeted low-income children who are eligible for child health assistance under the plan and have access to such coverage in accordance with the requirements of this paragraph.

“(B) QUALIFIED EMPLOYER-SPONSORED COVERAGE.—

“(i) IN GENERAL.—Subject to clauses (ii) and (iii), in this paragraph, the term ‘qualified employer-sponsored coverage’ means a group health plan or health insurance coverage offered through an employer—

“(I) that qualifies as creditable coverage as a group health plan under section 2701(c)(1) of the Public Health Service Act;

“(II) for which the employer contribution toward any premium for such coverage is at least 40 percent; and

“(III) to all individuals in a manner that would be considered a nondiscriminatory eligibility classification for purposes of paragraph (3)(A)(ii) of section 105(h) of the Internal Revenue Code of 1986 (but determined without regard to clause (i) of subparagraph (B) of such paragraph).

“(ii) EXCEPTION.—Such term does not include coverage consisting of—

“(I) benefits provided under a health flexible spending arrangement (as defined in section 106(c)(2) of the Internal Revenue Code of 1986); or

“(II) a high deductible health plan (as defined in section 223(c)(2) of such Code) purchased in conjunction with a health savings account (as defined under section 223(d) of such Code).

“(iii) COST-EFFECTIVENESS ALTERNATIVE TO REQUIRED EMPLOYER CONTRIBUTION.—A group health plan or health insurance coverage offered through an employer that would be considered qualified employer-sponsored coverage but for the application of clause (i)(II) may be deemed to satisfy the requirement of such clause if either of the following applies:

“(I) APPLICATION OF CHILD-BASED OR FAMILY-BASED TEST.—The State establishes to the satisfaction of the Secretary that the cost of such coverage is less than the expenditures that the State would have made to enroll the child or the family (as applicable) in the State child health plan.

“(II) AGGREGATE PROGRAM OPERATIONAL COSTS DO NOT EXCEED THE COST OF PROVIDING COVERAGE UNDER THE STATE CHILD HEALTH PLAN.—If subclause (I) does not apply, the

State establishes to the satisfaction of the Secretary that the aggregate amount of expenditures by the State for the purchase of all such coverage for targeted low-income children under the State child health plan (including administrative expenditures) does not exceed the aggregate amount of expenditures that the State would have made for providing coverage under the State child health plan for all such children.

“(C) PREMIUM ASSISTANCE SUBSIDY.—

“(i) IN GENERAL.—In this paragraph, the term ‘premium assistance subsidy’ means, with respect to a targeted low-income child, the amount equal to the difference between the employee contribution required for enrollment only of the employee under qualified employer-sponsored coverage and the employee contribution required for enrollment of the employee and the child in such coverage, less any applicable premium cost-sharing applied under the State child health plan (subject to the limitations imposed under section 2103(e), including the requirement to count the total amount of the employee contribution required for enrollment of the employee and the child in such coverage toward the annual aggregate cost-sharing limit applied under paragraph (3)(B) of such section).

“(ii) STATE PAYMENT OPTION.—A State may provide a premium assistance subsidy either as reimbursement to an employee for out-of-pocket expenditures or, subject to clause (iii), directly to the employee’s employer.

“(iii) EMPLOYER OPT-OUT.—An employer may notify a State that it elects to opt-out of being directly paid a premium assistance subsidy on behalf of an employee. In the event of such a notification, an employer shall withhold the total amount of the employee contribution required for enrollment of the employee and the child in the qualified employer-sponsored coverage and the State shall pay the premium assistance subsidy directly to the employee.

“(iv) TREATMENT AS CHILD HEALTH ASSISTANCE.—Expenditures for the provision of premium assistance subsidies shall be considered child health assistance described in paragraph (1)(C) of subsection (a) for purposes of making payments under that subsection.

“(D) APPLICATION OF SECONDARY PAYOR RULES.—The State shall be a secondary payor for any items or services provided under the qualified employer-sponsored coverage for which the State provides child health assistance under the State child health plan.

“(E) REQUIREMENT TO PROVIDE SUPPLEMENTAL COVERAGE FOR BENEFITS AND COST-SHARING PROTECTION PROVIDED UNDER THE STATE CHILD HEALTH PLAN.—

“(i) IN GENERAL.—Notwithstanding section 2110(b)(1)(C), the State shall provide for each targeted low-income child enrolled in qualified employer-sponsored coverage, supplemental coverage consisting of—

“(I) items or services that are not covered, or are only partially covered, under the qualified employer-sponsored coverage; and

“(II) cost-sharing protection consistent with section 2103(e).

“(ii) RECORD KEEPING REQUIREMENTS.—For purposes of carrying out clause (i), a State may elect to directly pay out-of-pocket expenditures for cost-sharing imposed under the qualified employer-sponsored coverage and collect or not collect all or any portion of such expenditures from the parent of the child.

“(F) APPLICATION OF WAITING PERIOD IMPOSED UNDER THE STATE.—Any waiting period imposed under the State child health plan prior to the provision of child health assistance to a targeted low-income child under the State plan shall apply to the same extent to the provision of a premium assistance subsidy for the child under this paragraph.

“(G) OPT-OUT PERMITTED FOR ANY MONTH.—A State shall establish a process for permitting the parent of a targeted low-income child receiving a premium assistance subsidy to disenroll the child from the qualified employer-sponsored coverage and enroll the child in, and receive child health assistance under, the State child health plan, effective on the first day of any month for which the child is eligible for such assistance and in a manner that ensures continuity of coverage for the child.

“(H) APPLICATION TO PARENTS.—If a State provides child health assistance or health benefits coverage to parents of a targeted low-income child in accordance with section 2111(b), the State may elect to offer a premium assistance subsidy to a parent of a targeted low-income child who is eligible for such a subsidy under this paragraph in the same manner as the State offers such a subsidy for the enrollment of the child in qualified employer-sponsored coverage, except that—

“(i) the amount of the premium assistance subsidy shall be increased to take into account the cost of the enrollment of the parent in the qualified employer-sponsored coverage or, at the option of the State if the State determines it cost-effective, the cost of the enrollment of the child’s family in such coverage; and

“(ii) any reference in this paragraph to a child is deemed to include a reference to the parent or, if applicable under clause (i), the family of the child.

“(I) ADDITIONAL STATE OPTION FOR PROVIDING PREMIUM ASSISTANCE.—

“(i) IN GENERAL.—A State may establish an employer-family premium assistance purchasing pool for employers with less than 250 employees who have at least 1 employee who is a pregnant woman eligible for assistance under the State child health plan (including through the application of an option described in section 2112(f)) or a member of a family with at least 1 targeted low-income child and to provide a premium assistance subsidy under this paragraph for enrollment in coverage made available through such pool.

“(ii) ACCESS TO CHOICE OF COVERAGE.—A State that elects the option under clause (i) shall identify and offer access to not less than 2 private health plans that are health benefits coverage that is equivalent to the benefits coverage in a benchmark benefit package described in section 2103(b) or benchmark-equivalent coverage that meets the requirements of section 2103(a)(2) for employees described in clause (i).

“(J) NO EFFECT ON PREMIUM ASSISTANCE WAIVER PROGRAMS.—Nothing in this paragraph shall be construed as limiting the authority of a State to offer premium assistance under section 1906, a waiver described in paragraph (2)(B) or (3), a waiver approved under section 1115, or other authority in effect prior to the date of enactment of the Children’s Health Insurance Program Reauthorization Act of 2007.

“(K) NOTICE OF AVAILABILITY.—If a State elects to provide premium assistance subsidies in accordance with this paragraph, the State shall—

“(i) include on any application or enrollment form for child health assistance a notice of the availability of premium assistance subsidies for the enrollment of targeted low-income children in qualified employer-sponsored coverage;

“(ii) provide, as part of the application and enrollment process under the State child health plan, information describing the availability of such subsidies and how to elect to obtain such a subsidy; and

“(iii) establish such other procedures as the State determines necessary to ensure that parents are fully informed of the choices for receiving child health assistance under the State child

health plan or through the receipt of premium assistance subsidies.

“(L) APPLICATION TO QUALIFIED EMPLOYER-SPONSORED BENCHMARK COVERAGE.—If a group health plan or health insurance coverage offered through an employer is certified by an actuary as health benefits coverage that is equivalent to the benefits coverage in a benchmark benefit package described in section 2103(b) or benchmark-equivalent coverage that meets the requirements of section 2103(a)(2), the State may provide premium assistance subsidies for enrollment of targeted low-income children in such group health plan or health insurance coverage in the same manner as such subsidies are provided under this paragraph for enrollment in qualified employer-sponsored coverage, but without regard to the requirement to provide supplemental coverage for benefits and cost-sharing protection provided under the State child health plan under subparagraph (E).”

(b) APPLICATION TO MEDICAID.—Section 1906 (42 U.S.C. 1396e) is amended by inserting after subsection (c) the following:

“(d) A State may elect to offer a premium assistance subsidy (as defined in section 2105(c)(10)(C)) for qualified employer-sponsored coverage (as defined in section 2105(c)(10)(B)) to a child who is eligible for medical assistance under the State plan under this title, to the parent of such a child, and to a pregnant woman, in the same manner as such a subsidy for such coverage may be offered under a State child health plan under title XXI in accordance with section 2105(c)(10) (except that subparagraph (E)(i)(II) of such section shall be applied by substituting ‘1916 or, if applicable, 1916A’ for ‘2103(e)’).”

(c) GAO STUDY AND REPORT.—Not later than January 1, 2009, the Comptroller General of the United States shall study cost and coverage issues relating to any State premium assistance programs for which Federal matching payments are made under title XIX or XXI of the Social Security Act, including under waiver authority, and shall submit a report to the appropriate committees of Congress on the results of such study.

SEC. 402. OUTREACH, EDUCATION, AND ENROLLMENT ASSISTANCE.

(a) REQUIREMENT TO INCLUDE DESCRIPTION OF OUTREACH, EDUCATION, AND ENROLLMENT EFFORTS RELATED TO PREMIUM ASSISTANCE SUBSIDIES IN STATE CHILD HEALTH PLAN.—Section 2102(c) (42 U.S.C. 1397bb(c)) is amended by adding at the end the following new paragraph:

“(3) PREMIUM ASSISTANCE SUBSIDIES.—Outreach, education, and enrollment assistance for families of children likely to be eligible for premium assistance subsidies under the State child health plan in accordance with paragraphs (2)(B), (3), or (10) of section 2105(c), or a waiver approved under section 1115, to inform such families of the availability of, and to assist them in enrolling their children in, such subsidies, and for employers likely to provide coverage that is eligible for such subsidies, including the specific, significant resources the State intends to apply to educate employers about the availability of premium assistance subsidies under the State child health plan.”

(b) NONAPPLICATION OF 10 PERCENT LIMIT ON OUTREACH AND CERTAIN OTHER EXPENDITURES.—Section 2105(c)(2)(C) (42 U.S.C. 1397ee(c)(2)(C)), as amended by section 301(c)(2), is amended by adding at the end the following new clause:

“(iv) EXPENDITURES FOR OUTREACH TO INCREASE THE ENROLLMENT OF CHILDREN UNDER THIS TITLE AND TITLE XIX THROUGH PREMIUM

ASSISTANCE SUBSIDIES.—Expenditures for outreach activities to families of children likely to be eligible for premium assistance subsidies in accordance with paragraphs (2)(B), (3), or (10), or a waiver approved under section 1115, to inform such families of the availability of, and to assist them in enrolling their children in, such subsidies, and to employers likely to provide qualified employer-sponsored coverage (as defined in subparagraph (B) of such paragraph).”.

Subtitle B—Coordinating Premium Assistance With Private Coverage

SEC. 411. SPECIAL ENROLLMENT PERIOD UNDER GROUP HEALTH PLANS IN CASE OF TERMINATION OF MEDICAID OR CHIP COVERAGE OR ELIGIBILITY FOR ASSISTANCE IN PURCHASE OF EMPLOYMENT-BASED COVERAGE; COORDINATION OF COVERAGE.

(a) AMENDMENTS TO INTERNAL REVENUE CODE OF 1986.—Section 9801(f) of the Internal Revenue Code of 1986 (relating to special enrollment periods) is amended by adding at the end the following new paragraph:

“(3) SPECIAL RULES RELATING TO MEDICAID AND CHIP.—

“(A) IN GENERAL.—A group health plan shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if either of the following conditions is met:

“(i) TERMINATION OF MEDICAID OR CHIP COVERAGE.—The employee or dependent is covered under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act and coverage of the employee or dependent under such a plan is terminated as a result of loss of eligibility for such coverage and the employee requests coverage under the group health plan not later than 60 days after the date of termination of such coverage.

“(ii) ELIGIBILITY FOR EMPLOYMENT ASSISTANCE UNDER MEDICAID OR CHIP.—The employee or dependent becomes eligible for assistance, with respect to coverage under the group health plan under such Medicaid plan or State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan), if the employee requests coverage under the group health plan not later than 60 days after the date the employee or dependent is determined to be eligible for such assistance.

“(B) EMPLOYEE OUTREACH AND DISCLOSURE.—

“(i) OUTREACH TO EMPLOYEES REGARDING AVAILABILITY OF MEDICAID AND CHIP COVERAGE.—

“(I) IN GENERAL.—Each employer that maintains a group health plan in a State that provides medical assistance under a State Medicaid plan under title XIX of the Social Security Act, or child health assistance under a State child health plan under title XXI of such Act, in the form of premium assistance for the purchase of coverage under a group health plan, shall provide to each employee a written notice informing the employee of potential opportunities then currently available in the State in which the employee resides for premium assistance under such plans for health coverage of the employee or the employee’s dependents. For purposes of compliance with this clause, the employer may use any State-specific model notice developed in accordance with section 701(f)(3)(B)(i)(II) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181(f)(3)(B)(i)(II)).

