long time. They were on 24-hour monitoring for a very, very long time.

If a doctor had come to me and said to me, Mr. GRAYSON, we can save your children but it will cost a million dollars, I would have said okay.

If a doctor had said, Mr. GRAYSON, we can save your children, but it is going to cost your right arm, I would have said okay because the life of a child is more important than money. And yet in America we have 25,000 children who die every year without reaching their first birthday.

This bill will cover 4 million children with health care who otherwise won't have it. I turn to the other side of the aisle and I say: Let's save those lives, let's choose life.

STOP BAILOUT BONUSES

(Mr. SAM JOHNSON of Texas asked and was given permission to address the House for 1 minute.)

Mr. SAM JOHNSON of Texas. Madam Speaker, last week Americans learned of 50,000 new layoffs in just one day. We also heard another startling fact: that the financial industry bailed out by Uncle Sam paid $18 billion in bonuses. That's just appalling.

The $18 billion payout in 2008 ranks as the sixth highest in bonus history and compares with 2004, a banner year, on Wall Street.

As a supporter of free enterprise, I back performance-based bonuses for a job well done.

Banks just barely getting by, thanks to taxpayer bailout money, have no business paying bonuses. With our economy sliding deeper into recession, this reckless decision to pay bonuses showcases the disgraceful behavior of greed and arrogance of Wall Street that Americans detest. It is flat irresponsible.

Let's stop the bailout bonus bonanza now.

RECKLESS SPENDING

(Mr. BURGESS asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. BURGESS. Madam Speaker, the American people understand the need for a stimulus. They understand the need for job creation. What they don't understand is why we are pursuing this reckless path of aimless spending.

Now we have heard it over and over again. Elections have consequences, they won, and we understand that. We also hear the need for bipartisan bills. But I have to ask you, Madam Speaker, doesn't legislation also have consequences?

We often ask ourselves what makes a bill bipartisan? Is it just because we all have a chance to vote one way or the other and for that reason it is a bipartisan effort even if you vote against it or for it.

In reality, a bipartisan bill begins at its inception where the ideas are talked about among Members and typically amongst their staff. Certainly it involves hearings and markups at the subcommittee level, and certainly it involves hearings and markups at the full committee level. But many of the bills we have before us fail to achieve that lofty goal.

We are about to pass a stimulus bill that will vastly increase Medicaid spending, but at the same time in this great wash of cash, we can do nothing to provide adequate payments to providers. That would have been a bipartisan effort.

CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009

Mr. POLIS of Colorado. Madam Speaker, by direction of the Committee on Rules, I call up House Resolution 107 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 107

Resolved, That upon adoption of this resolution it shall be in order to take from the Speaker's table the bill (H.R. 2) to amend title XXI of the Social Security Act to extend and improve the Children's Health Insurance Program, and for other purposes, with the Senate amendment thereto, and to consider in the House, without intervention of any point of order except those arising under clause 10 of rule XXI, a motion offered by the chair of the Committee on Energy and Commerce or his designee that the House concur in the Senate amendment. The Senate amendment and the motion shall be considered as read. The motion shall be debatable for one hour equally divided among and controlled by the chair and ranking minority member of the Committee on Energy and Commerce and the chair and ranking minority member of the Committee on Ways and Means. The previous question shall be considered as ordered on the motion to adoption without intervening motion.

The SPEAKER pro tempore. The gentleman from Colorado is recognized for 1 hour.

Mr. POLIS of Colorado. Madam Speaker, for the purposes of debate only, I yield the customary 30 minutes to the gentleman from Texas and my colleague on the Rules Committee, Mr. SESSIONS. All time yielded during consideration of the rule is for debate only.

GENERAL LEAVE

Mr. POLIS of Colorado. I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and insert extraneous material into the RECORD.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Colorado?

There was no objection.

Mr. POLIS of Colorado. Madam Speaker, I yield myself such time as I may consume.

Madam Speaker, House Resolution 107 provides for consideration of the Senate amendment to H.R. 2, the Children's Health Insurance Program Reauthorization Act of 2009.

I rise in support of House Resolution 107, the Children's Health Insurance Program Reauthorization Act. I again wish to thank Speaker PELOSI who has been an unrelenting champion on this important issue. I also want to thank Chairman RANGEL and Chairman DINGELL for sponsoring bills that were vetoed in the 110th Congress, and Chairman WAXMAN and all of my colleagues for their leadership on this issue in this Congress, and I want to recognize everyone's efforts to bring this bill to where it is today.

Although I began my House service only a few weeks ago, I have received hundreds of letters from constituents who have serious concerns about health care cost and coverage. Too common is the story of hardworking, low-income moms and dads forced to choose between buying groceries and visiting their family doctor. I have heard from those who have either lost their health care coverage or feared that they will lose it because they simply can't afford it.

□ 1030

I have heard from parents who are denied necessary health care by their insurers, and as a result, their children are suffering too. I have heard from caregivers who have been laid off losing not only their health coverage, but that of their children's as well. This is a serious problem that we can no longer afford to ignore.

No longer can we lay the blame at the front door of the White House. With the change in administration, we can ensure that this legislation passes the House today and reaches the President's desk as soon as possible. With our approval, President Obama has indicated he will sign this bill into law today and change the lives of millions of children and families. Delay is simply not an option.

A large majority of Americans of all political persuasions support this important bill. It's a fiscally responsible way to not only extend the number of children in our Nation who will receive health care, but to improve the quality of that care. This bill relieves the burden of taxpayers who currently subsidize millions of costly and inefficient uninsured emergency room visits. By encouraging preventative care for children who lack insurance today, we can actually reduce costs from the system and provide healthier outcomes for young people.

This bill is just common sense, given the Nation's skyrocketing health care costs, coupled with our current economic challenges. It is an investment where the return is a generation of healthy, happy and productive Americans. This legislation will provide health care coverage for more than 11 million children nationally.

Tomorrow morning, 170,000 children in my home State of Colorado wake up without health insurance. That is 170,000 too many. This bill will change that terrible statistic for the better by

giving States the vital tools needed to reach out to uninsured children who are eligible for SCHIP and Medicaid, but not yet enrolled. This is not only critical to Colorado, but to all our States and territories.

Madam Speaker, the epidemic of the uninsured is not just a consequence of our struggling economy, it is a component of it. Under a new administration, with the political will of this new Congress, we have the power to set this particular wrong right. A healthy economy is supported by healthy people. Providing health care insurance for millions of uninsured Americans is an important beginning to keeping our people and our economy healthy. But it is just a beginning.

Protecting the health of our Nation's young children is of paramount importance to society and the security of our Nation. A recent military study reveals that one-third of American teenagers are incapable of passing a basic physical test. This legislation will help give every child a chance at a healthy start.

With rising unemployment, a battered economy and more layoffs coming every day, the plight of the uninsured is likely to only get worse. Next month, Madam Speaker, SCHIP will expire. Our failure today would add millions of children to the rolls of the uninsured. To me, my constituents, and hopefully to my colleagues, as well, this is unacceptable. Today we have an opportunity to protect millions of children across the Nation who don't have a voice and to safeguard their future.

I urge you to vote for this legislation.

I reserve the balance of my time.

Mr. SESSIONS. Madam Speaker, I rise today in strong opposition to this completely closed rule and to the ill-conceived underlying legislation.

Madam Speaker, the gentleman from Colorado, who has extended me the time, well understands, as a freshman, that we have a good number of new Members to this body and who will be making a decision and voting for very important public policy decisions. It's my hope today that I will be able to gather together an argument, not to rebut the gentleman, but to show him and many of his other new colleagues, my new colleagues, why the statement ''cost effective and common sense'' does not apply to the SCHIP bill that the gentleman brings forth today.

Madam Speaker, 2 weeks ago I questioned my Democrat colleagues about their claim to be the most honest, open and transparent House in history when they tout that that is what the leadership of this body is attempting to accomplish. Once again, I will question that claim, because we're provided with a product and a process that is none of the above.

I know that the gentleman on the Rules Committee had a chance, just last night, to hear a debate in the Rules Committee about this SCHIP bill. And I believe that that hearing would produce enough evidence to suggest that this bill is neither cost effective nor common sense. Since the beginning of the 111th Congress, my colleagues on the other side of the aisle have had no regard—no regard—for regular order and continue to cram legislation through this body without Republican input.