“(II) OPTION TO PROVIDE CONCURRENT WITH PROVISION OF SUMMARY PLAN DESCRIPTION.—An employer may provide the model notice applicable to the State in which an employee resides concurrent with the furnishing of the summary plan description as provided in section 104(b) of

the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1024).

“(ii) DISCLOSURE ABOUT GROUP HEALTH PLAN BENEFITS TO STATES FOR MEDICAID AND CHIP ELIGIBLE INDIVIDUALS.—In the case of a participant or beneficiary of a group health plan who is covered under a Medicaid plan of a State under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act, the plan administrator of the group health plan shall disclose to the State, upon request, information about the benefits available under the group health plan in sufficient specificity, as determined under regulations of the Secretary of Health and Human Services in consultation with the Secretary that require use of the model coverage coordination disclosure form developed under section 411(b)(1)(C) of the Children’s Health Insurance Program Reauthorization Act of 2007, so as to permit the State to make a determination (under paragraph (2)(B), (3), or (10) of section 2105(c) of the Social Security Act or otherwise) concerning the cost-effectiveness of the State providing medical or child health assistance through premium assistance for the purchase of coverage under such group health plan and in order for the State to provide supplemental benefits required under paragraph (10)(E) of such section or other authority.”.

(b) CONFORMING AMENDMENTS.—

(1) AMENDMENTS TO EMPLOYEE RETIREMENT INCOME SECURITY ACT.—

(A) IN GENERAL.—Section 701(f) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181(f)) is amended by adding at the end the following new paragraph:

“(3) SPECIAL RULES FOR APPLICATION IN CASE OF MEDICAID AND CHIP.—

“(A) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if either of the following conditions is met:

“(i) TERMINATION OF MEDICAID OR CHIP COVERAGE.—The employee or dependent is covered under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act and coverage of the employee or dependent under such a plan is terminated as a result of loss of eligibility for such coverage and the employee requests coverage under the group health plan (or health insurance coverage) not later than 60 days after the date of termination of such coverage.

“(ii) ELIGIBILITY FOR EMPLOYMENT ASSISTANCE UNDER MEDICAID OR CHIP.—The employee or dependent becomes eligible for assistance, with respect to coverage under the group health plan or health insurance coverage, under such Medicaid plan or State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan), if the employee requests coverage under the group health plan or health insurance coverage not later than 60 days after the date the employee or dependent is determined to be eligible for such assistance.

(B) COORDINATION WITH MEDICAID AND CHIP.—

“(i) OUTREACH TO EMPLOYEES REGARDING AVAILABILITY OF MEDICAID AND CHIP COVERAGE.—

“(I) IN GENERAL.—Each employer that maintains a group health plan in a State that provides medical assistance under a State Medicaid plan under title XIX of the Social Security Act, or child health assistance under a State child health plan under title XXI of such Act, in the form of premium assistance for the purchase of coverage under a group health plan, shall provide to each employee a written notice informing

the employee of potential opportunities then currently available in the State in which the employee resides for premium assistance under such plans for health coverage of the employee or the employee’s dependents.

“(II) MODEL NOTICE.—Not later than 1 year after the date of enactment of the Children’s Health Insurance Program Reauthorization Act of 2007, the Secretary and the Secretary of Health and Human Services, in consultation with Directors of State Medicaid agencies under title XIX of the Social Security Act and Directors of State CHIP agencies under title XXI of such Act, shall jointly develop national and State-specific model notices for purposes of subparagraph (A). The Secretary shall provide employers with such model notices so as to enable employers to timely comply with the requirements of subparagraph (A). Such model notices shall include information regarding how an employee may contact the State in which the employee resides for additional information regarding potential opportunities for such premium assistance, including how to apply for such assistance.

“(III) OPTION TO PROVIDE CONCURRENT WITH PROVISION OF SUMMARY PLAN DESCRIPTION.—An employer may provide the model notice applicable to the State in which an employee resides concurrent with the furnishing of the summary plan description as provided in section 104(b).

“(ii) DISCLOSURE ABOUT GROUP HEALTH PLAN BENEFITS TO STATES FOR MEDICAID AND CHIP ELIGIBLE INDIVIDUALS.—In the case of a participant or beneficiary of a group health plan who is covered under a Medicaid plan of a State under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act, the plan administrator of the group health plan shall disclose to the State, upon request, information about the benefits available under the group health plan in sufficient specificity, as determined under regulations of the Secretary of Health and Human Services in consultation with the Secretary that require use of the model coverage coordination disclosure form developed under section 411(b)(1)(C) of the Children’s Health Insurance Program Reauthorization Act of 2007, so as to permit the State to make a determination (under paragraph (2)(B), (3), or (10) of section 2105(c) of the Social Security Act or otherwise) concerning the cost-effectiveness of the State providing medical or child health assistance through premium assistance for the purchase of coverage under such group health plan and in order for the State to provide supplemental benefits required under paragraph (10)(E) of such section or other authority.”.

(B) CONFORMING AMENDMENT.—Section 102(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1022(b)) is amended—

(i) by striking “and the remedies” and inserting “, the remedies”; and

(ii) by inserting before the period the following: “, and if the employer so elects for purposes of complying with section 701(f)(3)(B)(i), the model notice applicable to the State in which the participants and beneficiaries reside”.

(C) WORKING GROUP TO DEVELOP MODEL COVERAGE COORDINATION DISCLOSURE FORM.—

(i) MEDICAID, CHIP, AND EMPLOYER-SPONSORED COVERAGE COORDINATION WORKING GROUP.—

(I) IN GENERAL.—Not later than 60 days after the date of enactment of this Act, the Secretary of Health and Human Services and the Secretary of Labor shall jointly establish a Medicaid, CHIP, and Employer-Sponsored Coverage Coordination Working Group (in this subparagraph referred to as the “Working Group”). The purpose of the Working Group shall be to develop the model coverage coordination disclosure form described in subclause (II) and to identify the impediments to the effective coordination of coverage available to families that include employees of employers that maintain group health

plans and members who are eligible for medical assistance under title XIX of the Social Security Act or child health assistance or other health benefits coverage under title XXI of such Act.

(II) MODEL COVERAGE COORDINATION DISCLOSURE FORM DESCRIBED.—The model form described in this subclause is a form for plan administrators of group health plans to complete for purposes of permitting a State to determine the availability and cost-effectiveness of the coverage available under such plans to employees who have family members who are eligible for premium assistance offered under a State plan under title XIX or XXI of such Act and to allow for coordination of coverage for enrollees of such plans. Such form shall provide the following information in addition to such other information as the Working Group determines appropriate:

(aa) A determination of whether the employee is eligible for coverage under the group health plan.

(bb) The name and contract information of the plan administrator of the group health plan.

(cc) The benefits offered under the plan.

(dd) The premiums and cost-sharing required under the plan.

(ee) Any other information relevant to coverage under the plan.

(ii) MEMBERSHIP.—The Working Group shall consist of not more than 30 members and shall be composed of representatives of—

(I) the Department of Labor;

(II) the Department of Health and Human Services;

(III) State directors of the Medicaid program under title XIX of the Social Security Act;

(IV) State directors of the State Children's Health Insurance Program under title XXI of the Social Security Act;

(V) employers, including owners of small businesses and their trade or industry representatives and certified human resource and payroll professionals;

(VI) plan administrators and plan sponsors of group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974);

(VII) health insurance issuers; and

(VIII) children and other beneficiaries of medical assistance under title XIX of the Social Security Act or child health assistance or other health benefits coverage under title XXI of such Act.

(iii) COMPENSATION.—The members of the Working Group shall serve without compensation.

(iv) ADMINISTRATIVE SUPPORT.—The Department of Health and Human Services and the Department of Labor shall jointly provide appropriate administrative support to the Working Group, including technical assistance. The Working Group may use the services and facilities of either such Department, with or without reimbursement, as jointly determined by such Departments.

(v) REPORT.—

(I) REPORT BY WORKING GROUP TO THE SECRETARIES.—Not later than 18 months after the date of the enactment of this Act, the Working Group shall submit to the Secretary of Labor and the Secretary of Health and Human Services the model form described in clause (i)(II) along with a report containing recommendations for appropriate measures to address the impediments to the effective coordination of coverage between group health plans and the State plans under titles XIX and XXI of the Social Security Act.

(II) REPORT BY SECRETARIES TO THE CONGRESS.—Not later than 2 months after receipt of the report pursuant to subclause (I), the Secretaries shall jointly submit a report to each House of the Congress regarding the recommendations contained in the report under such subclause.

(vi) TERMINATION.—The Working Group shall terminate 30 days after the date of the issuance of its report under clause (v).

(D) EFFECTIVE DATES.—The Secretary of Labor and the Secretary of Health and Human Services shall develop the initial model notices under section 701(f)(3)(B)(i)(II) of the Employee Retirement Income Security Act of 1974, and the Secretary of Labor shall provide such notices to employers, not later than the date that is 1 year after the date of enactment of this Act, and each employer shall provide the initial annual notices to such employer's employees beginning with the first plan year that begins after the date on which such initial model notices are first issued. The model coverage coordination disclosure form developed under subparagraph (C) shall apply with respect to requests made by States beginning with the first plan year that begins after the date on which such model coverage coordination disclosure form is first issued.

(E) ENFORCEMENT.—Section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132) is amended—

(i) in subsection (a)(6), by striking “or (8)” and inserting “(8), or (9)”; and

(ii) in subsection (c), by redesignating paragraph (9) as paragraph (10), and by inserting after paragraph (8) the following:

“(9)(A) The Secretary may assess a civil penalty against any employer of up to \$100 a day from the date of the employer's failure to meet the notice requirement of section 701(f)(3)(B)(i)(I). For purposes of this subparagraph, each violation with respect to any single employee shall be treated as a separate violation.”

“(B) The Secretary may assess a civil penalty against any plan administrator of up to \$100 a day from the date of the plan administrator's failure to timely provide to any State the information required to be disclosed under section 701(f)(3)(B)(ii). For purposes of this subparagraph, each violation with respect to any single participant or beneficiary shall be treated as a separate violation.”

(2) AMENDMENTS TO PUBLIC HEALTH SERVICE ACT.—Section 2701(f) of the Public Health Service Act (42 U.S.C. 300gg(f)) is amended by adding at the end the following new paragraph:

“(3) SPECIAL RULES FOR APPLICATION IN CASE OF MEDICAID AND CHIP.—

“(A) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if either of the following conditions is met:

“(i) TERMINATION OF MEDICAID OR CHIP COVERAGE.—The employee or dependent is covered under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act and coverage of the employee or dependent under such a plan is terminated as a result of loss of eligibility for such coverage and the employee requests coverage under the group health plan (or health insurance coverage) not later than 60 days after the date of termination of such coverage.

“(ii) ELIGIBILITY FOR EMPLOYMENT ASSISTANCE UNDER MEDICAID OR CHIP.—The employee or dependent becomes eligible for assistance, with respect to coverage under the group health plan or health insurance coverage, under such Medicaid plan or State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan), if the employee requests coverage under the group health plan or health insurance coverage not later than 60 days after the date the employee or dependent is determined to be eligible for such assistance.

“(B) COORDINATION WITH MEDICAID AND CHIP.—

“(i) OUTREACH TO EMPLOYEES REGARDING AVAILABILITY OF MEDICAID AND CHIP COVERAGE.—

“(I) IN GENERAL.—Each employer that maintains a group health plan in a State that provides medical assistance under a State Medicaid plan under title XIX of the Social Security Act, or child health assistance under a State child health plan under title XXI of such Act, in the form of premium assistance for the purchase of coverage under a group health plan, shall provide to each employee a written notice informing the employee of potential opportunities then currently available in the State in which the employee resides for premium assistance under such plans for health coverage of the employee or the employee's dependents. For purposes of compliance with this subclause, the employer may use any State-specific model notice developed in accordance with section 701(f)(3)(B)(i)(II) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181(f)(3)(B)(i)(II)).

“(II) OPTION TO PROVIDE CONCURRENT WITH PROVISION OF SUMMARY PLAN DESCRIPTION.—An employer may provide the model notice applicable to the State in which an employee resides concurrent with the furnishing of the summary plan description as provided in section 104(b) of the Employee Retirement Income Security Act of 1974.

“(ii) DISCLOSURE ABOUT GROUP HEALTH PLAN BENEFITS TO STATES FOR MEDICAID AND CHIP ELIGIBLE INDIVIDUALS.—In the case of an enrollee in a group health plan who is covered under a Medicaid plan of a State under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act, the plan administrator of the group health plan shall disclose to the State, upon request, information about the benefits available under the group health plan in sufficient specificity, as determined under regulations of the Secretary of Health and Human Services in consultation with the Secretary that require use of the model coverage coordination disclosure form developed under section 411(b)(1)(C) of the Children's Health Insurance Reauthorization Act of 2007, so as to permit the State to make a determination (under paragraph (2)(B), (3), or (10) of section 2105(c) of the Social Security Act or otherwise) concerning the cost-effectiveness of the State providing medical or child health assistance through premium assistance for the purchase of coverage under such group health plan and in order for the State to provide supplemental benefits required under paragraph (10)(E) of such section or other authority.”

TITLE V—STRENGTHENING QUALITY OF CARE AND HEALTH OUTCOMES OF CHILDREN

SEC. 501. CHILD HEALTH QUALITY IMPROVEMENT ACTIVITIES FOR CHILDREN ENROLLED IN MEDICAID OR CHIP.

(a) DEVELOPMENT OF CHILD HEALTH QUALITY MEASURES FOR CHILDREN ENROLLED IN MEDICAID OR CHIP.—Title XI (42 U.S.C. 1301 et seq.) is amended by inserting after section 1139 the following new section:

“SEC. 1139A. CHILD HEALTH QUALITY MEASURES.

“(a) DEVELOPMENT OF AN INITIAL CORE SET OF HEALTH CARE QUALITY MEASURES FOR CHILDREN ENROLLED IN MEDICAID OR CHIP.—

“(1) IN GENERAL.—Not later than January 1, 2009, the Secretary shall identify and publish for general comment an initial, recommended core set of child health quality measures for use by State programs administered under titles XIX and XXI, health insurance issuers and managed care entities that enter into contracts with such programs, and providers of items and services under such programs.

“(2) IDENTIFICATION OF INITIAL CORE MEASURES.—In consultation with the individuals and entities described in subsection (b)(3), the Secretary shall identify existing quality of care measures for children that are in use under public and privately sponsored health care coverage arrangements, or that are part of reporting systems that measure both the presence and duration of health insurance coverage over time.

“(3) RECOMMENDATIONS AND DISSEMINATION.—Based on such existing and identified measures, the Secretary shall publish an initial core set of child health quality measures that includes (but is not limited to) the following:

“(A) The duration of children’s health insurance coverage over a 12-month time period.

“(B) The availability of a full range of—

“(i) preventive services, treatments, and services for acute conditions, including services to promote healthy birth and prevent and treat premature birth; and

“(ii) treatments to correct or ameliorate the effects of chronic physical and mental conditions in infants, young children, school-age children, and adolescents.

“(C) The availability of care in a range of ambulatory and inpatient health care settings in which such care is furnished.

“(D) The types of measures that, taken together, can be used to estimate the overall national quality of health care for children and to perform comparative analyses of pediatric health care quality and racial, ethnic, and socioeconomic disparities in child health and health care for children.

“(4) ENCOURAGE VOLUNTARY AND STANDARDIZED REPORTING.—Not later than 2 years after the date of enactment of the Children’s Health Insurance Program Reauthorization Act of 2007, the Secretary, in consultation with States, shall develop a standardized format for reporting information and procedures and approaches that encourage States to use the initial core measurement set to voluntarily report information regarding the quality of pediatric health care under titles XIX and XXI.

“(5) ADOPTION OF BEST PRACTICES IN IMPLEMENTING QUALITY PROGRAMS.—The Secretary shall disseminate information to States regarding best practices among States with respect to measuring and reporting on the quality of health care for children, and shall facilitate the adoption of such best practices. In developing best practices approaches, the Secretary shall give particular attention to State measurement techniques that ensure the timeliness and accuracy of provider reporting, encourage provider reporting compliance, encourage successful quality improvement strategies, and improve efficiency in data collection using health information technology.

“(6) REPORTS TO CONGRESS.—Not later than January 1, 2010, and every 3 years thereafter, the Secretary shall report to Congress on—

“(A) the status of the Secretary’s efforts to improve—

“(i) quality related to the duration and stability of health insurance coverage for children under titles XIX and XXI;

“(ii) the quality of children’s health care under such titles, including preventive health services, health care for acute conditions, chronic health care, and health services to ameliorate the effects of physical and mental conditions and to aid in growth and development of infants, young children, school-age children, and adolescents with special health care needs; and

“(iii) the quality of children’s health care under such titles across the domains of quality, including clinical quality, health care safety, family experience with health care, health care in the most integrated setting, and elimination of racial, ethnic, and socioeconomic disparities in health and health care;

“(B) the status of voluntary reporting by States under titles XIX and XXI, utilizing the initial core quality measurement set; and

“(C) any recommendations for legislative changes needed to improve the quality of care provided to children under titles XIX and XXI, including recommendations for quality reporting by States.

“(7) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to States to assist them in adopting and utilizing core child health quality measures in administering the State plans under titles XIX and XXI.

“(8) DEFINITION OF CORE SET.—In this section, the term ‘core set’ means a group of valid, reliable, and evidence-based quality measures that, taken together—

“(A) provide information regarding the quality of health coverage and health care for children;

“(B) address the needs of children throughout the developmental age span; and

“(C) allow purchasers, families, and health care providers to understand the quality of care in relation to the preventive needs of children, treatments aimed at managing and resolving acute conditions, and diagnostic and treatment services whose purpose is to correct or ameliorate physical, mental, or developmental conditions that could, if untreated or poorly treated, become chronic.

“(b) ADVANCING AND IMPROVING PEDIATRIC QUALITY MEASURES.—

“(1) ESTABLISHMENT OF PEDIATRIC QUALITY MEASURES PROGRAM.—Not later than January 1, 2010, the Secretary shall establish a pediatric quality measures program to—

“(A) improve and strengthen the initial core child health care quality measures established by the Secretary under subsection (a);

“(B) expand on existing pediatric quality measures used by public and private health care purchasers and advance the development of such new and emerging quality measures; and

“(C) increase the portfolio of evidence-based, consensus pediatric quality measures available to public and private purchasers of children’s health care services, providers, and consumers.

“(2) EVIDENCE-BASED MEASURES.—The measures developed under the pediatric quality measures program shall, at a minimum, be—

“(A) evidence-based and, where appropriate, risk adjusted;

“(B) designed to identify and eliminate racial and ethnic disparities in child health and the provision of health care;

“(C) designed to ensure that the data required for such measures is collected and reported in a standard format that permits comparison of quality and data at a State, plan, and provider level;

“(D) periodically updated; and

“(E) responsive to the child health needs, services, and domains of health care quality described in clauses (i), (ii), and (iii) of subsection (a)(6)(A).

“(3) PROCESS FOR PEDIATRIC QUALITY MEASURES PROGRAM.—In identifying gaps in existing pediatric quality measures and establishing priorities for development and advancement of such measures, the Secretary shall consult with—

“(A) States;

“(B) pediatricians, children’s hospitals, and other primary and specialized pediatric health care professionals (including members of the allied health professions) who specialize in the care and treatment of children, particularly children with special physical, mental, and developmental health care needs;

“(C) dental professionals, including pediatric dental professionals;

“(D) health care providers that furnish primary health care to children and families who live in urban and rural medically underserved communities or who are members of distinct population sub-groups at heightened risk for poor health outcomes;

“(E) national organizations representing consumers and purchasers of children’s health care;

“(F) national organizations and individuals with expertise in pediatric health quality measurement; and

“(G) voluntary consensus standards setting organizations and other organizations involved in the advancement of evidence-based measures of health care.

“(4) DEVELOPING, VALIDATING, AND TESTING A PORTFOLIO OF PEDIATRIC QUALITY MEASURES.—As part of the program to advance pediatric quality measures, the Secretary shall—

“(A) award grants and contracts for the development, testing, and validation of new, emerging, and innovative evidence-based measures for children’s health care services across the domains of quality described in clauses (i), (ii), and (iii) of subsection (a)(6)(A); and

“(B) award grants and contracts for—

“(i) the development of consensus on evidence-based measures for children’s health care services;

“(ii) the dissemination of such measures to public and private purchasers of health care for children; and

“(iii) the updating of such measures as necessary.

“(5) REVISING, STRENGTHENING, AND IMPROVING INITIAL CORE MEASURES.—Beginning no later than January 1, 2012, and annually thereafter, the Secretary shall publish recommended changes to the core measures described in subsection (a) that shall reflect the testing, validation, and consensus process for the development of pediatric quality measures described in subsection paragraphs (1) through (4).

“(6) DEFINITION OF PEDIATRIC QUALITY MEASURE.—In this subsection, the term ‘pediatric quality measure’ means a measurement of clinical care that is capable of being examined through the collection and analysis of relevant information, that is developed in order to assess 1 or more aspects of pediatric health care quality in various institutional and ambulatory health care settings, including the structure of the clinical care system, the process of care, the outcome of care, or patient experiences in care.

“(c) ANNUAL STATE REPORTS REGARDING STATE-SPECIFIC QUALITY OF CARE MEASURES APPLIED UNDER MEDICAID OR CHIP.—

“(1) ANNUAL STATE REPORTS.—Each State with a State plan approved under title XIX or a State child health plan approved under title XXI shall annually report to the Secretary on the—

“(A) State-specific child health quality measures applied by the States under such plans, including measures described in subparagraphs (A) and (B) of subsection (a)(6); and

“(B) State-specific information on the quality of health care furnished to children under such plans, including information collected through external quality reviews of managed care organizations under section 1932 of the Social Security Act (42 U.S.C. 1396u-4) and benchmark plans under sections 1937 and 2103 of such Act (42 U.S.C. 1396u-7, 1397cc).

“(2) PUBLICATION.—Not later than September 30, 2009, and annually thereafter, the Secretary shall collect, analyze, and make publicly available the information reported by States under paragraph (1).

“(d) DEMONSTRATION PROJECTS FOR IMPROVING THE QUALITY OF CHILDREN’S HEALTH CARE AND THE USE OF HEALTH INFORMATION TECHNOLOGY.—

“(1) IN GENERAL.—During the period of fiscal years 2008 through 2012, the Secretary shall award not more than 10 grants to States and child health providers to conduct demonstration projects to evaluate promising ideas for improving the quality of children’s health care provided under title XIX or XXI, including projects to—

“(A) experiment with, and evaluate the use of, new measures of the quality of children’s health care under such titles (including testing the validity and suitability for reporting of such measures);

“(B) promote the use of health information technology in care delivery for children under such titles;

“(C) evaluate provider-based models which improve the delivery of children’s health care services under such titles, including care management for children with chronic conditions and the use of evidence-based approaches to improve the effectiveness, safety, and efficiency of health care services for children; or

“(D) demonstrate the impact of the model electronic health record format for children developed and disseminated under subsection (f) on improving pediatric health, including the effects of chronic childhood health conditions, and pediatric health care quality as well as reducing health care costs.

“(2) REQUIREMENTS.—In awarding grants under this subsection, the Secretary shall ensure that—

“(A) only 1 demonstration project funded under a grant awarded under this subsection shall be conducted in a State; and

“(B) demonstration projects funded under grants awarded under this subsection shall be conducted evenly between States with large urban areas and States with large rural areas.

“(3) AUTHORITY FOR MULTISTATE PROJECTS.—A demonstration project conducted with a grant awarded under this subsection may be conducted on a multistate basis, as needed.

“(4) FUNDING.—\$20,000,000 of the amount appropriated under subsection (i) for a fiscal year shall be used to carry out this subsection.

“(e) CHILDHOOD OBESITY DEMONSTRATION PROJECT.—

“(1) AUTHORITY TO CONDUCT DEMONSTRATION.—The Secretary, in consultation with the Administrator of the Centers for Medicare & Medicaid Services, shall conduct a demonstration project to develop a comprehensive and systematic model for reducing childhood obesity by awarding grants to eligible entities to carry out such project. Such model shall—

“(A) identify, through self-assessment, behavioral risk factors for obesity among children;

“(B) identify, through self-assessment, needed clinical preventive and screening benefits among those children identified as target individuals on the basis of such risk factors;

“(C) provide ongoing support to such target individuals and their families to reduce risk factors and promote the appropriate use of preventive and screening benefits; and

“(D) be designed to improve health outcomes, satisfaction, quality of life, and appropriate use of items and services for which medical assistance is available under title XIX or child health assistance is available under title XXI among such target individuals.

“(2) ELIGIBILITY ENTITIES.—For purposes of this subsection, an eligible entity is any of the following:

“(A) A city, county, or Indian tribe.

“(B) A local or tribal educational agency.

“(C) An accredited university, college, or community college.

“(D) A Federally-qualified health center.

“(E) A local health department.

“(F) A health care provider.

“(G) A community-based organization.

“(H) Any other entity determined appropriate by the Secretary, including a consortia or partnership of entities described in any of subparagraphs (A) through (G).

“(3) USE OF FUNDS.—An eligible entity awarded a grant under this subsection shall use the funds made available under the grant to—

“(A) carry out community-based activities related to reducing childhood obesity, including by—

“(i) forming partnerships with entities, including schools and other facilities providing recreational services, to establish programs for after school and weekend community activities that are designed to reduce childhood obesity;

“(ii) forming partnerships with daycare facilities to establish programs that promote healthy eating behaviors and physical activity; and

“(iii) developing and evaluating community educational activities targeting good nutrition and promoting healthy eating behaviors;

“(B) carry out age-appropriate school-based activities that are designed to reduce childhood obesity, including by—

“(i) developing and testing educational curricula and intervention programs designed to promote healthy eating behaviors and habits in youth, which may include—

“(I) after hours physical activity programs; and

“(II) science-based interventions with multiple components to prevent eating disorders including nutritional content, understanding and responding to hunger and satiety, positive body image development, positive self-esteem development, and learning life skills (such as stress management, communication skills, problem-solving and decisionmaking skills), as well as consideration of cultural and developmental issues, and the role of family, school, and community;

“(ii) providing education and training to educational professionals regarding how to promote a healthy lifestyle and a healthy school environment for children;

“(iii) planning and implementing a healthy lifestyle curriculum or program with an emphasis on healthy eating behaviors and physical activity; and

“(iv) planning and implementing healthy lifestyle classes or programs for parents or guardians, with an emphasis on healthy eating behaviors and physical activity for children;

“(C) carry out educational, counseling, promotional, and training activities through the local health care delivery systems including by—

“(i) promoting healthy eating behaviors and physical activity services to treat or prevent eating disorders, being overweight, and obesity;

“(ii) providing patient education and counseling to increase physical activity and promote healthy eating behaviors;

“(iii) training health professionals on how to identify and treat obese and overweight individuals which may include nutrition and physical activity counseling; and

“(iv) providing community education by a health professional on good nutrition and physical activity to develop a better understanding of the relationship between diet, physical activity, and eating disorders, obesity, or being overweight; and

“(D) provide, through qualified health professionals, training and supervision for community health workers to—

“(i) educate families regarding the relationship between nutrition, eating habits, physical activity, and obesity;

“(ii) educate families about effective strategies to improve nutrition, establish healthy eating patterns, and establish appropriate levels of physical activity; and

“(iii) educate and guide parents regarding the ability to model and communicate positive health behaviors.