When I came to the floor last month to oppose the previous version of this legislation, I explained my opposition on the way that it had been brought to the floor without a single legislative markup. So unfortunately, the new Members of this body, unless they serve on the Rules Committee, have not heard the real facts of the case.

The real facts of the case, unfortunately, have not changed. In fact, neither Republican leadership nor Republican members on the Energy and Commerce Committee have had any opportunity to participate in crafting this 280-plus pages piece of legislation. I will repeat that. Republican members or Republican leadership have had no chance to craft any part of this 280-page legislative bill.

On January 12 of this year, my Republican colleagues and myself sent to President Obama and Speaker PELOSI, which I would like included in the RECORD, a letter outlining what Republicans would like to see the majority party, the Democrats, consider before expanding the current SCHIP program. We still, as of this morning, have received no answer, no answer, to a forthright and open letter. In responding to this, we are simply asking today on the floor of the House of Representatives for the opportunity not only to be heard but also to make sure that the newest Members of this body have a chance to know the facts of the case. And in reauthorizing this program, the first priority should be, should be, to make sure that our Nation's poorest uninsured children are covered. The intent of the program is that. And we must first fulfill that goal.

Currently, at least two-thirds of the children who do not have health insurance are already eligible for Federal help through either SCHIP or Medicaid. The second priority is to ensure that SCHIP does not replace or significantly impact those who already have private health insurance and replace it with a government-run program. Speaking of common sense, why would you take someone who has private health insurance and move them to a government-run program?

Madam Speaker, if this legislation passes, we know that there are 2.4 million children who will be moved from private insurance to SCHIP, a program that reimburses physicians 30 to 50 percent less than private health insurance. As a matter of fact, last night in the Rules Committee, there was in the debate that took place an acknowledgment from the Democrat side lead who said, yes, he did understand. They're even having problems getting physicians who will accept the patients because of the reduction in the reimbursement. Common sense would tell you that alone is not cost effective nor common sense.

More to my point about the newest Members of this body understanding the facts of the case because regular order did not take place, how would we expect them to know what they were going to vote on? Congress should be encouraging superior health care for our Nation's children, not undermining it. That is common sense.

Furthermore, a citizenship verification standard is critical to ensuring that only U.S. citizens and certain legal immigrants are allowed to access taxpayer-funded benefits, not illegal immigrants. The underlying legislation takes out from the law and offers no safeguards to ensure a check that it will be for American children before illegal immigrants. Once again, cost effective, and once again, common sense for the new Members of this body.

The Democrats' proposed $32.8 billion expansion of a program that has yet to accomplish its original intent is typical of my friends on the other side. My friends, the Democrats, continue to push their government-run health care agenda, ''universal coverage'' as they call it, even though this legislation moves 2.4 million children currently on private health coverage to an inferior public program with less access. Common sense says you should not be doing that.

So, then, with physicians scaling back on Medicaid and SCHIP due to the extremely low government reimbursement rate, why would we want to subject 4 million more children to this type of care? Once again, the standard of common sense. I don't know that this bill passes that hurdle. Madam Speaker, it seems likely that my Democratic colleagues are putting their agenda first, not our children's health care.

In the days where Congress is faced with a second $350 billion financial services bailout and a proposed $1.2 trillion stimulus package, is the Federal Government in any financial shape to be financing health care costs for children who are already receiving priority health insurance? Once again, the test of common sense and cost effectiveness would fail this legislation.

The current legislation before us recklessly increases entitlement spending by at least $73.3 billion over the next 10 years. That is increasing it due to the new entitlements. That is neither cost effective nor common sense. This expansion will allow SCHIP to grow at an annual rate of 23.7 percent over the next 5 years. Once again, not cost effective and not common sense. Based on the Treasury Department's financial report, the government has $56 trillion in unfunded liabilities, the majority of which are in the Federal Government's health care program. Why not do something that would be for the Nation's poorest children rather than

trying to push 2.4 million more children, unless you have a political agenda rather than a public policy agenda?

Each year that Congress fails to act on a solution, the long-term problem grows by $2 to $3 trillion. Do my friends on the other side of the aisle not see the writing on the wall? Where is common sense?

Madam Speaker, last week, a bipartisan group of Members voted against the Democratic Party's $1.2 trillion stimulus package. Not only was the Democrat plan full of wasteful government spending that would not stimulate the economy, but my friends on the other side of the aisle shut out Republicans from the process much as they are doing today.

The American people are hurting. And the economy is struggling. Americans know that we cannot borrow and spend our way back to a growing economy. Republicans have a plan for fast-acting tax relief that will release the resources and creativity of the American people to create 6.2 million new jobs. Madam Speaker, I ask my Democrat colleagues, if the American people had the choice between fast-acting tax relief and slow, wasteful government spending, which would they choose? Trust me. A number of Democrats and every single Republican knew the answer on this floor. It is common sense to vote ''no.''

This so-called ''stimulus bill'' includes $524 billion in spending provisions, $3 billion in prevention and wellness, including $400 million for STD prevention, sexually transmitted disease prevention, and $600 million to buy new cars for government workers. That will make sure we don't have to ask for reform out of the Big Three auto makers. We will just buy them at the current rate. The bill includes $150 million for building repairs for the Smithsonian, $1 billion for follow-up on the 2010 Census that does not even begin until April 1, 2010, $1 billion for Amtrak which has not turned a profit in 40 years, $400 million for global-warming research, and another $2.2 billion for carbon-capture demonstration projects. The list goes on and on and on.

The American people deserve to know how their hard-earned tax dollars will stimulate the economy, not government spending where Washington gets fatter, but those with good explanations so that the American people have confidence, not only in Congress, but in their own individual Member of Congress who casts that vote.

If expanding SCHIP to families making $80,000 a year isn't enough, as this bill does, last week my Democrat colleagues voted in favor of making Wall Street millionaires and billionaires, like the former Lehman Brothers CEO, who was reported to have earned nearly half a billion dollars in compensation, eligible for public health subsidies. Approximately $100 billion of our friends', the Democrats', $1.2 trillion stimulus is the bailout for the failing Medicaid program. One such bailout provision is section 3003, which expands Medicaid eligibility to all individuals currently receiving unemployment benefits, regardless of their personal income or financial assets.

□ 1045

Boy, once again that standard of common sense and cost effectiveness that my good friend from Colorado talked about is simply not there.

Madam Speaker, why are our friends, the Democrats, trying to force American taxpayers to pay for free health coverage for the very same executives who helped create the financial crisis in the stimulus package able to get this help?

Adding another trillion dollars to the Federal deficit and swelling the number of persons dependent on subsidized, government-run health care is hazardous to the health of the American economy and an unfair burden to place on our grandchildren.

The American people want more than just welfare. They want freedom. They want jobs. They want a real stimulus package and a real SCHIP bill. That's what this Congress is failing to provide. The American people want more innovation, more efficiency, more accountability, and they want cost effectiveness and common sense. Evidently, this body is in short supply of each of those items under this leadership.

The American people hate waste in government, but our friends, the Democrats, who are the majority party, are spending like never before, delaying even the thought of addressing the underlying programs of the already burdensome Medicaid and SCHIP programs. My friends on the other side of the aisle seem to be playing with money that does not even exist. We are printing it at this time. The printing presses are alive and working 24 hours a day, just simply first to meet the $700 billion bailout, and then to prepare for the $1.3 trillion stimulus package that is prepared for the President's signature soon.

So what's next? A $32.8 billion expansion of SCHIP, and finally, the massive omnibus which is expected this week or next.

We should be demanding more accountability. We should be demanding cost effectiveness, and we should be demanding common sense. That's what the American people want, Madam Speaker.

Madam Speaker, we need a fast-acting tax relief bill that will stimulate the economy and create jobs. We cannot borrow and spend our way out of this crisis. We need to secure the original intent of the current government programs before expanding additional programs.

I came to Congress to protect the American taxpayer, which is why I encourage my colleagues to oppose this rule and the underlying legislation.

WASHINGTON, DC,
January 12, 2009.

President-elect BARACK OBAMA,
Presidential Transition Office,
Washington, DC.

Hon. NANCY PELOSI,
Speaker, Capitol,
Washington, DC.