“(4) PRIORITY.—In awarding grants under paragraph (1), the Secretary shall give priority to awarding grants to eligible entities—

“(A) that demonstrate that they have previously applied successfully for funds to carry out activities that seek to promote individual and community health and to prevent the incidence of chronic disease and that can cite published and peer-reviewed research demonstrating that the activities that the entities propose to carry out with funds made available under the grant are effective;

“(B) that will carry out programs or activities that seek to accomplish a goal or goals set by the State in the Healthy People 2010 plan of the State;

“(C) that provide non-Federal contributions, either in cash or in-kind, to the costs of funding activities under the grants;

“(D) that develop comprehensive plans that include a strategy for extending program activities developed under grants in the years following the fiscal years for which they receive grants under this subsection;

“(E) located in communities that are medically underserved, as determined by the Secretary;

“(F) located in areas in which the average poverty rate is at least 150 percent or higher of the average poverty rate in the State involved, as determined by the Secretary; and

“(G) that submit plans that exhibit multisectoral, cooperative conduct that includes the involvement of a broad range of stakeholders, including—

“(i) community-based organizations;

“(ii) local governments;

“(iii) local educational agencies;

“(iv) the private sector;

“(v) State or local departments of health;

“(vi) accredited colleges, universities, and community colleges;

“(vii) health care providers;

“(viii) State and local departments of transportation and city planning; and

“(ix) other entities determined appropriate by the Secretary.

“(5) PROGRAM DESIGN.—

“(A) INITIAL DESIGN.—Not later than 1 year after the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2007, the Secretary shall design the demonstration project. The demonstration should draw upon promising, innovative models and incentives to reduce behavioral risk factors. The Administrator of the Centers for Medicare & Medicaid Services shall consult with the Director of the Centers for Disease Control and Prevention, the Director of the Office of Minority Health, the heads of other agencies in the Department of Health and Human Services, and such professional organizations, as the Secretary determines to be appropriate, on the design, conduct, and evaluation of the demonstration.

“(B) NUMBER AND PROJECT AREAS.—Not later than 2 years after the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2007, the Secretary shall award 1 grant that is specifically designed to determine whether programs similar to programs to be conducted by other grantees under this subsection should be implemented with respect to the general population of children who are eligible for child health assistance under State child health plans under title XXI in order to reduce the incidence of childhood obesity among such population.

“(6) REPORT TO CONGRESS.—Not later than 3 years after the date the Secretary implements the demonstration project under this subsection, the Secretary shall submit to Congress a report that describes the project, evaluates the effectiveness and cost effectiveness of the project, evaluates the beneficiary satisfaction under the project, and includes any such other information as the Secretary determines to be appropriate.

“(7) DEFINITIONS.—In this subsection:

“(A) FEDERALLY-QUALIFIED HEALTH CENTER.—The term ‘Federally-qualified health center’ has the meaning given that term in section 1905(l)(2)(B).

“(B) INDIAN TRIBE.—The term ‘Indian tribe’ has the meaning given that term in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

“(C) SELF-ASSESSMENT.—The term ‘self-assessment’ means a form that—

“(i) includes questions regarding—

“(I) behavioral risk factors;

“(II) needed preventive and screening services; and

“(III) target individuals' preferences for receiving follow-up information;

“(ii) is assessed using such computer generated assessment programs; and

“(iii) allows for the provision of such ongoing support to the individual as the Secretary determines appropriate.

“(D) ONGOING SUPPORT.—The term ‘ongoing support’ means—

“(i) to provide any target individual with information, feedback, health coaching, and recommendations regarding—

“(I) the results of a self-assessment given to the individual;

“(II) behavior modification based on the self-assessment; and

“(III) any need for clinical preventive and screening services or treatment including medical nutrition therapy;

“(ii) to provide any target individual with referrals to community resources and programs available to assist the target individual in reducing health risks; and

“(iii) to provide the information described in clause (i) to a health care provider, if designated by the target individual to receive such information.

“(8) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection, \$25,000,000 for the period of fiscal years 2008 through 2012.

“(f) DEVELOPMENT OF MODEL ELECTRONIC HEALTH RECORD FORMAT FOR CHILDREN ENROLLED IN MEDICAID OR CHIP.—

“(1) IN GENERAL.—Not later than January 1, 2009, the Secretary shall establish a program to encourage the development and dissemination of a model electronic health record format for children enrolled in the State plan under title XIX or the State child health plan under title XXI that is—

“(A) subject to State laws, accessible to parents, caregivers, and other consumers for the sole purpose of demonstrating compliance with school or leisure activity requirements, such as appropriate immunizations or physicals;

“(B) designed to allow interoperable exchanges that conform with Federal and State privacy and security requirements;

“(C) structured in a manner that permits parents and caregivers to view and understand the extent to which the care their children receive is clinically appropriate and of high quality; and

“(D) capable of being incorporated into, and otherwise compatible with, other standards developed for electronic health records.

“(2) FUNDING.—\$5,000,000 of the amount appropriated under subsection (i) for a fiscal year shall be used to carry out this subsection.

“(g) STUDY OF PEDIATRIC HEALTH AND HEALTH CARE QUALITY MEASURES.—

“(1) IN GENERAL.—Not later than July 1, 2009, the Institute of Medicine shall study and report to Congress on the extent and quality of efforts to measure child health status and the quality of health care for children across the age span and in relation to preventive care, treatments for acute conditions, and treatments aimed at ameliorating or correcting physical, mental, and developmental conditions in children. In conducting such study and preparing such report, the Institute of Medicine shall—

“(A) consider all of the major national population-based reporting systems sponsored by the Federal Government that are currently in place, including reporting requirements under Federal grant programs and national population surveys and estimates conducted directly by the Federal Government;

“(B) identify the information regarding child health and health care quality that each system is designed to capture and generate, the study and reporting periods covered by each system, and the extent to which the information so generated is made widely available through publication;

“(C) identify gaps in knowledge related to children's health status, health disparities among subgroups of children, the effects of social conditions on children's health status and use and effectiveness of health care, and the relationship between child health status and family income, family stability and preservation, and children's school readiness and educational achievement and attainment; and

“(D) make recommendations regarding improving and strengthening the timeliness, quality, and public transparency and accessibility of information about child health and health care quality.

“(2) FUNDING.—Up to \$1,000,000 of the amount appropriated under subsection (i) for a fiscal year shall be used to carry out this subsection.

“(h) RULE OF CONSTRUCTION.—Notwithstanding any other provision in this section, no

evidence based quality measure developed, published, or used as a basis of measurement or reporting under this section may be used to establish an irrebuttable presumption regarding either the medical necessity of care or the maximum permissible coverage for any individual child who is eligible for and receiving medical assistance under title XIX or child health assistance under title XXI.

“(i) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated for each of fiscal years 2008 through 2012, \$45,000,000 for the purpose of carrying out this section (other than subsection (e)). Funds appropriated under this subsection shall remain available until expended.”

(b) INCREASED MATCHING RATE FOR COLLECTING AND REPORTING ON CHILD HEALTH MEASURES.—Section 1903(a)(3)(A) (42 U.S.C. 1396b(a)(3)(A)), is amended—

(1) by striking “and” at the end of clause (i); and

(2) by adding at the end the following new clause:

“(iii) an amount equal to the Federal medical assistance percentage (as defined in section 1905(b)) of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to such developments or modifications of systems of the type described in clause (i) as are necessary for the efficient collection and reporting on child health measures; and”.

SEC. 502. IMPROVED INFORMATION REGARDING ACCESS TO COVERAGE UNDER CHIP.

(a) INCLUSION OF PROCESS AND ACCESS MEASURES IN ANNUAL STATE REPORTS.—Section 2108 (42 U.S.C. 1397hh) is amended—

(1) in subsection (a), in the matter preceding paragraph (1), by striking “The State” and inserting “Subject to subsection (e), the State”;

(2) by adding at the end the following new subsection:

“(e) INFORMATION REQUIRED FOR INCLUSION IN STATE ANNUAL REPORT.—The State shall include the following information in the annual report required under subsection (a):

“(1) Eligibility criteria, enrollment, and retention data (including data with respect to continuity of coverage or duration of benefits).

“(2) Data regarding the extent to which the State uses process measures with respect to determining the eligibility of children under the State child health plan, including measures such as 12-month continuous eligibility, self-declaration of income for applications or renewals, or presumptive eligibility.

“(3) Data regarding denials of eligibility and redeterminations of eligibility.

“(4) Data regarding access to primary and specialty services, access to networks of care, and care coordination provided under the State child health plan, using quality care and consumer satisfaction measures included in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.

“(5) If the State provides child health assistance in the form of premium assistance for the purchase of coverage under a group health plan, data regarding the provision of such assistance, including the extent to which employer-sponsored health insurance coverage is available for children eligible for child health assistance under the State child health plan, the range of the monthly amount of such assistance provided on behalf of a child or family, the number of children or families provided such assistance on a monthly basis, the income of the children or families provided such assistance, the benefits and cost-sharing protection provided under the State child health plan to supplement the coverage purchased with such premium assistance, the effective strategies the State engages in to reduce any administrative barriers to the provision of such assistance, and the effects, if any, of the provision of such as-

sistance on preventing the coverage provided under the State child health plan from substituting for coverage provided under employer-sponsored health insurance offered in the State.

“(6) To the extent applicable, a description of any State activities that are designed to reduce the number of uncovered children in the State, including through a State health insurance connector program or support for innovative private health coverage initiatives.”

(b) GAO STUDY AND REPORT ON ACCESS TO PRIMARY AND SPECIALTY SERVICES.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study of children's access to primary and specialty services under Medicaid and CHIP, including—

(A) the extent to which providers are willing to treat children eligible for such programs;

(B) information on such children's access to networks of care;

(C) geographic availability of primary and specialty services under such programs;

(D) the extent to which care coordination is provided for children's care under Medicaid and CHIP; and

(E) as appropriate, information on the degree of availability of services for children under such programs.

(2) REPORT.—Not later than 2 years after the date of enactment of this Act, the Comptroller General shall submit a report to the appropriate committees of Congress on the study conducted under paragraph (1) that includes recommendations for such Federal and State legislative and administrative changes as the Comptroller General determines are necessary to address any barriers to access to children's care under Medicaid and CHIP that may exist.

SEC. 503. APPLICATION OF CERTAIN MANAGED CARE QUALITY SAFEGUARDS TO CHIP.

Section 2107(e)(1) (42 U.S.C. 1397gg(e)(1)), as amended by section 204(b), is amended by redesignating subparagraph (E) (as added by such section) as subparagraph (F) and by inserting after subparagraph (D) the following new subparagraph:

“(E) Subsections (a)(4), (a)(5), (b), (c), (d), and (e) of section 1932 (relating to requirements for managed care).”

TITLE VI—MISCELLANEOUS

SEC. 601. TECHNICAL CORRECTION REGARDING CURRENT STATE AUTHORITY UNDER MEDICAID.

(a) IN GENERAL.—Only with respect to expenditures for medical assistance under a State Medicaid plan, including any waiver of such plan, for fiscal years 2007 and 2008, a State may elect, notwithstanding the fourth sentence of subsection (b) of section 1905 of the Social Security Act (42 U.S.C. 1396d) or subsection (u) of such section—

(1) to cover individuals described in section 1902(a)(10)(A)(ii)(IX) of the Social Security Act and, at its option, to apply less restrictive methodologies to such individuals under section 1902(r)(2) of such Act or 1931(b)(2)(C) of such Act and thereby receive Federal financial participation for medical assistance for such individuals under title XIX of the Social Security Act; or

(2) to receive Federal financial participation for expenditures for medical assistance under title XIX of such Act for children described in paragraph (2)(B) or (3) of section 1905(u) of such Act based on the Federal medical assistance percentage, as otherwise determined based on the first and third sentences of subsection (b) of section 1905 of the Social Security Act, rather than on the basis of an enhanced FMAP (as defined in section 2105(b) of such Act).

(b) REPEAL.—Effective October 1, 2008, subsection (a) is repealed.

(c) HOLD HARMLESS.—No State that elects the option described in subsection (a) shall be treated as not having been authorized to make such election and to receive Federal financial participation for expenditures for medical assistance

described in that subsection for fiscal years 2007 and 2008 as a result of the repeal of the subsection under subsection (b).

SEC. 602. PAYMENT ERROR RATE MEASUREMENT (“PERM”).

(a) EXPENDITURES RELATED TO COMPLIANCE WITH REQUIREMENTS.—

(1) ENHANCED PAYMENTS.—Section 2105(c) (42 U.S.C. 1397ee(c)), as amended by section 401(a), is amended by adding at the end the following new paragraph:

“(11) ENHANCED PAYMENTS.—Notwithstanding subsection (b), the enhanced FMAP with respect to payments under subsection (a) for expenditures related to the administration of the payment error rate measurement (PERM) requirements applicable to the State child health plan in accordance with the Improper Payments Information Act of 2002 and parts 431 and 457 of title 42, Code of Federal Regulations (or any related or successor guidance or regulations) shall in no event be less than 90 percent.”.

(2) EXCLUSION OF FROM CAP ON ADMINISTRATIVE EXPENDITURES.—Section 2105(c)(2)(C) (42 U.S.C. 1397ee(c)(2)(C)), as amended by section 402(b), is amended by adding at the end the following:

“(v) PAYMENT ERROR RATE MEASUREMENT (PERM) EXPENDITURES.—Expenditures related to the administration of the payment error rate measurement (PERM) requirements applicable to the State child health plan in accordance with the Improper Payments Information Act of 2002 and parts 431 and 457 of title 42, Code of Federal Regulations (or any related or successor guidance or regulations).”.