DEAR PRESIDENT-ELECT OBAMA AND SPEAKER PELOSI: Thank you for expressing your desire to work with us to address the needs of the American people. We recognize that reauthorizing the State Children's Health Insurance Program (SCHIP) is an early legislative priority, and we hope that you will consider this legislation to be one of the first opportunities for bipartisan cooperation.

During the last Congress, significant efforts were made in an attempt to address concerns raised by House Republicans about how the underlying bills would impact uninsured children. Despite the progress that was made, there are still a few outstanding issues that we hope you agree should be addressed when we work to reauthorize the program this year:

SERVING ELIGIBLE LOW-INCOME CHILDREN FIRST

SCHIP is intended to serve those that are neediest first. As low-income families continue to face more economic insecurity, providing access to affordable health care coverage, regardless of any job change or displacement, should be our first priority. The legislation should demand success from the states in enrolling poor and low-income children below 200 percent of the federal poverty level, especially those who are currently eligible for Medicaid and/or SCHIP, but are not yet enrolled. Demanding success from the states could be as simple as requiring that states meet a threshold of enrollment before further expansions. Nearly all the states have demonstrated over the past year to the Centers for Medicare and Medicaid Services that meeting this standard is indeed possible.

Furthermore, in the current economic environment, several states have indicated that they will be experiencing shortfalls that could impact their ability to provide Medicaid benefits and services. Asking states to expand their SCHIP program before they are able to finance their existing Medicaid program would be a mistake. Expanding SCHIP to higher income families will only exacerbate the real access to care problem in the Medicaid program.

CITIZENSHIP STATUS

We believe that only U.S. citizens and certain legal residents should be permitted to benefit from a program like SCHIP. We also think it is fair to say that both parties believe that our immigration system is broken. That is why it is so important that the legislation include stronger provisions to prevent fraud by including citizenship verification standards to ensure that only eligible U.S. citizens and certain legal residents are enrolled in the program.

PROTECTING PRIVATE INSURANCE OPTIONS

We agree that those with private coverage should not be forced into a government-run plan. SCHIP legislation should focus expansion efforts on children who are currently uninsured instead of moving children who have private health insurance options into government-run health insurance. Moving a child from private health insurance to government-run health insurance should not be part of your stated goal of providing SCHIP for 10 million children, a number we assume to be targeted towards low-income uninsured children.

STABLE FUNDING SOURCE

In order to guarantee access to the program and long term stability, SCHIP should

be funded through a stable funding source, not budget gimmicks. Further, the legislation should not include extraneous provisions unrelated to SCHIP that limit patient choice or prohibit access to quality medical care. Our nation's Governors need a stable SCHIP program so they may properly budget. Every American faces the crushing burden of a declining economy. This should not be a time Congress raises taxes, especially on the poorest Americans, to finance program expansions as part of the SCHIP reauthorization bill.

We believe these to be critical elements to improve this vital program that if fully incorporated would dramatically increase bipartisan support for the legislation. Thank you for the consideration of this request. We look forward hearing from you and working with you towards a bipartisan agreement.

Sincerely,

Robert B. Aderholt, Steve Austria, Michele Bachmann, Spencer Bachus, J. Gresham Barrett, Roscoe G. Bartlett, Joe Barton, Judy Biggert, Gus M. Bilirakis, Rob Bishop, Marsha Blackburn, Roy Blunt, John A. Boehner, Mary Bono Mack, John Boozman, Charles W. Boustany, Jr., Kevin Brady, Paul C. Broun, Henry E. Brown, Jr., Ginny Brown-Waite, Michael C. Burgess, Dan Burton, Steve Buyer, Ken Calvert, Dave Camp, Eric Cantor, John R. Carter, Bill Cassidy, Jason Chaffetz, Howard Coble,

Mike Coffman, Tom Cole, K. Michael Conaway, Ander Crenshaw, John Abney Culberson, Geoff Davis, Nathan Deal, David Dreier, Mary Fallin, Jeff Flake, John Fleming, J. Randy Forbes, Jeff Fortenberry, Virginia Foxx, Trent Franks, Rodney P. Frelinghuysen, Phil Gingrey, Louie Gohmert, Bob Goodlatte, Kay Granger, Sam Graves, Ralph M. Hall, Doc Hastings, Dean Heller, Jeb Hensarling, Wally Herger, Peter Hoekstra, Duncan Hunter, Bob Inglis, Darrell E. Issa,

Lynn Jenkins, Sam Johnson, Walter B. Jones, Jim Jordan, Steve King, Jack Kingston, Mark Steven Kirk, John Kline, Doug Lamborn, Christopher John Lee, Jerry Lewis, Blaine Luetkemeyer, Cynthia M. Lummis, Daniel E. Lungren, Donald A. Manzullo, Kevin McCarthy, Thaddeus G. McCotter, Patrick T. McHenry, John M. McHugh, Cathy McMorris Rodgers, Jeff Miller, Sue Wilkins Myrick, Devin Nunes, Pete Olson, Erik Paulsen, Mike Pence, Joseph R. Pitts, Todd Russell Platts, Ted Poe, Bill Posey.

Tom Price, Adam H. Putnam, George Radanovich, Harold Rogers, Mike Rogers (MI), Thomas J. Rooney, Peter J. Roskam, Paul Ryan, Steve Scalise, Jean Schmidt, Aaron Schock, F. James Sensenbrenner, Jr., Pete Sessions, John B. Shadegg, John Shimkus, Bill Shuster, Michael K. Simpson, Adrian Smith, Lamar Smith, Cliff Stearns, John Sullivan, Lee Terry, Glenn Thompson, Patrick J. Tiberi, Fred Upton, Greg Walden, Zach Wamp, Lynn A. Westmoreland, Ed Whitfield, Joe Wilson, Robert J. Wittman.

Madam Speaker, I reserve the balance of my time.

Mr. POLIS of Colorado. Madam Speaker, as you know, children do not control what family they are born into. And an important part of the meritocracy that makes our country great is that every child should have the opportunity to succeed. Establishing healthy habits and a healthy life early in life, regardless of the parent's station, is an important part of making sure that a child has the opportunity to climb to whatever station they are capable of.

Madam Speaker, I would like to yield 2 minutes to the gentlewoman from Connecticut (Ms. DELAURO).

Ms. DELAURO. Madam Speaker, at a time when more and more mothers and fathers are huddled around their kitchen table worried about how to cope with a job loss or pay their most basic expenses, we have an opportunity today, an opportunity to ensure that 11 million children can get affordable health care coverage through the Children's Health Insurance Program.

In my home State of Connecticut, unemployment keeps rising, and people are going from worried to scared. At such a time, it is our most basic economic and moral responsibility to provide health care to the most vulnerable among us. In this country, where 9 million children are uninsured, we cannot let another day go by without passing this legislation.

This is a smart investment in children, in their health and in their success at school and in life. It provides critical dental and mental health care for children, prenatal care to make sure every child has the best chance at a healthy start. It will help to discourage millions of children from smoking, a smart step towards a healthier Nation. We must shore up this vital safety net. We can afford it. It is a simple choice about fulfilling America's promise for our Nation's children and giving a small measure of peace of mind for their families.

I might say to my colleague on the other side of the aisle that, on a bipartisan basis, overwhelmingly, this House voted to pass the children's health insurance bill. The United States Senate overwhelmingly on a bipartisan basis voted to pass the children's health insurance bill. It was the former President of the United States who decided to veto that legislation when a majority of the American public supports health insurance for our children. Today we have an opportunity to right a wrong. Let's pass the children's health insurance bill. Let's get it to the President's desk. Let's get it signed, and let's give relief to the millions of families out there who are struggling.

Members of this body have health insurance, and their children have it. Why shouldn't the children of working and middle class Americans?

Mr. SESSIONS. Madam Speaker, I would like to yield 1½ minutes to the gentleman from Lewisville, Texas, Dr. BURGESS.

Mr. BURGESS. I do urge my colleagues to look long and hard before voting on this rule today, and I urge a ''no'' vote on the rule.

The fact is, Madam Speaker, that over half of the country has not had an opportunity to participate in this debate. 40 percent of this country is represented by Republican Members. We have not had input into this bill.

12 percent of this Congress is new. They have had no input into this bill. That leaves over half the country who haven't been part of this debate.

And what does it say about a bipartisan bill when the two principal Republican sponsors in the other body withdrew their support for this bill as it came through the Senate?