(b) FINAL RULE REQUIRED TO BE IN EFFECT FOR ALL STATES.—Notwithstanding parts 431 and 457 of title 42, Code of Federal Regulations (as in effect on the date of enactment of this Act), the Secretary shall not calculate or publish any national or State-specific error rate based on the application of the payment error rate measurement (in this section referred to as “PERM”) requirements to CHIP until after the date that is 6 months after the date on which a final rule implementing such requirements in accordance with the requirements of subsection (c) is in effect for all States. Any calculation of a national error rate or a State specific error rate after such final rule is in effect for all States may only be inclusive of errors, as defined in such final rule or in guidance issued within a reasonable time frame after the effective date for such final rule that includes detailed guidance for the specific methodology for error determinations.

(c) REQUIREMENTS FOR FINAL RULE.—For purposes of subsection (b), the requirements of this subsection are that the final rule implementing the PERM requirements shall include—

(1) clearly defined criteria for errors for both States and providers;

(2) a clearly defined process for appealing error determinations by review contractors; and

(3) clearly defined responsibilities and deadlines for States in implementing any corrective action plans.

(d) OPTION FOR APPLICATION OF DATA FOR CERTAIN STATES UNDER THE INTERIM FINAL RULE.—

(1) OPTION FOR STATES IN FIRST APPLICATION CYCLE.—After the final rule implementing the PERM requirements in accordance with the requirements of subsection (c) is in effect for all States, a State for which the PERM requirements were first in effect under an interim final rule for fiscal year 2007 may elect to accept any payment error rate determined in whole or in part for the State on the basis of data for that fiscal year or may elect to not have any payment error rate determined on the basis of such data and, instead, shall be treated as if fiscal year 2010 were the first fiscal year for which the PERM requirements apply to the State.

(2) OPTION FOR STATES IN SECOND APPLICATION CYCLE.—If such final rule is not in effect for all States by July 1, 2008, a State for which the

PERM requirements were first in effect under an interim final rule for fiscal year 2008 may elect to accept any payment error rate determined in whole or in part for the State on the basis of data for that fiscal year or may elect to not have any payment error rate determined on the basis of such data and, instead, shall be treated as if fiscal year 2011 were the first fiscal year for which the PERM requirements apply to the State.

(e) HARMONIZATION OF MEQC AND PERM.—

(1) REDUCTION OF REDUNDANCIES.—The Secretary shall review the Medicaid Eligibility Quality Control (in this subsection referred to as the “MEQC”) requirements with the PERM requirements and coordinate consistent implementation of both sets of requirements, while reducing redundancies.

(2) STATE OPTION TO APPLY PERM DATA.—A State may elect, for purposes of determining the erroneous excess payments for medical assistance ratio applicable to the State for a fiscal year under section 1903(u) of the Social Security Act (42 U.S.C. 1396b(u)) to substitute data resulting from the application of the PERM requirements to the State after the final rule implementing such requirements is in effect for all States for data obtained from the application of the MEQC requirements to the State with respect to a fiscal year.

(f) IDENTIFICATION OF IMPROVED STATE-SPECIFIC SAMPLE SIZES.—The Secretary shall establish State-specific sample sizes for application of the PERM requirements with respect to State child health plans for fiscal years beginning with fiscal year 2009, on the basis of such information as the Secretary determines appropriate. In establishing such sample sizes, the Secretary shall, to the greatest extent practicable—

(1) minimize the administrative cost burden on States under Medicaid and CHIP; and

(2) maintain State flexibility to manage such programs.

SEC. 603. ELIMINATION OF COUNTING MEDICAID CHILD PRESUMPTIVE ELIGIBILITY COSTS AGAINST TITLE XXI ALLOTMENT.

Section 2105(a)(1) (42 U.S.C. 1397ee(a)(1)) is amended—

(1) in the matter preceding subparagraph (A), by striking “(or, in the case of expenditures described in subparagraph (B), the Federal medical assistance percentage (as defined in the first sentence of section 1905(b)))”; and

(2) by striking subparagraph (B) and inserting the following new subparagraph:

“(B) [reserved]”.

SEC. 604. IMPROVING DATA COLLECTION.

(a) INCREASED APPROPRIATION.—Section 2109(b)(2) (42 U.S.C. 1397ii(b)(2)) is amended by striking “\$10,000,000 for fiscal year 2008” and inserting “\$20,000,000 for fiscal year 2008”.

(b) USE OF ADDITIONAL FUNDS.—Section 2109(b) (42 U.S.C. 1397ii(b)), as amended by subsection (a), is amended—

(1) by redesignating paragraph (2) as paragraph (4); and

(2) by inserting after paragraph (1), the following new paragraphs:

“(2) ADDITIONAL REQUIREMENTS.—In addition to making the adjustments required to produce the data described in paragraph (1), with respect to data collection occurring for fiscal years beginning with fiscal year 2008, in appropriate consultation with the Secretary of Health and Human Services, the Secretary of Commerce shall do the following:

“(A) Make appropriate adjustments to the Current Population Survey to develop more accurate State-specific estimates of the number of children enrolled in health coverage under title XIX or this title.

“(B) Make appropriate adjustments to the Current Population Survey to improve the survey estimates used to compile the State-specific and national number of low-income children without health insurance for purposes of determining allotments under subsections (c) and (i)

of section 2104 and making payments to States from the CHIP Incentive Bonuses Pool established under subsection (j) of such section, the CHIP Contingency Fund established under subsection (k) of such section, and, to the extent applicable to a State, from the block grant set aside under section 2111(b)(2)(B)(i) for each of fiscal years 2010 through 2012.

“(C) Include health insurance survey information in the American Community Survey related to children.

“(D) Assess whether American Community Survey estimates, once such survey data are first available, produce more reliable estimates than the Current Population Survey with respect to the purposes described in subparagraph (B).

“(E) On the basis of the assessment required under subparagraph (D), recommend to the Secretary of Health and Human Services whether American Community Survey estimates should be used in lieu of, or in some combination with, Current Population Survey estimates for the purposes described in subparagraph (B).

“(F) Continue making the adjustments described in the last sentence of paragraph (1) with respect to expansion of the sample size used in State sampling units, the number of sampling units in a State, and using an appropriate verification element.

“(3) AUTHORITY FOR THE SECRETARY OF HEALTH AND HUMAN SERVICES TO TRANSITION TO THE USE OF ALL, OR SOME COMBINATION OF, ACS ESTIMATES UPON RECOMMENDATION OF THE SECRETARY OF COMMERCE.—If, on the basis of the assessment required under paragraph (2)(D), the Secretary of Commerce recommends to the Secretary of Health and Human Services that American Community Survey estimates should be used in lieu of, or in some combination with, Current Population Survey estimates for the purposes described in paragraph (2)(B), the Secretary of Health and Human Services may provide for a period during which the Secretary may transition from carrying out such purposes through the use of Current Population Survey estimates to the use of American Community Survey estimates (in lieu of, or in combination with the Current Population Survey estimates, as recommended), provided that any such transition is implemented in a manner that is designed to avoid adverse impacts upon States with approved State child health plans under this title.”.

SEC. 605. DEFICIT REDUCTION ACT TECHNICAL CORRECTIONS.

(a) STATE FLEXIBILITY IN BENEFIT PACKAGES.—

(1) CLARIFICATION OF REQUIREMENT TO PROVIDE EPSDT SERVICES FOR ALL CHILDREN IN BENCHMARK BENEFIT PACKAGES.—Section 1937(a)(1) (42 U.S.C. 1396u-7(a)(1)), as inserted by section 604(a) of the Deficit Reduction Act of 2005 (Public Law 109-171, 120 Stat. 88), is amended—

(A) in subparagraph (A)—

(i) in the matter before clause (i), by striking “enrollment in coverage that provides” and inserting “coverage that”;

(ii) in clause (i), by inserting “provides” after “(i)”; and

(iii) by striking clause (ii) and inserting the following:

“(ii) for any individual described in section 1905(a)(4)(B) who is eligible under the State plan in accordance with paragraphs (10) and (17) of section 1902(a), consists of the items and services described in section 1905(a)(4)(B) (relating to early and periodic screening, diagnostic, and treatment services defined in section 1905(r)) and provided in accordance with the requirements of section 1902(a)(43).”;

(B) in subparagraph (C)—

(i) in the heading, by striking “WRAP-AROUND” and inserting “ADDITIONAL”; and

(ii) by striking “wrap-around or”; and

(C) by adding at the end the following new subparagraph:

“(E) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as—

“(i) requiring a State to offer all or any of the items and services required by subparagraph (A)(i) through an issuer of benchmark coverage described in subsection (b)(1) or benchmark equivalent coverage described in subsection (b)(2); or

“(ii) preventing a State from offering all or any of the items and services required by subparagraph (A)(ii) through an issuer of benchmark coverage described in subsection (b)(1) or benchmark equivalent coverage described in subsection (b)(2).”.

(2) CORRECTION OF REFERENCE TO CHILDREN IN FOSTER CARE RECEIVING CHILD WELFARE SERVICES.—Section 1937(a)(2)(B)(viii) (42 U.S.C. 1396u-7(a)(2)(B)(viii)), as inserted by section 6044(a) of the Deficit Reduction Act of 2005, is amended by striking “aid or assistance is made available under part B of title IV to children in foster care and individuals” and inserting “child welfare services are made available under part B of title IV on the basis of being a child in foster care or”.

(3) TRANSPARENCY.—Section 1937 (42 U.S.C. 1396u-7), as inserted by section 6044(a) of the Deficit Reduction Act of 2005, is amended by adding at the end the following:

“(c) PUBLICATION OF PROVISIONS AFFECTED.—Not later than 30 days after the date the Secretary approves a State plan amendment to provide benchmark benefits in accordance with subsections (a) and (b), the Secretary shall publish in the Federal Register and on the Internet website of the Centers for Medicare & Medicaid Services, a list of the provisions of this title that the Secretary has determined do not apply in order to enable the State to carry out such plan amendment and the reason for each such determination.”.

(4) EFFECTIVE DATE.—The amendments made by this subsection shall take effect as if included in the amendment made by section 6044(a) of the Deficit Reduction Act of 2005.

SEC. 606. ELIMINATION OF CONFUSING PROGRAM REFERENCES.

Section 704 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, as enacted into law by division B of Public Law 106-113 (113 Stat. 1501A-402) is repealed.

SEC. 607. MENTAL HEALTH PARITY IN CHIP PLANS.

(a) ASSURANCE OF PARITY.—Section 2103(c) (42 U.S.C. 1397cc(c)) is amended—

(1) by redesignating paragraph (5) as paragraph (6); and

(2) by inserting after paragraph (4), the following:

“(5) MENTAL HEALTH SERVICES PARITY.—“(A) IN GENERAL.—In the case of a State child health plan that provides both medical and surgical benefits and mental health or substance abuse benefits, such plan shall ensure that the financial requirements and treatment limitations applicable to such mental health or substance abuse benefits are no more restrictive than the financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the plan.

“(B) DEEMED COMPLIANCE.—To the extent that a State child health plan includes coverage with respect to an individual described in section 1905(a)(4)(B) and covered under the State plan under section 1902(a)(10)(A) of the services described in section 1905(a)(4)(B) (relating to early and periodic screening, diagnostic, and treatment services defined in section 1905(r)) and provided in accordance with section 1902(a)(43), such plan shall be deemed to satisfy the requirements of subparagraph (A).”.

(b) CONFORMING AMENDMENTS.—Section 2103 (42 U.S.C. 1397cc) is amended—

(1) in subsection (a), in the matter preceding paragraph (1), by striking “subsection (c)(5)” and inserting “paragraphs (5) and (6) of subsection (c)”;

(2) in subsection (c)(2), by striking subparagraph (B) and redesignating subparagraphs (C) and (D) as subparagraphs (B) and (C), respectively.

SEC. 608. DENTAL HEALTH GRANTS.

(a) IN GENERAL.—Title XXI (42 U.S.C. 1397aa et seq.), as amended by section 201, is amended by adding at the end the following:

“SEC. 2114. DENTAL HEALTH GRANTS.

“(a) AUTHORITY TO AWARD GRANTS.—

“(1) IN GENERAL.—From the amount appropriated under subsection (f), the Secretary shall award grants from amounts to the eligible States for the purpose of carrying out programs and activities that are designed to improve the availability of dental services and strengthen dental coverage for targeted low-income children enrolled in State child health plans.

“(2) ELIGIBLE STATE.—In this section, the term ‘eligible State’ means a State with an approved State child health plan under this title that submits an application under subsection (b) that is approved by Secretary.

“(b) APPLICATION.—An eligible State that desires to receive a grant under this paragraph shall submit an application to the Secretary in such form and manner, and containing such information, as the Secretary may require. Such application shall include—

“(1) a detailed description of—

“(A) the dental services (if any) covered under the State child health plan; and

“(B) how the State intends to improve dental coverage and services during fiscal years 2008 through 2012;

“(2) a detailed description of the programs and activities proposed to be conducted with funds awarded under the grant;

“(3) quality and outcomes performance measures to evaluate the effectiveness of such activities; and

“(4) an assurance that the State shall—

“(A) conduct an assessment of the effectiveness of such activities against such performance measures; and

“(B) cooperate with the collection and reporting of data and other information determined as a result of conducting such assessments to the Secretary, in such form and manner as the Secretary shall require.

“(c) USE OF FUNDS.—The programs and activities described in subsection (a)(1) may include the provision of enhanced dental coverage under the State child health plan.

“(d) MAINTENANCE OF EFFORT FOR STATES AWARDED GRANTS; NO STATE MATCH REQUIRED.—In the case of a State that is awarded a grant under this section—

“(1) the State share of funds expended for dental services under the State child health plan shall not be less than the State share of such funds expended in the fiscal year preceding the first fiscal year for which the grant is awarded; and

“(2) no State matching funds shall be required for the State to receive a grant under this section.