Last night in the Rules Committee in one last attempt, I tried to modify the bill to perhaps make it a better product before it came before us on the floor of the House today. I brought amendments that would have required identity, a person to provide proper identification before they signed up for SCHIP; not another step, but just simply another line that needed to be filled out on the form, and that was rejected.

You have to show your ID before you cash a check at the grocery store. Why should we not require someone to show identification before they sign up for this benefit?

I also introduced an amendment, after all, we are, as the Member from Texas said, the gentleman from Texas said we are taking 2½ million children off of private health insurance and putting them on public health insurance. Why should we not at least ensure that we will pay the providers a sufficient amount so that they will participate in the system?

Currently, it is difficult to find providers who will accept Medicaid and SCHIP. I introduced an amendment that would have required 90 percent of the reimbursement from the Federal Blue Cross/Blue Shield program or the States' largest——

The SPEAKER pro tempore. The time of the gentleman has expired.

Mr. SESSIONS. I give the gentleman 30 additional seconds.

Mr. BURGESS. Last night in the Rules Committee I introduced an amendment that would have required States to reimburse physicians at 90 percent of the Blue Cross/Blue Shield rate or the largest State HMO rate in that State or the insurance that the State provides for their own employees. That amendment was not even allowed a vote on the floor. This is the type of exclusionary politics that is being practiced in the House of Representatives, and the sooner we get past this point, the President asked for a more open and bipartisan government, the sooner we get past that point, the better for the American people.

Mr. POLIS of Colorado. Madam Speaker, a brief history on the SCHIP legislation and why this is so critical for us to pass here today. This rule before the House would permit the House to concur in the Senate amendment because this legislation has been considered repeatedly and thoroughly in the House in this Congress and the last.

In July of 2007 the House considered H.R. 3162 to reauthorize and amend

SCHIP and the bill passed. In September 2007 the House considered H.R. 976 to reauthorize and amend SCHIP. The bill passed. The Senate also passed the bill and it was presented to President Bush and received a veto. In October of 2007 the House again tried to reauthorize SCHIP. 3963 was the House bill. Passed the House, passed the Senate. The President again vetoed the bill and the House was unable to override the veto.

Ultimately, legislation to merely extend SCHIP as it was enacted into law will expire next month. Children's lives are at stake. That's what's so critical about passing this bill today.

When people lack health care insurance they often don't seek preventative care and are forced to use emergency rooms as their primary care provider. Not only does this cost more, this also provides for worse health outcomes, and conditions that could have been dealt with less expensively and more successfully in the onset are instead deferred, and incur more expense and worse health outcomes.

By passing this bill today, we can ensure that hundreds of thousands of poor children across our country receive adequate health care and are able to succeed and grow in school and be able to succeed in their lives.

Madam Speaker, I would like to reserve the balance of my time.

Mr. SESSIONS. Madam Speaker, at this time I would like to yield 1½ minutes to the gentleman from Marietta, Georgia, Dr. GINGREY.

Mr. GINGREY of Georgia. Madam Speaker, I do rise in strong opposition to this closed rule, as well as the underlying legislation, the Children's Health Insurance Program Reauthorization Act of 2009.

The Democratic majority has once again brought forward a closed rule that only tramples on the rights of the minority. And at no point in the development of this legislation has the majority even entertained the idea of allowing Republicans to work with them in a bipartisan manner to improve the bill.

As a physician Member, I keenly know how important it is that the Federal Government plays a role in providing health care to low-income children. At the same time, we must pass legislation that first reaches those who are most in need of this assistance.

During the initial consideration of H.R. 2 by the House, I offered an amendment that would have addressed a very important problem within current law that H.R. 2 overlooks, the practice of some States using loopholes to allow people to disregard significant portions of their income to make them eligible for CHIP and Medicaid. At the same time, some of these same States, these loophole States, have not provided for the children who demonstrate the most need for these programs.

Madam Speaker, my commonsense amendment would have simply instituted a gross income cap of 250 percent of the Federal poverty level for both CHIP and Medicaid eligibility, and it would limit any income disregards to a maximum of $250 a month or $3,000 per year. This amendment would grandfather in those individuals who are already receiving Medicaid and CHIP so that we do not deprive current beneficiaries.

Therefore, Madam Speaker, I urge all my colleagues oppose the closed rule.

The SPEAKER pro tempore. The time of the gentleman has expired.

Mr. SESSIONS. I yield the gentleman 15 additional seconds.

Mr. GINGREY of Georgia. I want to just in closing, Madam Speaker, urge all my colleagues, oppose the closed rule and this underlying legislation. Give us a chance, in a bipartisan spirit, to make this good law even better.

Mr. POLIS of Colorado. Madam Speaker, I am proud to back a plan to help improve the health and chance for success of 11 million children. It also reduces the more costly nature of emergency room use, and moves us closer to providing every child in our Nation with affordable, high quality health care.

This bill also extends health care coverage to 4.1 million additional low-income children who are currently uninsured.

A healthy child is better prepared for learning and success. Studies show that early childhood health is indicative and can, in fact, impact the learning processes, the special education needs of the child and indeed, even the IQ of the child as the child matriculates through education. By making sure that children have health care coverage, we can, in fact, prevent a lot of gaps within our education system from arising before they arise, and ensure that children, regardless of their background, have the opportunity to succeed in our country. This is the change that America needs.

Providing health care coverage for children and indeed, all Americans, is one of the reasons that I ran for Congress. Providing health care to 4 million more children will be a clear demonstration that change has come to Washington.

This is legislation that President Bush vetoed twice in the 110th Congress. Today we have the opportunity to send this bill to a new President who has committed to sign it this very afternoon and begin implementing it immediately to help cover 4.1 million additional children in our Nation.

Madam Speaker, I reserve the balance of my time.

□ 1100

Mr. SESSIONS. Madam Speaker, at this time, I would like to yield 2½ minutes to the gentleman from San Dimas, California, the ranking member of the committee, Mr. DREIER.

(Mr. DREIER asked and was given permission to revise and extend his remarks.)

Mr. DREIER. Madam Speaker, in the spirit of comity in debate, I would like to yield to my good friend from Lafayette, Louisiana (Mr. BOUSTANY). I am always happy to yield to people to engage in debate on the floor.

Mr. BOUSTANY. Madam Speaker, I just want to make a correction here to the gentleman's comments. While providing coverage is one thing, providing real access to care, to a primary care physician, is another, and far too many of these children are receiving care in the emergency room, which is the most expensive and least effective way to provide care.

Mr. DREIER. Let me say, Madam Speaker, that getting the American economy back on track is priority number one for all of us, and ensuring that children who are truly in need have access to the best quality health care is right there as a very high priority. It is obvious that this measure that is before us does not accomplish that.

In his testimony last night before the Rules Committee, Dr. BURGESS was very clear in addressing a number of the concerns that we have been raising consistently on this. Unfortunately, they undermine the opportunity for us to ensure that the dollars get to those who are truly in need.

I find it very, very troubling that we are continuing down a path where potentially people who are in this country illegally will have access to the State Children's Health Insurance Program. We are with the crowd-out actually incentivizing people to move off of private insurance onto government insurance, and we are still creating an opportunity for those who are wealthy and adults to be beneficiaries of this program. No matter what it says in the bill, as Dr. BURGESS has pointed out, those four concerns are very justified.

So, as we seek to get the American economy back on track with an economic stimulus package that will, in fact, grow our economy—not a massive spending program—and as we address this issue of children's health, which is a very, very, very high priority, we need to do it in the most cost-effective way possible.

Unfortunately, this rule is completely shutting out Members, like Dr. BURGESS and others, from having the opportunity to participate, so I urge my colleagues to vote ''no'' on the rule and, if the rule passes, to defeat the underlying legislation. We can do better for our Nation's children.

Mr. POLIS of Colorado. Madam Speaker, with regard to the delivery of the services, most SCHIP and Medicaid beneficiaries receive service delivery through private doctors and through private management care plans, not through government doctors. So, when we are talking about how the service is delivered, we are talking about an important aspect of what insurance and what coverage allows. Yes, separately, we certainly hope that we will be able to address universal coverage, in rural areas in particular, as an important component of health care in this country.

With regard to income limits, this bill does provide that if a State covers children in families of three with income over $52,800, which is 300 percent of the poverty rate, then the States get the regular Medicaid match rate. There are, in fact, income provisions in here as well. There is also section 605 of the bill, which prevents payments to individuals not lawfully residing in the United States. So I believe that the issues that have been raised by my colleagues are addressed in the bill.

It does, of course, matter what the bill says. The bill says very clearly that individuals not lawfully residing in the United States will not receive payments, and it also is very clear with regard to the income level. So I think that this bill has been clear.

As I have mentioned, this bill has been voted on a number of times in Congress. The main difference now is we are sending it to a President who has indicated that he is, in fact, willing to sign it and, indeed, is willing to do so on this very afternoon.

Madam Speaker, I reserve the balance of my time.

Mr. SESSIONS. Madam Speaker, at this time, I would like to yield 2 minutes to the gentleman from Lafayette, Louisiana (Mr. BOUSTANY).

Mr. BOUSTANY. Madam Speaker, I rise in opposition to the rule and to the underlying bill.

Last week, the Democratic majority rushed a massive bill through the process, laden with wasteful spending of borrowed money that has not been shown or demonstrated to create jobs.

The American people are hurting. They are clearly hurting. We have tough economic times, and we have a responsibility to legislate and to legislate in a responsible way. Too often, children on Medicaid or on SCHIP receive fewer visits with primary care providers than those with private coverage. According to the Center on Budget and Policy Priorities, children on these programs were 2 times more likely to visit hospital emergency rooms multiple times in a given year.

As a physician, I know that government-run programs must achieve better results. My State has the eighth highest ER visit rate. This is unacceptable and we can do better. Now, the GAO has criticized government-run programs, like SCHIP, for disregarding patients' access problems. It warned: ''Coverage alone does not guarantee services will be available or that children will receive needed care.''

It is disappointing to me that the majority rushed this flawed bill to the floor without permitting any opportunity for improvements. In fact, as proposed, this bill would exacerbate enrolled children's access problems. The CBO warned that a similar bill would force more than 2.4 million children out of private health care plans and onto government rolls.

Working together, I know we can do better. I know we can make SCHIP help children who really need it—those who really already qualify for it but who are not enrolled. There are far too many of these children out there. This massive expansion fails to help those children most of all. States should measure also and report provider access problems in SCHIP programs to measure their progress. We asked for this, and it was not even entertained in the Rules Committee. I do not understand the closed debate here, the closed opportunity.

The SPEAKER pro tempore. The time of the gentleman has expired.

Mr. SESSIONS. I yield the gentleman an additional 15 seconds.

Mr. BOUSTANY. We also need to limit the crowd-out of private coverage and target the neediest children for enrollment first. We need to help poor children first. I know we can do better.

Oppose this rule. Oppose this bill.

Mr. POLIS of Colorado. Madam Speaker, I would also like to discuss that SCHIP provides quality dental care, alleviating the most common childhood disease—tooth decay.

I cannot help but remember a story that was told to me when I was visiting a free dental clinic in Boulder, Colorado that provides services to those who are uninsured. This story is about a young girl who was in the third grade. Due to the lack of dental care and poor dental hygiene practices at home, her teeth had actually rotted out. This is when she was a young girl. She had received no care for that as well. As a result, she was very, very shy, and was constantly in pain. Her diet suffered. She suffered malnutrition because of the condition of her teeth. Fortunately, the community there was able to help her, but there are hundreds of thousands of young people across the country who suffer from no or from poor quality dental care, which has vast ramifications as well.

In addition, this bill gives the option of providing pregnant women critical prenatal care. When we talk about the impact on reducing the need for special education and for increasing one's IQ, these things start in the prenatal stage, and they continue through early childhood. I think that that is a very important aspect in terms of giving States that option as well as covering 4.1 million additional low-income children who currently lack insurance.

Madam Speaker, I reserve the balance of my time.

Mr. SESSIONS. Madam Speaker, because there were no hearings held on this subject, many, many Republicans are coming down to the floor today to give their feedback and thoughts on this issue. Our next speaker is one of the most thoughtful and caring Members of Congress.

I would like to yield 1½ minutes to the gentlewoman from Fort Worth, Texas (Ms. GRANGER).

Ms. GRANGER. Madam Speaker, I rise in opposition to the rule for the consideration of the SCHIP bill we will be considering later today.

The rule does not allow for the consideration of any amendments, and it bars the Republican motion to recommit. That is not a good way to reauthorize what has been a bipartisan program.

In its original form, the SCHIP program is an excellent program that ensures medical care is available to uninsured children. During my first time in Congress, I voted to help create the SCHIP program, and I believe we need to responsibly reauthorize it. That is why I have introduced a bill to expand the SCHIP program to cover millions of uninsured kids. It is a bill that is paid for without budget gimmicks and without raising taxes.

My bill, the Kids First Act, expands SCHIP by $19.3 billion over the same 4½-year period as the Democrat bill. According to the Congressional Budget Office, the Kids First Act will cover 3.6 million previously uninsured children. Without raising taxes and without budget gimmicks, the Kids First Act truly puts kids first, eliminating nearly all adults from this program designed for children so that more children can be covered.

I urge my colleagues to oppose this rule as well as the majority's SCHIP bill and, instead, to support the Kids First Act.

Mr. POLIS of Colorado. Madam Speaker, another story from Colorado is about someone who I know firsthand, a student at one of the schools that I was involved in running.

Like many of the students I worked with, this student lacked health care insurance. She was diagnosed with diabetes, and she was not diagnosed early. She had severe symptoms, weakness, et cetera, but because of economic barriers to seeking health care and because of her lack of insurance, she did not seek any form of preventative treatment. When she then went in, she went into the emergency room, and she needed emergency dialysis immediately. So a condition that could have been dealt with through a combination of diet and insulin instead became an acute condition which had to be dealt with at a much greater cost and with a much worse health outcome for the individual.

These are the stories that are taking place across our great Nation. By passing this bill today, we can make a dent in making sure that people have access to preventative care and to health care throughout their childhoods.

Madam Speaker, I reserve the balance of my time.

Mr. SESSIONS. Madam Speaker, if I could please inquire as to the time remaining on both sides.

The SPEAKER pro tempore. The gentleman from Texas has 5 minutes remaining. The gentleman from Colorado has 16½ minutes remaining.

Mr. SESSIONS. Madam Speaker, due to the time inequity at this point, I would like to reserve my time.

Mr. POLIS of Colorado. Madam Speaker, I am the last speaker for this

side. I would like to reserve my time until the gentleman has closed for his side and has yielded back his time.

Mr. SESSIONS. Madam Speaker, we have had a series of Members who have come to the floor—Republican Members—who have talked, I believe, very adequately about the frailties of this bill. The frailties of this bill are obvious. The gentleman representing the Democratic majority has indicated that there were two tests laid forth—cost-effectiveness and common sense. I believe that the feedback from the Members of Congress on the Republican side have enunciated and have talked about several things that are important.

First of all, no hearings were held. Second of all, no Republican or bipartisan feedback was allowed in this bill. Thirdly, it is a huge expansion that will place this great Nation in terrible financial circumstances for the future. It expands a program that was working well for poor children. Lastly, it will move 2.4 million children from a private-run insurance program to a government-run insurance program. We think that is a failure. We believe the two tests have not passed.

In closing, I want to say that I oppose this closed rule. With the current program not expiring until March 31 of this year, we have seen enough Members question the underlying legislation, and it deserves to be debated, I believe, openly and, I believe, in the committees of jurisdiction before we take a vote to pass on such a large expansion of a government program.

This legislation spends billions of dollars to substitute superior, private health care coverage with an inferior government-run program. It enables illegal aliens to fraudulently enroll in Medicaid and SCHIP. The majority party knows that, and so does every Member of this body. The legislation increases the number of adults on SCHIP, allowing even more resources to be taken away from low-income, uninsured children who need it the most and what this legislation should be about.

Madam Speaker, this legislation moves us closer and closer and closer to not only financial insanity but also to a government-run health care program and further away from access to quality health care, which is what this should be about. It should be about quality health care for poor children. That is not what we are doing here today.

I encourage all of my colleagues to vote ''no'' on the rule and ''no'' on the underlying piece of legislation because, today, unlike before today, each of my colleagues has had a chance to hear the facts of the case. The facts of the case are compelling. The test that was established by our Democrat majority colleagues about cost-effectiveness and commonsense simply does not hold water. For these reasons on these issues, I believe that the Republicans have stated the case of why we should not only vote ''no'' but why this is a bad deal not just for the taxpayers but for the children it was intended to help.