“(e) ANNUAL REPORT.—The Secretary shall submit an annual report to the appropriate committees of Congress regarding the grants awarded under this section that includes—

“(1) State specific descriptions of the programs and activities conducted with funds awarded under such grants; and

“(2) information regarding the assessments required of States under subsection (b)(4).

“(f) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated, \$200,000,000 for the period of fiscal years 2008 through 2012, to remain available until expended, for the purpose of awarding grants to States under this section. Amounts appropriated and paid under the authority of this section shall be in addition to amounts appropriated under section 2104 and paid to States in accordance with section 2105.”.

(b) IMPROVED ACCESSIBILITY OF DENTAL PROVIDER INFORMATION MORE ACCESSIBLE TO EN-

ROLLEES UNDER MEDICAID AND CHIP.—The Secretary shall—

(1) work with States, pediatric dentists, and other dental providers to include on the Insure Kids Now website (<http://www.insurekidsnow.gov/>) and hotline (1-877-KIDS-NOW) a current and accurate list of all dentists and other dental providers within each State that provide dental services to children enrolled in the State plan (or waiver) under Medicaid or the State child health plan (or waiver) under CHIP, and shall ensure that such list is updated at least quarterly; and

(2) work with States to include a description of the dental services provided under each State plan (or waiver) under Medicaid and each State child health plan (or waiver) under CHIP on such Insure Kids Now website.

(c) GAO STUDY AND REPORT ON ACCESS TO ORAL HEALTH CARE, INCLUDING PREVENTIVE AND RESTORATIVE SERVICES.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study of children’s access to oral health care, including preventive and restorative services, under Medicaid and CHIP, including—

(A) the extent to which providers are willing to treat children eligible for such programs;

(B) information on such children’s access to networks of care;

(C) geographic availability of oral health care, including preventive and restorative services, under such programs; and

(D) as appropriate, information on the degree of availability of oral health care, including preventive and restorative services, for children under such programs.

(2) REPORT.—Not later than 2 years after the date of enactment of this Act, the Comptroller General shall submit a report to the appropriate committees of Congress on the study conducted under paragraph (1) that includes recommendations for such Federal and State legislative and administrative changes as the Comptroller General determines are necessary to address any barriers to access to oral health care, including preventive and restorative services, under Medicaid and CHIP that may exist.

(d) INCLUSION OF STATUS OF EFFORTS TO IMPROVE DENTAL CARE IN REPORTS ON THE QUALITY OF CHILDREN’S HEALTH CARE UNDER MEDICAID AND CHIP.—Section 1139A(a)(6)(ii), as added by section 501(a), is amended by inserting “dental care,” after “preventive health services.”.

SEC. 609. APPLICATION OF PROSPECTIVE PAYMENT SYSTEM FOR SERVICES PROVIDED BY FEDERALLY-QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS.

(a) APPLICATION OF PROSPECTIVE PAYMENT SYSTEM.—

(1) IN GENERAL.—Section 2107(e)(1) (42 U.S.C. 1397gg(e)(1)), as amended by sections 204(b) and 503, is amended by inserting after subparagraph (A) the following new subparagraph (and redesignating the succeeding subparagraphs accordingly):

“(B) Section 1902(bb) (relating to payment for services provided by Federally-qualified health centers and rural health clinics).”.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to services provided on or after October 1, 2008.

(b) TRANSITION GRANTS.—

(1) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary for fiscal year 2008, \$5,000,000, to remain available until expended, for the purpose of awarding grants to States with State child health plans under CHIP that are operated separately from the State Medicaid plan under title XIX of the Social Security Act (including any waiver of such plan), or in combination with the State Medicaid plan, for expenditures related to transitioning to compliance with the requirement of section 2107(e)(1)(B) of the Social Security Act (as

added by subsection (a) to apply the prospective payment system established under section 1902(bb) of the such Act (42 U.S.C. 1396a(bb)) to services provided by Federally-qualified health centers and rural health clinics.

(2) **MONITORING AND REPORT.**—The Secretary shall monitor the impact of the application of such prospective payment system on the States described in paragraph (1) and, not later than October 1, 2010, shall report to Congress on any effect on access to benefits, provider payment rates, or scope of benefits offered by such States as a result of the application of such payment system.

SEC. 610. SUPPORT FOR INJURED SERVICEMEMBERS.

(a) **SHORT TITLE.**—This section may be cited as the “Support for Injured Servicemembers Act”.

(b) **SERVICEMEMBER FAMILY LEAVE.**—

(1) **DEFINITIONS.**—Section 101 of the Family and Medical Leave Act of 1993 (29 U.S.C. 2611) is amended by adding at the end the following:

“(14) **ACTIVE DUTY.**—The term ‘active duty’ means duty under a call or order to active duty under a provision of law referred to in section 101(a)(13)(B) of title 10, United States Code.

“(15) **COVERED SERVICEMEMBER.**—The term ‘covered servicemember’ means a member of the Armed Forces, including a member of the National Guard or a Reserve, who is undergoing medical treatment, recuperation, or therapy, is otherwise in medical hold or medical holdover status, or is otherwise on the temporary disability retired list, for a serious injury or illness.

“(16) **MEDICAL HOLD OR MEDICAL HOLDOVER STATUS.**—The term ‘medical hold or medical holdover status’ means—

“(A) the status of a member of the Armed Forces, including a member of the National Guard or a Reserve, assigned or attached to a military hospital for medical care; and

“(B) the status of a member of a reserve component of the Armed Forces who is separated, whether pre-deployment or post-deployment, from the member’s unit while in need of health care based on a medical condition identified while the member is on active duty in the Armed Forces.

“(17) **NEXT OF KIN.**—The term ‘next of kin’, used with respect to an individual, means the nearest blood relative of that individual.

“(18) **SERIOUS INJURY OR ILLNESS.**—The term ‘serious injury or illness’, in the case of a member of the Armed Forces, means an injury or illness incurred by the member in line of duty on active duty in the Armed Forces that may render the member medically unfit to perform the duties of the member’s office, grade, rank, or rating.”.

(2) **ENTITLEMENT TO LEAVE.**—Section 102(a) of such Act (29 U.S.C. 2612(a)) is amended by adding at the end the following:

“(3) **SERVICEMEMBER FAMILY LEAVE.**—Subject to section 103, an eligible employee who is the spouse, son, daughter, parent, or next of kin of a covered servicemember shall be entitled to a total of 26 workweeks of leave during a 12-month period to care for the servicemember. The leave described in this paragraph shall only be available during a single 12-month period.

“(4) **COMBINED LEAVE TOTAL.**—During the single 12-month period described in paragraph (3), an eligible employee shall be entitled to a combined total of 26 workweeks of leave under paragraphs (1) and (3). Nothing in this paragraph shall be construed to limit the availability of leave under paragraph (1) during any other 12-month period.”.

(3) **REQUIREMENTS RELATING TO LEAVE.**—

(A) **SCHEDULE.**—Section 102(b) of such Act (29 U.S.C. 2612(b)) is amended—

(i) in paragraph (1), in the second sentence—
(I) by striking “section 103(b)(5)” and inserting “subsection (b)(5) or (f) (as appropriate) of section 103”; and

(II) by inserting “or under subsection (a)(3)” after “subsection (a)(1)”; and

(ii) in paragraph (2), by inserting “or under subsection (a)(3)” after “subsection (a)(1)”.

(B) **SUBSTITUTION OF PAID LEAVE.**—Section 102(d) of such Act (29 U.S.C. 2612(d)) is amended—

(i) in paragraph (1)—

(I) by inserting “(or 26 workweeks in the case of leave provided under subsection (a)(3))” after “12 workweeks” the first place it appears; and

(II) by inserting “(or 26 workweeks, as appropriate)” after “12 workweeks” the second place it appears; and

(ii) in paragraph (2)(B), by adding at the end the following: “An eligible employee may elect, or an employer may require the employee, to substitute any of the accrued paid vacation leave, personal leave, family leave, or medical or sick leave of the employee for leave provided under subsection (a)(3) for any part of the 26-week period of such leave under such subsection.”.

(C) **NOTICE.**—Section 102(e)(2) of such Act (29 U.S.C. 2612(e)(2)) is amended by inserting “or under subsection (a)(3)” after “subsection (a)(1)”.

(D) **SPOUSES EMPLOYED BY SAME EMPLOYER.**—Section 102(f) of such Act (29 U.S.C. 2612(f)) is amended—

(i) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), and aligning the margins of the subparagraphs with the margins of section 102(e)(2)(A);

(ii) by striking “In any” and inserting the following:

“(1) **IN GENERAL.**—In any”; and

(iii) by adding at the end the following:

“(2) **SERVICEMEMBER FAMILY LEAVE.**—

“(A) **IN GENERAL.**—The aggregate number of workweeks of leave to which both that husband and wife may be entitled under subsection (a) may be limited to 26 workweeks during the single 12-month period described in subsection (a)(3) if the leave is—

“(i) leave under subsection (a)(3); or

“(ii) a combination of leave under subsection (a)(3) and leave described in paragraph (1).

“(B) **BOTH LIMITATIONS APPLICABLE.**—If the leave taken by the husband and wife includes leave described in paragraph (1), the limitation in paragraph (1) shall apply to the leave described in paragraph (1).”.

(E) **CERTIFICATION.**—Section 103 of such Act (29 U.S.C. 2613) is amended by adding at the end the following:

“(f) **CERTIFICATION FOR SERVICEMEMBER FAMILY LEAVE.**—An employer may require that a request for leave under section 102(a)(3) be supported by a certification issued at such time and in such manner as the Secretary may by regulation prescribe.”.

(F) **FAILURE TO RETURN.**—Section 104(c) of such Act (29 U.S.C. 2614(c)) is amended—

(i) in paragraph (2)(B)(i), by inserting “or under section 102(a)(3)” before the semicolon; and

(ii) in paragraph (3)(A)—

(I) in clause (i), by striking “or” at the end;

(II) in clause (ii), by striking the period and inserting “; or”; and

(III) by adding at the end the following:

“(iii) a certification issued by the health care provider of the servicemember being cared for by the employee, in the case of an employee unable to return to work because of a condition specified in section 102(a)(3).”.

(G) **ENFORCEMENT.**—Section 107 of such Act (29 U.S.C. 2617) is amended, in subsection (a)(1)(A)(i)(II), by inserting “(or 26 weeks, in a case involving leave under section 102(a)(3))” after “12 weeks”.

(H) **INSTRUCTIONAL EMPLOYEES.**—Section 108 of such Act (29 U.S.C. 2618) is amended, in subsections (c)(1), (d)(2), and (d)(3), by inserting “or under section 102(a)(3)” after “section 102(a)(1)”.

(c) **SERVICEMEMBER FAMILY LEAVE FOR CIVIL SERVICE EMPLOYEES.**—

(1) **DEFINITIONS.**—Section 6381 of title 5, United States Code, is amended—

(A) in paragraph (5), by striking “and” at the end;

(B) in paragraph (6), by striking the period and inserting “; and”; and

(C) by adding at the end the following:

“(7) the term ‘active duty’ means duty under a call or order to active duty under a provision of law referred to in section 101(a)(13)(B) of title 10, United States Code;

“(8) the term ‘covered servicemember’ means a member of the Armed Forces, including a member of the National Guard or a Reserve, who is undergoing medical treatment, recuperation, or therapy, is otherwise in medical hold or medical holdover status, or is otherwise on the temporary disability retired list, for a serious injury or illness;

“(9) the term ‘medical hold or medical holdover status’ means—

“(A) the status of a member of the Armed Forces, including a member of the National Guard or a Reserve, assigned or attached to a military hospital for medical care; and

“(B) the status of a member of a reserve component of the Armed Forces who is separated, whether pre-deployment or post-deployment, from the member’s unit while in need of health care based on a medical condition identified while the member is on active duty in the Armed Forces;

“(10) the term ‘next of kin’, used with respect to an individual, means the nearest blood relative of that individual; and

“(11) the term ‘serious injury or illness’, in the case of a member of the Armed Forces, means an injury or illness incurred by the member in line of duty on active duty in the Armed Forces that may render the member medically unfit to perform the duties of the member’s office, grade, rank, or rating.”.

(2) **ENTITLEMENT TO LEAVE.**—Section 6382(a) of such title is amended by adding at the end the following:

“(3) Subject to section 6383, an employee who is the spouse, son, daughter, parent, or next of kin of a covered servicemember shall be entitled to a total of 26 administrative workweeks of leave during a 12-month period to care for the servicemember. The leave described in this paragraph shall only be available during a single 12-month period.

“(4) During the single 12-month period described in paragraph (3), an employee shall be entitled to a combined total of 26 administrative workweeks of leave under paragraphs (1) and (3). Nothing in this paragraph shall be construed to limit the availability of leave under paragraph (1) during any other 12-month period.”.

(3) **REQUIREMENTS RELATING TO LEAVE.**—

(A) **SCHEDULE.**—Section 6382(b) of such title is amended—

(i) in paragraph (1), in the second sentence—
(I) by striking “(section 6383(b)(5))” and inserting “subsection (b)(5) or (f) (as appropriate) of section 6383”; and

(II) by inserting “or under subsection (a)(3)” after “subsection (a)(1)”; and

(ii) in paragraph (2), by inserting “or under subsection (a)(3)” after “subsection (a)(1)”.

(B) **SUBSTITUTION OF PAID LEAVE.**—Section 6382(d) of such title is amended by adding at the end the following: “An employee may elect to substitute for leave under subsection (a)(3) any of the employee’s accrued or accumulated annual or sick leave under subchapter I for any part of the 26-week period of leave under such subsection.”.