I yield back the balance of my time.

□ 1115

Mr. POLIS of Colorado. Madam Speaker, SCHIP currently provides for coverage of 7 million children. This bill before us today would also allow for extending the coverage to 4.1 million uninsured children, every single one of them who is currently eligible for but not enrolled in SCHIP and Medicaid.

Polls have shown that more than 8 percent of the American people support this bipartisan legislation, including large majorities of both major political parties. This is not only popular, Madam Speaker; this is the right thing to do for American families.

I urge a ''yes'' vote on the previous question and on the rule.

Ms. CASTOR of Florida. Madam Speaker, I rise in support of H.R. 2 as amended and this rule. We will finally pass the children's health care bill today, send it to President Obama for his signature, and provide affordable medical care to millions of children across America.

I was in the pediatrician's office last Friday with my daughters. There is nothing like the feeling of knowing that your children are healthy after a checkup or that they are on the road to recovery. I speak for millions of parents who can share that sense of relief because they can take their kids to the doctor's office and do so without breaking the family bank.

What good news for all Americans that one of the first bills President Obama will sign today will be one that improves access to quality affordable health care and reduces the cost of health care for families.

More affordable health care is central to our economic recovery and it is fundamental for families.

I am proud to say that the precursor to SCHIP originated in the 1990s as a novel health care initiative in my home State of Florida where the innovators enrolled kids in a health care plan at the start of the school year. They understood that healthy kids succeed in school at higher rates.

President Clinton and the Congress were so impressed by what Florida was doing in Florida Kidcare, they took the blueprint and fashioned the national SCHIP partnership.

Access to health care for working families in my community and all over America through this innovative partnership between Federal, State and local communities is a winning proposition.

The new law will make it easier for parents and kids to afford the doctor's office visits, and encourage States to cut costly bureaucratic red tape.

Our children's health care initiative ensures that newborn babies receive the medical checkups and immunizations they need, ensures that toddlers and children are taken care of as they grow, and ensures that we all save money through preventative care.

Suffering through President Bush's opposition over the past years has been very costly, and we have lost ground. In Florida alone, over 800,000 children lack health insurance and that's the third highest rate in the U.S. It's more than the population of some States and it is growing. The lack of affordable health care for these working families is making it more expensive for everyone.

We are on a different path now.

I thank the many members who championed SCHIP as an initiative that works within a broader health care system that leaves many unable to afford health care in America, especially Speaker PELOSI, who never gave up and kept the promise that in the first days of a new Congress with a new President, the health of America's kids and the pocketbooks of hardworking families would be paramount.

Mr. POLIS of Colorado. I yield back the balance of my time, and I move the previous question on the resolution.

The previous question was ordered.

The resolution was agreed to.

A motion to reconsider was laid on the table.

Mr. WAXMAN. Madam Speaker, pursuant to House Resolution 107, I call up from the Speaker's table the bill (H.R. 2) to amend title XXI of the Social Security Act to extend and improve the Children's Health Insurance Program, and for other purposes, with the Senate amendment thereto, and I have a motion at the desk.

The SPEAKER pro tempore. The Clerk will report the title of the bill, designate the Senate amendment, and designate the motion.

The Clerk read the title of the bill.

The text of the Senate amendment is as follows:

Senate amendment:

Strike all after the enacting clause and insert the following:

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 2009''.

(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 CHIP; MEDICAID; 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 of this Act is as follows:

Sec. 1. Short title; amendments to Social Security Act; references; table of contents.
Sec. 2. Purpose.
Sec. 3. General effective date; exception for State legislation; contingent effective date; reliance on law.

TITLE I—FINANCING

Subtitle A—Funding

Sec. 101. Extension of CHIP.
Sec. 102. Allotments for States and territories for fiscal years 2009 through 2013.
Sec. 103. Child Enrollment Contingency Fund.
Sec. 104. CHIP performance bonus payment to offset additional enrollment costs resulting from enrollment and retention efforts.

Sec. 105. Two-year initial availability of CHIP allotments.
Sec. 106. Redistribution of unused allotments.
Sec. 107. Option for qualifying States to receive the enhanced portion of the CHIP matching rate for Medicaid coverage of certain children.
Sec. 108. One-time appropriation.
Sec. 109. Improving funding for the territories under CHIP and Medicaid.

Subtitle B—Focus on Low-Income Children and Pregnant Women

Sec. 111. State option to cover low-income pregnant women under CHIP through a State plan amendment.
Sec. 112. Phase-out of coverage for nonpregnant childless adults under CHIP; conditions for coverage of parents.
Sec. 113. Elimination of counting Medicaid child presumptive eligibility costs against title XXI allotment.
Sec. 114. Limitation on matching rate for States that propose to cover children with effective family income that exceeds 300 percent of the poverty line.
Sec. 115. State authority under Medicaid.

TITLE II—OUTREACH AND ENROLLMENT

Subtitle A—Outreach and Enrollment Activities

Sec. 201. Grants and enhanced administrative funding for outreach and enrollment.
Sec. 202. Increased outreach and enrollment of Indians.
Sec. 203. State option to rely on findings from an Express Lane agency to conduct simplified eligibility determinations.

Subtitle B—Reducing Barriers to Enrollment

Sec. 211. Verification of declaration of citizenship or nationality for purposes of eligibility for Medicaid and CHIP.
Sec. 212. Reducing administrative barriers to enrollment.
Sec. 213. Model of Interstate coordinated enrollment and coverage process.
Sec. 214. Permitting States to ensure coverage without a 5-year delay of certain children and pregnant women under the Medicaid program and CHIP.

TITLE III—REDUCING BARRIERS TO PROVIDING PREMIUM ASSISTANCE

Subtitle A—Additional State Option for Providing Premium Assistance

Sec. 301. Additional State option for providing premium assistance.
Sec. 302. Outreach, education, and enrollment assistance.

Subtitle B—Coordinating Premium Assistance With Private Coverage

Sec. 311. 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 IV—STRENGTHENING QUALITY OF CARE AND HEALTH OUTCOMES

Sec. 401. Child health quality improvement activities for children enrolled in Medicaid or CHIP.
Sec. 402. Improved availability of public information regarding enrollment of children in CHIP and Medicaid.
Sec. 403. Application of certain managed care quality safeguards to CHIP.

TITLE V—IMPROVING ACCESS TO BENEFITS

Sec. 501. Dental benefits.
Sec. 502. Mental health parity in CHIP plans.
Sec. 503. Application of prospective payment system for services provided by Federally-qualified health centers and rural health clinics.
Sec. 504. Premium grace period.
Sec. 505. Clarification of coverage of services provided through school-based health centers.
Sec. 506. Medicaid and CHIP Payment and Access Commission.

TITLE VI—PROGRAM INTEGRITY AND OTHER MISCELLANEOUS PROVISIONS

Subtitle A—Program Integrity and Data Collection

Sec. 601. Payment error rate measurement (''PERM'').
Sec. 602. Improving data collection.
Sec. 603. Updated Federal evaluation of CHIP.
Sec. 604. Access to records for IG and GAO audits and evaluations.
Sec. 605. No Federal funding for illegal aliens; disallowance for unauthorized expenditures.

Subtitle B—Miscellaneous Health Provisions

Sec. 611. Deficit Reduction Act technical corrections.
Sec. 612. References to title XXI.
Sec. 613. Prohibiting initiation of new health opportunity account demonstration programs.
Sec. 614. Adjustment in computation of Medicaid FMAP to disregard an extraordinary employer pension contribution.
Sec. 615. Clarification treatment of regional medical center.
Sec. 616. Extension of Medicaid DSH allotments for Tennessee and Hawaii.
Sec. 617. GAO report on Medicaid managed care payment rates.

Subtitle C—Other Provisions

Sec. 621. Outreach regarding health insurance options available to children.
Sec. 622. Sense of the Senate regarding access to affordable and meaningful health insurance coverage.

TITLE VII—REVENUE PROVISIONS

Sec. 701. Increase in excise tax rate on tobacco products.
Sec. 702. Administrative improvements.
Sec. 703. Treasury study concerning magnitude of tobacco smuggling in the United States.
Sec. 704. Time for payment of corporate estimated taxes.

SEC. 2. PURPOSE.

It is the purpose of this Act to provide dependable and stable funding for children's health insurance under titles XXI and XIX of the Social Security Act in order to enroll all six million uninsured children who are eligible, but not enrolled, for coverage today through such titles.

SEC. 3. GENERAL EFFECTIVE DATE; EXCEPTION FOR STATE LEGISLATION; CONTINGENT EFFECTIVE DATE; RELIANCE ON LAW.

(a) GENERAL EFFECTIVE DATE.—Unless otherwise provided in this Act, subject to subsections (b) through (d), this Act (and the amendments made by this Act) shall take effect on April 1, 2009, and shall apply to child health assistance and medical assistance provided on or after that date.

(b) EXCEPTION FOR STATE LEGISLATION.—In the case of a State plan under title XIX or State child health plan under XXI of the Social Security Act, which the Secretary of Health and Human Services determines requires State legislation in order for the respective plan to meet one or more additional requirements imposed by amendments made by this Act, the respective plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet such an additional requirement 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 previous 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.

(c) COORDINATION OF CHIP FUNDING FOR FISCAL YEAR 2009.—Notwithstanding any other provision of law, insofar as funds have been appropriated under section 2104(a)(11), 2104(k), or 2104(l) of the Social Security Act, as amended by section 201 of Public Law 110–173, to provide allotments to States under CHIP for fiscal year 2009—

(1) any amounts that are so appropriated that are not so allotted and obligated before April 1, 2009 are rescinded; and

(2) any amount provided for CHIP allotments to a State under this Act (and the amendments made by this Act) for such fiscal year shall be reduced by the amount of such appropriations so allotted and obligated before such date.

(d) RELIANCE ON LAW.—With respect to amendments made by this Act (other than title VII) that become effective as of a date—

(1) such amendments are effective as of such date whether or not regulations implementing such amendments have been issued; and

(2) Federal financial participation for medical assistance or child health assistance furnished under title XIX or XXI, respectively, of the Social Security Act on or after such date by a State in good faith reliance on such amendments before the date of promulgation of final regulations, if any, to carry out such amendments (or before the date of guidance, if any, regarding the implementation of such amendments) shall not be denied on the basis of the State's failure to comply with such regulations or guidance.

TITLE I—FINANCING

Subtitle A—Funding

SEC. 101. EXTENSION OF CHIP.

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

(1) in paragraph (10), by striking ''and'' at the end;

(2) by amending paragraph (11), by striking ''each of fiscal years 2008 and 2009'' and inserting ''fiscal year 2008''; and

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

''(12) for fiscal year 2009, $10,562,000,000;

''(13) for fiscal year 2010, $12,520,000,000;

''(14) for fiscal year 2011, $13,459,000,000;

''(15) for fiscal year 2012, $14,982,000,000; and

''(16) for fiscal year 2013, for purposes of making 2 semi-annual allotments—

''(A) $2,850,000,000 for the period beginning on October 1, 2012, and ending on March 31, 2013, and

''(B) $2,850,000,000 for the period beginning on April 1, 2013, and ending on September 30, 2013.''.

SEC. 102. ALLOTMENTS FOR STATES AND TERRITORIES FOR FISCAL YEARS 2009 THROUGH 2013.

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

(1) in subsection (b)(1), by striking ''subsection (d)'' and inserting ''subsections (d) and (m)'';

(2) in subsection (c)(1), by striking ''subsection (d)'' and inserting ''subsections (d) and (m)(4)''; and

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

''(m) ALLOTMENTS FOR FISCAL YEARS 2009 THROUGH 2013.—

''(1) FOR FISCAL YEAR 2009.—

''(A) FOR THE 50 STATES AND THE DISTRICT OF COLUMBIA.—Subject to the succeeding provisions of this paragraph and paragraph (4), the Secretary shall allot for fiscal year 2009 from the amount made available under subsection (a)(12), to each of the 50 States and the District of Columbia 110 percent of the highest of the following amounts for such State or District:

''(i) The total Federal payments to the State under this title for fiscal year 2008, multiplied by the allotment increase factor determined under paragraph (5) for fiscal year 2009.

''(ii) The amount allotted to the State for fiscal year 2008 under subsection (b), multiplied by the allotment increase factor determined under paragraph (5) for fiscal year 2009.

''(iii) The projected total Federal payments to the State under this title for fiscal year 2009, as determined on the basis of the February 2009 projections certified by the State to the Secretary by not later than March 31, 2009.

''(B) FOR THE COMMONWEALTHS AND TERRITORIES.—Subject to the succeeding provisions of this paragraph and paragraph (4), the Secretary shall allot for fiscal year 2009 from the amount made available under subsection (a)(12) to each of the commonwealths and territories described in subsection (c)(3) an amount equal to 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 1999 through 2008, multiplied by the allotment increase factor determined under paragraph (5) for fiscal year 2009, except that subparagraph (B) thereof shall be applied by substituting 'the United States' for 'the State'.

''(C) ADJUSTMENT FOR QUALIFYING STATES.—In the case of a qualifying State described in paragraph (2) of section 2105(g), the Secretary shall permit the State to submit a revised projection described in subparagraph (A)(iii) in order to take into account changes in such projections attributable to the application of paragraph (4) of such section.

''(2) FOR FISCAL YEARS 2010 THROUGH 2012.—

''(A) IN GENERAL.—Subject to paragraphs (4) and (6), from the amount made available under paragraphs (13) through (15) of subsection (a) for each of fiscal years 2010 through 2012, respectively, the Secretary shall compute a State allotment for each State (including the District of Columbia and each commonwealth and territory) for each such fiscal year as follows:

''(i) GROWTH FACTOR UPDATE FOR FISCAL YEAR 2010.—For fiscal year 2010, the allotment of the State is equal to the sum of—

''(I) the amount of the State allotment under paragraph (1) for fiscal year 2009; and

''(II) the amount of any payments made to the State under subsection (k), (l), or (n) for fiscal year 2009,

multiplied by the allotment increase factor under paragraph (5) for fiscal year 2010.

''(ii) REBASING IN FISCAL YEAR 2011.—For fiscal year 2011, the allotment of the State is equal to the Federal payments to the State that are attributable to (and countable towards) the total amount of allotments available under this section to the State in fiscal year 2010 (including payments made to the State under subsection (n) for fiscal year 2010 as well as amounts redistributed to the State in fiscal year 2010), multiplied by the allotment increase factor under paragraph (5) for fiscal year 2011.

''(iii) GROWTH FACTOR UPDATE FOR FISCAL YEAR 2012.—For fiscal year 2012, the allotment of the State is equal to the sum of—

''(I) the amount of the State allotment under clause (ii) for fiscal year 2011; and

''(II) the amount of any payments made to the State under subsection (n) for fiscal year 2011,

multiplied by the allotment increase factor under paragraph (5) for fiscal year 2012.

''(3) FOR FISCAL YEAR 2013.—

''(A) FIRST HALF.—Subject to paragraphs (4) and (6), from the amount made available under subparagraph (A) of paragraph (16) of subsection (a) for the semi-annual period described in such paragraph, increased by the amount of the appropriation for such period under section 108 of the Children's Health Insurance Program Reauthorization Act of 2009, the Secretary shall compute a State allotment for each State (including the District of Columbia and each commonwealth and territory) for such semi-annual period in an amount equal to the first half ratio (described in subparagraph (D)) of the amount described in subparagraph (C).

''(B) SECOND HALF.—Subject to paragraphs (4) and (6), from the amount made available under subparagraph (B) of paragraph (16) of subsection (a) for the semi-annual period described in such paragraph, the Secretary shall compute a State allotment for each State (including the District of Columbia and each commonwealth and territory) for such semi-annual period in an amount equal to the amount made available under such subparagraph, multiplied by the ratio of—

''(i) the amount of the allotment to such State under subparagraph (A); to

''(ii) the total of the amount of all of the allotments made available under such subparagraph.

''(C) FULL YEAR AMOUNT BASED ON REBASED AMOUNT.—The amount described in this subparagraph for a State is equal to the Federal payments to the State that are attributable to (and countable towards) the total amount of allotments available under this section to the State in fiscal year 2012 (including payments made to the State under subsection (n) for fiscal year 2012 as well as amounts redistributed to the State in fiscal year 2012), multiplied by the allotment increase factor under paragraph (5) for fiscal year 2013.