(C) **NOTICE.**—Section 6382(e) of such title is amended by inserting “or under subsection (a)(3)” after “subsection (a)(1)”.

(D) **CERTIFICATION.**—Section 6383 of such title is amended by adding at the end the following:

“(f) An employing agency may require that a request for leave under section 6382(a)(3) be supported by a certification issued at such time and in such manner as the Office of Personnel Management may by regulation prescribe.”.

SEC. 611. MILITARY FAMILY JOB PROTECTION.

(a) **SHORT TITLE.**—This section may be cited as the “Military Family Job Protection Act”.

(b) **PROHIBITION ON DISCRIMINATION IN EMPLOYMENT AGAINST CERTAIN FAMILY MEMBERS CARING FOR RECOVERING MEMBERS OF THE ARMED FORCES.**—A family member of a recovering servicemember described in subsection (c) shall not be denied retention in employment, promotion, or any benefit of employment by an employer on the basis of the family member’s absence from employment as described in that subsection, for a period of not more than 52 workweeks.

(c) **COVERED FAMILY MEMBERS.**—A family member described in this subsection is a family member of a recovering servicemember who is—

(1) on invitational orders while caring for the recovering servicemember;

(2) a non-medical attendee caring for the recovering servicemember; or

(3) receiving per diem payments from the Department of Defense while caring for the recovering servicemember.

(d) **TREATMENT OF ACTIONS.**—An employer shall be considered to have engaged in an action prohibited by subsection (b) with respect to a person described in that subsection if the absence from employment of the person as described in that subsection is a motivating factor in the employer’s action, unless the employer can prove that the action would have been taken in the absence of the absence of employment of the person.

(e) **DEFINITIONS.**—In this section:

(1) **BENEFIT OF EMPLOYMENT.**—The term “benefit of employment” has the meaning given such term in section 4303 of title 38, United States Code.

(2) **CARING FOR.**—The term “caring for”, used with respect to a recovering servicemember, means providing personal, medical, or convalescent care to the recovering servicemember, under circumstances that substantially interfere with an employee’s ability to work.

(3) **EMPLOYER.**—The term “employer” has the meaning given such term in section 4303 of title 38, United States Code, except that the term does not include any person who is not considered to be an employer under title I of the Family and Medical Leave Act of 1993 (29 U.S.C. 2611 et seq.) because the person does not meet the requirements of section 101(4)(A)(i) of such Act (29 U.S.C. 2611(4)(A)(i)).

(4) **FAMILY MEMBER.**—The term “family member”, with respect to a recovering servicemember, has the meaning given that term in section 411h(b) of title 37, United States Code.

(5) **RECOVERING SERVICEMEMBER.**—The term “recovering servicemember” means a member of the Armed Forces, including a member of the National Guard or a Reserve, who is undergoing medical treatment, recuperation, or therapy, or is otherwise in medical hold or medical holdover status, for an injury, illness, or disease incurred or aggravated while on active duty in the Armed Forces.

SEC. 612. SENSE OF SENATE REGARDING ACCESS TO AFFORDABLE AND MEANINGFUL HEALTH INSURANCE COVERAGE.

(a) **FINDINGS.**—The Senate finds the following:

(1) There are approximately 45 million Americans currently without health insurance.

(2) More than half of uninsured workers are employed by businesses with less than 25 employees or are self-employed.

(3) Health insurance premiums continue to rise at more than twice the rate of inflation for all consumer goods.

(4) Individuals in the small group and individual health insurance markets usually pay more for similar coverage than those in the large group market.

(5) The rapid growth in health insurance costs over the last few years has forced many employers, particularly small employers, to increase deductibles and co-pays or to drop coverage completely.

(b) **SENSE OF THE SENATE.**—The Senate—

(1) recognizes the necessity to improve affordability and access to health insurance for all Americans;

(2) acknowledges the value of building upon the existing private health insurance market; and

(3) affirms its intent to enact legislation this year that, with appropriate protection for consumers, improves access to affordable and meaningful health insurance coverage for employees of small businesses and individuals by—

(A) facilitating pooling mechanisms, including pooling across State lines, and

(B) providing assistance to small businesses and individuals, including financial assistance and tax incentives, for the purchase of private insurance coverage.

SEC. 613. DEMONSTRATION PROJECTS RELATING TO DIABETES PREVENTION.

There is authorized to be appropriated \$15,000,000 during the period of fiscal years 2008 through 2012 to fund demonstration projects in up to 10 States over 3 years for voluntary incentive programs to promote children’s receipt of relevant screenings and improvements in healthy eating and physical activity with the aim of reducing the incidence of type 2 diabetes. Such programs may involve reductions in cost-sharing or premiums when children receive regular screening and reach certain benchmarks in healthy eating and physical activity. Under such programs, a State may also provide financial bonuses for partnerships with entities, such as schools, which increase their education and efforts with respect to reducing the incidence of type 2 diabetes and may also devise incentives for providers serving children covered under this title and title XIX to perform relevant screening and counseling regarding healthy eating and physical activity. Upon completion of these demonstrations, the Secretary shall provide a report to Congress on the results of the State demonstration projects and the degree to which they helped improve health outcomes related to type 2 diabetes in children in those States.”.

SEC. 614. OUTREACH REGARDING HEALTH INSURANCE OPTIONS AVAILABLE TO CHILDREN.

(a) **DEFINITIONS.**—In this section—

(1) the terms “Administration” and “Administrator” means the Small Business Administration and the Administrator thereof, respectively;

(2) the term “certified development company” means a development company participating in the program under title V of the Small Business Investment Act of 1958 (15 U.S.C. 695 et seq.);

(3) the term “Medicaid program” means the program established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.);

(4) the term “Service Corps of Retired Executives” means the Service Corps of Retired Executives authorized by section 8(b)(1) of the Small Business Act (15 U.S.C. 637(b)(1));

(5) the term “small business concern” has the meaning given that term in section 3 of the Small Business Act (15 U.S.C. 632);

(6) the term “small business development center” means a small business development center described in section 21 of the Small Business Act (15 U.S.C. 648);

(7) the term “State” has the meaning given that term for purposes of title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.);

(8) the term “State Children’s Health Insurance Program” means the State Children’s Health Insurance Program established under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.);

(9) the term “task force” means the task force established under subsection (b)(1); and

(10) the term “women’s business center” means a women’s business center described in section 29 of the Small Business Act (15 U.S.C. 656).

(b) **ESTABLISHMENT OF TASK FORCE.**—

(1) **ESTABLISHMENT.**—There is established a task force to conduct a nationwide campaign of

education and outreach for small business concerns regarding the availability of coverage for children through private insurance options, the Medicaid program, and the State Children’s Health Insurance Program.

(2) **MEMBERSHIP.**—The task force shall consist of the Administrator, the Secretary of Health and Human Services, the Secretary of Labor, and the Secretary of the Treasury.

(3) **RESPONSIBILITIES.**—The campaign conducted under this subsection shall include—

(A) efforts to educate the owners of small business concerns about the value of health coverage for children;

(B) information regarding options available to the owners and employees of small business concerns to make insurance more affordable, including Federal and State tax deductions and credits for health care-related expenses and health insurance expenses and Federal tax exclusion for health insurance options available under employer-sponsored cafeteria plans under section 125 of the Internal Revenue Code of 1986;

(C) efforts to educate the owners of small business concerns about assistance available through public programs; and

(D) efforts to educate the owners and employees of small business concerns regarding the availability of the hotline operated as part of the Insure Kids Now program of the Department of Health and Human Services.

(4) **IMPLEMENTATION.**—In carrying out this subsection, the task force may—

(A) use any business partner of the Administration, including—

- (i) a small business development center;
- (ii) a certified development company;
- (iii) a women’s business center; and
- (iv) the Service Corps of Retired Executives;

(B) enter into—

(i) a memorandum of understanding with a chamber of commerce; and

(ii) a partnership with any appropriate small business concern or health advocacy group; and

(C) designate outreach programs at regional offices of the Department of Health and Human Services to work with district offices of the Administration.

(5) **WEBSITE.**—The Administrator shall ensure that links to information on the eligibility and enrollment requirements for the Medicaid program and State Children’s Health Insurance Program of each State are prominently displayed on the website of the Administration.

(6) **REPORT.**—

(A) **IN GENERAL.**—Not later than 2 years after the date of enactment of this Act, and every 2 years thereafter, the Administrator shall submit to the Committee on Small Business and Entrepreneurship of the Senate and the Committee on Small Business of the House of Representatives a report on the status of the nationwide campaign conducted under paragraph (1).

(B) **CONTENTS.**—Each report submitted under subparagraph (A) shall include a status update on all efforts made to educate owners and employees of small business concerns on options for providing health insurance for children through public and private alternatives.

TITLE VII—REVENUE PROVISIONS**SEC. 701. INCREASE IN EXCISE TAX RATE ON TOBACCO PRODUCTS.**

(a) **CIGARS.**—Section 5701(a) of the Internal Revenue Code of 1986 is amended—

(1) by striking “\$1.828 cents per thousand (\$1.594 cents per thousand on cigars removed during 2000 or 2001)” in paragraph (1) and inserting “\$50.00 per thousand”;

(2) by striking “20.719 percent (18.063 percent on cigars removed during 2000 or 2001)” in paragraph (2) and inserting “53.13 percent”;

(3) by striking “\$48.75 per thousand (\$42.50 per thousand on cigars removed during 2000 or 2001)” in paragraph (2) and inserting “\$3.00 per cigar”.

(b) **CIGARETTES.**—Section 5701(b) of such Code is amended—

(1) by striking “\$19.50 per thousand (\$17 per thousand on cigarettes removed during 2000 or 2001)” in paragraph (1) and inserting “\$50.00 per thousand”, and

(2) by striking “\$40.95 per thousand (\$35.70 per thousand on cigarettes removed during 2000 or 2001)” in paragraph (2) and inserting “\$104.9999 cents per thousand”.

(c) CIGARETTE PAPERS.—Section 5701(c) of such Code is amended by striking “1.22 cents (1.06 cents on cigarette papers removed during 2000 or 2001)” and inserting “3.13 cents”.

(d) CIGARETTE TUBES.—Section 5701(d) of such Code is amended by striking “2.44 cents (2.13 cents on cigarette tubes removed during 2000 or 2001)” and inserting “6.26 cents”.

(e) SMOKELESS TOBACCO.—Section 5701(e) of such Code is amended—

(1) by striking “58.5 cents (51 cents on snuff removed during 2000 or 2001)” in paragraph (1) and inserting “\$1.50”, and

(2) by striking “19.5 cents (17 cents on chewing tobacco removed during 2000 or 2001)” in paragraph (2) and inserting “50 cents”.

(f) PIPE TOBACCO.—Section 5701(f) of such Code is amended by striking “\$1.0969 cents (95.67 cents on pipe tobacco removed during 2000 or 2001)” and inserting “\$2.8126 cents”.

(g) ROLL-YOUR-OWN TOBACCO.—Section 5701(g) of such Code is amended by striking “\$1.0969 cents (95.67 cents on roll-your-own tobacco removed during 2000 or 2001)” and inserting “\$8.8889 cents”.

(h) FLOOR STOCKS TAXES.—

(1) IMPOSITION OF TAX.—On tobacco products and cigarette papers and tubes manufactured in or imported into the United States which are removed before January 1, 2008, and held on such date for sale by any person, there is hereby imposed a tax in an amount equal to the excess of—

(A) the tax which would be imposed under section 5701 of the Internal Revenue Code of 1986 on the article if the article had been removed on such date, over

(B) the prior tax (if any) imposed under section 5701 of such Code on such article.

(2) CREDIT AGAINST TAX.—Each person shall be allowed as a credit against the taxes imposed by paragraph (1) an amount equal to \$500. Such credit shall not exceed the amount of taxes imposed by paragraph (1) on January 1, 2008, for which such person is liable.

(3) LIABILITY FOR TAX AND METHOD OF PAYMENT.—

(A) LIABILITY FOR TAX.—A person holding tobacco products, cigarette papers, or cigarette tubes on January 1, 2008, to which any tax imposed by paragraph (1) applies shall be liable for such tax.

(B) METHOD OF PAYMENT.—The tax imposed by paragraph (1) shall be paid in such manner as the Secretary shall prescribe by regulations.

(C) TIME FOR PAYMENT.—The tax imposed by paragraph (1) shall be paid on or before April 1, 2008.

(4) ARTICLES IN FOREIGN TRADE ZONES.—Notwithstanding the Act of June 18, 1934 (commonly known as the Foreign Trade Zone Act, 48 Stat. 998, 19 U.S.C. 81a et seq.) or any other provision of law, any article which is located in a foreign trade zone on January 1, 2008, shall be subject to the tax imposed by paragraph (1) if—

(A) internal revenue taxes have been determined, or customs duties liquidated, with respect to such article before such date pursuant to a request made under the 1st proviso of section 3(a) of such Act, or

(B) such article is held on such date under the supervision of an officer of the United States Customs and Border Protection of the Department of Homeland Security pursuant to the 2d proviso of such section 3(a).

(5) DEFINITIONS.—For purposes of this subsection—

(A) IN GENERAL.—Any term used in this subsection which is also used in section 5702 of the Internal Revenue Code of 1986 shall have the same meaning as such term has in such section.

(B) SECRETARY.—The term “Secretary” means the Secretary of the Treasury or the Secretary’s delegate.

(6) CONTROLLED GROUPS.—Rules similar to the rules of section 5061(e)(3) of such Code shall apply for purposes of this subsection.

(7) OTHER LAWS APPLICABLE.—All provisions of law, including penalties, applicable with respect to the taxes imposed by section 5701 of such Code shall, insofar as applicable and not inconsistent with the provisions of this subsection, apply to the floor stocks taxes imposed by paragraph (1), to the same extent as if such taxes were imposed by such section 5701. The Secretary may treat any person who bore the ultimate burden of the tax imposed by paragraph (1) as the person to whom a credit or refund under such provisions may be allowed or made.

(i) EFFECTIVE DATE.—The amendments made by this section shall apply to articles removed (as defined in section 5702(j) of the Internal Revenue Code of 1986) after December 31, 2007.

SEC. 702. ADMINISTRATIVE IMPROVEMENTS.

(a) PERMIT, REPORT, AND RECORD REQUIREMENTS FOR MANUFACTURERS AND IMPORTERS OF PROCESSED TOBACCO.—

(1) PERMITS.—

(A) APPLICATION.—Section 5712 of the Internal Revenue Code of 1986 is amended by inserting “or processed tobacco” after “tobacco products”.

(B) ISSUANCE.—Section 5713(a) of such Code is amended by inserting “or processed tobacco” after “tobacco products”.

(2) INVENTORIES AND REPORTS.—

(A) INVENTORIES.—Section 5721 of such Code is amended by inserting “, processed tobacco,” after “tobacco products”.

(B) REPORTS.—Section 5722 of such Code is amended by inserting “, processed tobacco,” after “tobacco products”.

(3) RECORDS.—Section 5741 of such Code is amended by inserting “, processed tobacco,” after “tobacco products”.

(4) MANUFACTURER OF PROCESSED TOBACCO.—Section 5702 of such Code is amended by adding at the end the following new subsection:

“(p) MANUFACTURER OF PROCESSED TOBACCO.—

“(1) IN GENERAL.—The term ‘manufacturer of processed tobacco’ means any person who processes any tobacco other than tobacco products.

“(2) PROCESSED TOBACCO.—The processing of tobacco shall not include the farming or growing of tobacco or the handling of tobacco solely for sale, shipment, or delivery to a manufacturer of tobacco products or processed tobacco.”.

(5) CONFORMING AMENDMENT.—Section 5702(k) of such Code is amended by inserting “, or any processed tobacco,” after “nontarpaid tobacco products or cigarette papers or tubes”.

(6) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on January 1, 2008.

(b) BASIS FOR DENIAL, SUSPENSION, OR REVOCATION OF PERMITS.—

(1) DENIAL.—Paragraph (3) of section 5712 of such Code is amended to read as follows:

“(3) such person (including, in the case of a corporation, any officer, director, or principal stockholder and, in the case of a partnership, a partner)—

“(A) is, by reason of his business experience, financial standing, or trade connections or by reason of previous or current legal proceedings involving a felony violation of any other provision of Federal criminal law relating to tobacco products, cigarette paper, or cigarette tubes, not likely to maintain operations in compliance with this chapter,

“(B) has been convicted of a felony violation of any provision of Federal or State criminal law relating to tobacco products, cigarette paper, or cigarette tubes, or

“(C) has failed to disclose any material information required or made any material false statement in the application therefor.”.

(2) SUSPENSION OR REVOCATION.—Subsection (b) of section 5713 of such Code is amended to read as follows:

“(b) SUSPENSION OR REVOCATION.—

“(1) SHOW CAUSE HEARING.—If the Secretary has reason to believe that any person holding a permit—

“(A) has not in good faith complied with this chapter, or with any other provision of this title involving intent to defraud,

“(B) has violated the conditions of such permit,

“(C) has failed to disclose any material information required or made any material false statement in the application for such permit,

“(D) has failed to maintain his premises in such manner as to protect the revenue,

“(E) is, by reason of previous or current legal proceedings involving a felony violation of any other provision of Federal criminal law relating to tobacco products, cigarette paper, or cigarette tubes, not likely to maintain operations in compliance with this chapter, or

“(F) has been convicted of a felony violation of any provision of Federal or State criminal law relating to tobacco products, cigarette paper, or cigarette tubes,

the Secretary shall issue an order, stating the facts charged, citing such person to show cause why his permit should not be suspended or revoked.

“(2) ACTION FOLLOWING HEARING.—If, after hearing, the Secretary finds that such person has not shown cause why his permit should not be suspended or revoked, such permit shall be suspended for such period as the Secretary deems proper or shall be revoked.”.

(c) APPLICATION OF INTERNAL REVENUE CODE STATUTE OF LIMITATIONS FOR ALCOHOL AND TOBACCO EXCISE TAXES.—Section 514(a) of the Tariff Act of 1930 (19 U.S.C. 1514(a)) is amended by striking “and section 520 (relating to refunds)” and inserting “section 520 (relating to refunds), and section 6501 of the Internal Revenue Code of 1986 (but only with respect to taxes imposed under chapters 51 and 52 of such Code)”.

(d) EXPANSION OF DEFINITION OF ROLL-YOUR-OWN TOBACCO.—

(1) IN GENERAL.—Section 5702(o) of the Internal Revenue Code of 1986 is amended by inserting “or cigars, or for use as wrappers thereof” before the period at the end.

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply to articles removed (as defined in section 5702(j) of the Internal Revenue Code of 1986) after December 31, 2007.

(e) TIME OF TAX FOR UNLAWFULLY MANUFACTURED TOBACCO PRODUCTS.—Section 5703(b)(2) of such Code is amended by adding at the end the following new subparagraph:

“(F) SPECIAL RULE FOR UNLAWFULLY MANUFACTURED TOBACCO PRODUCTS.—In the case of any tobacco products, cigarette paper, or cigarette tubes produced in the United States at any place other than the premises of a manufacturer of tobacco products, cigarette paper, or cigarette tubes that has filed the bond and obtained the permit required under this chapter, tax shall be due and payable immediately upon manufacture.”.

SEC. 703. TIME FOR PAYMENT OF CORPORATE ESTIMATED TAXES.

Subparagraph (B) of section 401(1) of the Tax Increase Prevention and Reconciliation Act of 2005 is amended by striking “114.50 percent” and inserting “113.25 percent”.

TITLE VIII—EFFECTIVE DATE

SEC. 801. EFFECTIVE DATE.

(a) IN GENERAL.—Unless otherwise provided in this Act, subject to subsection (b), the amendments made by this Act shall take effect on October 1, 2007, and shall apply to child health assistance and medical assistance provided on or after that date without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(b) *EXCEPTION FOR STATE LEGISLATION.*—*In the case of a State plan under title XIX or XXI of the Social Security Act, which the Secretary determines requires State legislation in order for the plan to meet the additional requirements imposed by an amendment made by this Act, the State plan shall not be regarded as failing to comply with the requirements of such Act solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the preceding sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be considered to be a separate regular session of the State legislature.*

Amend the title so as to read: "An Act to amend title XXI of the Social Security Act to reauthorize the State Children's Health Insurance Program, and for other purposes."

UNANIMOUS CONSENT AGREE-
MENT—EXECUTIVE CALENDAR
NO. 278

Mr. REID. Mr. President, I ask unanimous consent that on Tuesday, September 4, at 2:30 p.m., the Senate proceed to executive session to consider Executive Calendar No. 278, Jim Nussle, to be Director of the Office of Management and Budget; that there be a time limit of 3 hours for debate on the nomination, 2 hours equally divided between the chairman and ranking member, 1 hour under the control of Senator SANDERS; that at the conclusion or yielding back of the time, the Senate vote on confirmation of the nomination, the motion to reconsider be laid on the table, the President be immediately notified of the Senate's action, and the Senate return to legislative session.

The PRESIDING OFFICER. Without objection, it is so ordered.

EXECUTIVE SESSION

EXECUTIVE CALENDAR AND
NOMINATIONS DISCHARGED

Mr. REID. Mr. President, I ask unanimous consent that the Senate proceed to executive session to consider Executive Calendar Nos. 245, 246, 247, 248, 249, 256, 273, 274, 276, 277, 279 through 290, and all nominations placed on the Secretary's desk; further that the HELP Committee be discharged from the following nominations: PN659, David W. James to be an Assistant Secretary of Labor; and PN485, Bradford Campbell to be an Assistant Secretary of Labor; that the Foreign Relations Committee be discharged from further consideration of PN641, Mark Green to be Ambassador to Tanzania; that the nominations be confirmed, the motions to reconsider be laid on the table, that any statements thereon be printed in the RECORD, the President be immediately notified of the Senate's action, and the Senate then return to legislative session.

The PRESIDING OFFICER. Without objection, it is so ordered.

The nominations considered and confirmed are as follows:

DEPARTMENT OF THE INTERIOR

Brent T. Wahlquist, of Pennsylvania, to be Director of the Office of Surface Mining Reclamation and Enforcement.

James L. Caswell, of Idaho, to be Director of the Bureau of Land Management.

DEPARTMENT OF ENERGY

Lisa E. Epifani, of Texas, to be an Assistant Secretary of Energy (Congressional and Intergovernment Affairs).

Kevin M. Kolevar, of Michigan, to be an Assistant Secretary of Energy (Electricity Delivery and Energy Reliability).

Clarence H. Albright, of South Carolina, to be Under Secretary of Energy.

MORRIS K. UDALL SCHOLARSHIP AND EXCELLENCE IN NATIONAL ENVIRONMENTAL POLICY FOUNDATION

Robert Boldrey, of Michigan, to be a Member of the Board of Trustees of the Morris K. Udall Scholarship and Excellence in National Environmental Policy Foundation for a term expiring May 26, 2013.

FEDERAL EMERGENCY MANAGEMENT AGENCY

Dennis R. Schrader, of Maryland, to be Deputy Administrator for National Preparedness, Federal Emergency Management Agency, Department of Homeland Security.

[NEW REPORTS]

DEPARTMENT OF COMMERCE

William G. Sutton, Jr., of Virginia, to be an Assistant Secretary of Commerce.

DEPARTMENT OF TRANSPORTATION

Thomas J. Barrett, of Alaska, to be Deputy Secretary of Transportation.

Paul R. Brubaker, of Virginia, to be Administrator of the Research and Innovative Technology Administration, Department of Transportation.

IN THE AIR FORCE

The following named officer for appointment in the United States Air Force to the grade indicated while assigned to a position of importance and responsibility under title 10, U.S.C., section 601:

To be lieutenant general

Lt. Gen. David A. Deptula, 0000

The following named officer for appointment in the United States Air Force to the grade indicated while assigned to a position of importance and responsibility under title 10, U.S.C., section 601:

To be general

Lt. Gen. Claude R. Kehler, 0000

IN THE ARMY

The following named officer for appointment in the United States Army to the grade indicated while assigned to a position of importance and responsibility under title 10, U.S.C., section 601:

To be lieutenant general

Maj. Gen. Kenneth W. Hunzeker, 0000

The following named officer for appointment in the United States Army to the grade indicated while assigned to a position of importance and responsibility under title 10, U.S.C., section 601:

To be lieutenant general

Lt. Gen. James D. Thurman, 0000

The following named officer for appointment in the United States Army to the grade indicated while assigned to a position of importance and responsibility under title 10, U.S.C., section 601:

To be lieutenant general

Lt. Gen. James J. Lovelace, 0000

The following named officer for appointment in the United States Army to the grade

indicated while assigned to a position of importance and responsibility under title 10, U.S.C., section 601:

To be lieutenant general

Maj. Gen. Carter F. Ham, 0000

The following Army National Guard of the United States officer for appointment in the Reserve of the Army to the grade indicated under title 10, U.S.C., section 12203:

To be brigadier general

Col. Lawrence A. Haskins, 0000

IN THE NAVY

The following named officer for appointment in the United States Navy to the grade indicated while assigned to a position of importance and responsibility under title 10, U.S.C., section 601:

To be vice admiral

Rear Adm. Richard K. Gallagher, 0000

The following named officer for appointment in the United States Navy to the grade indicated while assigned to a position of importance and responsibility under title 10, U.S.C., section 601:

To be vice admiral

Rear Adm. Robert T. Moeller, 0000

The following named officer for appointment in the United States Navy to the grade indicated while assigned to a position of importance and responsibility under title 10, U.S.C., section 601:

To be vice admiral

Rear Adm. James A. Winnefeld, Jr., 0000

The following named officer for appointment as the Chairman of the Joint Chiefs of Staff and appointment to the grade indicated while assigned to a position of importance and responsibility under title 10, U.S.C., sections 152 and 601:

To be admiral

Adm. Michael G. Mullen, 0000

IN THE MARINE CORPS

The following named officer for appointment as the Vice Chairman of the Joint Chiefs of Staff and appointment to the grade indicated while assigned to a position of importance and responsibility under title 10, U.S.C., sections 601 and 154:

To be general

Gen. James E. Cartwright, 0000

NOMINATIONS PLACED ON THE SECRETARY'S
DESK

IN THE AIR FORCE

PN793 AIR FORCE nomination of Damion T. Gottlieb, which was received by the Senate and appeared in the Congressional Record of July 25, 2007.

PN794 AIR FORCE nomination of Francis E. Lowe, which was received by the Senate and appeared in the Congressional Record of July 25, 2007.

PN795 AIR FORCE nominations (25) beginning LISTA M. BENSON, and ending KAREN L. WEIS, which nominations were received by the Senate and appeared in the Congressional Record of July 25, 2007.

P796 AIR FORCE nominations (17) beginning KEVIN C. BLAKLEY, and ending ROBERT A. TETLA, which nominations were received by the Senate and appeared in the Congressional Record of July 25, 2007.

PN797 AIR FORCE nominations (556) beginning ROBERT K. ABERNATHY, and ending ANTHONY J. ZUCCO, which nominations were received by the Senate and appeared in the Congressional Record of July 25, 2007.

PN800 AIR FORCE nominations (36) beginning MARY ANN BEHAN, and ending PAUL A. WILLINGHAM, which nominations were received by the Senate and appeared in the Congressional Record of July 25, 2007.

IN THE ARMY

PN801 ARMY nominations (53) beginning DAWUD A. AGBERE, and ending EDWARD