''(D) FIRST HALF RATIO.—The first half ratio described in this subparagraph is the ratio of—

''(i) the sum of—

''(I) the amount made available under subsection (a)(16)(A); and

''(II) the amount of the appropriation for such period under section 108 of the Children's Health Insurance Program Reauthorization Act of 2009; to

''(ii) the sum of the—

''(I) amount described in clause (i); and

''(II) the amount made available under subsection (a)(16)(B).

''(4) PRORATION RULE.—If, after the application of this subsection without regard to this paragraph, the sum of the allotments determined under paragraph (1), (2), or (3) for a fiscal year (or, in the case of fiscal year 2013, for a semi-annual period in such fiscal year) exceeds the amount available under subsection (a) for such fiscal year or period, the Secretary shall reduce each allotment for any State under such paragraph for such fiscal year or period on a proportional basis.

''(5) ALLOTMENT INCREASE FACTOR.—The allotment increase factor under this paragraph for a fiscal year is equal to the product of the following:

''(A) PER CAPITA HEALTH CARE GROWTH FACTOR.—1 plus the percentage increase in the projected per capita amount of National Health Expenditures from the calendar year in which the previous fiscal year ends to the calendar year in which the fiscal year involved ends, as most recently published by the Secretary before the beginning of the fiscal year.

''(B) CHILD POPULATION GROWTH FACTOR.—1 plus the percentage increase (if any) in the population of children in the State from July 1 in the previous fiscal year to July 1 in the fiscal year involved, as determined by the Secretary based on the most recent published estimates of the Bureau of the Census before the beginning of the fiscal year involved, plus 1 percentage point.

''(6) INCREASE IN ALLOTMENT TO ACCOUNT FOR APPROVED PROGRAM EXPANSIONS.—In the case of one of the 50 States or the District of Columbia that—

''(A) has submitted to the Secretary, and has approved by the Secretary, a State plan amendment or waiver request relating to an expansion of eligibility for children or benefits under this title that becomes effective for a fiscal year (beginning with fiscal year 2010 and ending with fiscal year 2013); and

''(B) has submitted to the Secretary, before the August 31 preceding the beginning of the fiscal year, a request for an expansion allotment adjustment under this paragraph for such fiscal year that specifies—

''(i) the additional expenditures that are attributable to the eligibility or benefit expansion provided under the amendment or waiver described in subparagraph (A), as certified by the State and submitted to the Secretary by not later than August 31 preceding the beginning of the fiscal year; and

''(ii) the extent to which such additional expenditures are projected to exceed the allotment of the State or District for the year,

subject to paragraph (4), the amount of the allotment of the State or District under this subsection for such fiscal year shall be increased by the excess amount described in subparagraph (B)(i). A State or District may only obtain an increase under this paragraph for an allotment for fiscal year 2010 or fiscal year 2012.

''(7) AVAILABILITY OF AMOUNTS FOR SEMI-ANNUAL PERIODS IN FISCAL YEAR 2013.—Each semi-annual allotment made under paragraph (3) for a period in fiscal year 2013 shall remain available for expenditure under this title for periods after the end of such fiscal year in the same manner as if the allotment had been made available for the entire fiscal year.''.

SEC. 103. CHILD ENROLLMENT CONTINGENCY FUND.

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

''(n) CHILD ENROLLMENT CONTINGENCY FUND.—

''(1) ESTABLISHMENT.—There is hereby established in the Treasury of the United States a fund which shall be known as the 'Child Enrollment Contingency Fund' (in this subsection referred to as the 'Fund'). Amounts in the Fund shall be available without further appropriations for payments under this subsection.

''(2) DEPOSITS INTO FUND.—

''(A) INITIAL AND SUBSEQUENT APPROPRIATIONS.—Subject to subparagraphs (B) and (D), 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 20 percent of the amount made available under paragraph (12) of subsection (a) for the fiscal year; and

''(ii) for each of fiscal years 2010 through 2012 (and for each of the semi-annual allotment periods for fiscal year 2013), such sums as are necessary for making payments to eligible States for such fiscal year or period, but not in excess of the aggregate cap described in subparagraph (B).

''(B) AGGREGATE CAP.—The total amount available for payment from the Fund for each of fiscal years 2010 through 2012 (and for each of the semi-annual allotment periods for fiscal year 2013), taking into account deposits made under subparagraph (C), shall not exceed 20 percent of the amount made available under subsection (a) for the fiscal year or period.

''(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) AVAILABILITY OF EXCESS FUNDS FOR PERFORMANCE BONUSES.—Any amounts in excess of the aggregate cap described in subparagraph (B) for a fiscal year or period shall be made available for purposes of carrying out section 2105(a)(3) for any succeeding fiscal year and the Secretary of the Treasury shall reduce the amount in the Fund by the amount so made available.

''(3) CHILD ENROLLMENT CONTINGENCY FUND PAYMENTS.—

''(A) IN GENERAL.—If a State's expenditures under this title in fiscal year 2009, fiscal year

2010, fiscal year 2011, fiscal year 2012, or a semi-annual allotment period for fiscal year 2013, exceed the total amount of allotments available under this section to the State in the fiscal year or period (determined without regard to any redistribution it receives under subsection (f) that is available for expenditure during such fiscal year or period, but including any carryover from a previous fiscal year) and if the average monthly unduplicated number of children enrolled under the State plan under this title (including children receiving health care coverage through funds under this title pursuant to a waiver under section 1115) during such fiscal year or period exceeds its target average number of such enrollees (as determined under subparagraph (B)) for that fiscal year or period, subject to subparagraph (D), the Secretary shall pay to the State from the Fund an amount equal to the product of—

''(i) the amount by which such average monthly caseload exceeds such target number of enrollees; and

''(ii) the projected per capita expenditures under the State child health plan (as determined under subparagraph (C) for the fiscal year), multiplied by the enhanced FMAP (as defined in section 2105(b)) for the State and fiscal year involved (or in which the period occurs).

''(B) TARGET AVERAGE NUMBER OF CHILD ENROLLEES.—In this paragraph, the target average number of child enrollees for a State—

''(i) for fiscal year 2009 is equal to the monthly average unduplicated number of children enrolled in the State child health plan under this title (including such children receiving health care coverage through funds under this title pursuant to a waiver under section 1115) during fiscal year 2008 increased by the population growth for children in that State for the year ending on June 30, 2007 (as estimated by the Bureau of the Census) plus 1 percentage point; or

''(ii) for a subsequent fiscal year (or semi-annual period occurring in a fiscal year) is equal to the target average number of child enrollees for the State for the previous fiscal year increased by the child population growth factor described in subsection (m)(5)(B) for the State for the prior fiscal year.

''(C) PROJECTED PER CAPITA EXPENDITURES.—For purposes of subparagraph (A)(ii), the projected per capita expenditures under a State child health plan—

''(i) for fiscal year 2009 is equal to the average per capita expenditures (including both State and Federal financial participation) under such plan for the targeted low-income children counted in the average monthly caseload for purposes of this paragraph during fiscal year 2008, increased by the annual percentage increase in the projected per capita amount of National Health Expenditures (as estimated by the Secretary) for 2009; or

''(ii) for a subsequent fiscal year (or semi-annual period occurring in a fiscal year) is equal to the projected per capita expenditures under such plan for the previous fiscal year (as determined under clause (i) or this clause) increased by the annual percentage increase in the projected per capita amount of National Health Expenditures (as estimated by the Secretary) for the year in which such subsequent fiscal year ends.

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

''(E) TIMELY PAYMENT; RECONCILIATION.—Payment under this paragraph for a fiscal year or period shall be made before the end of the fiscal year or period based upon the most recent data for expenditures and enrollment and the provisions of subsection (e) of section 2105 shall apply to payments under this subsection in the same manner as they apply to payments under such section.

''(F) CONTINUED REPORTING.—For purposes of this paragraph and subsection (f), the State shall submit to the Secretary the State's projected Federal expenditures, even if the amount of such expenditures exceeds the total amount of allotments available to the State in such fiscal year or period.

''(G) APPLICATION TO COMMONWEALTHS AND TERRITORIES.—No payment shall be made under this paragraph to a commonwealth or territory described in subsection (c)(3) until such time as the Secretary determines that there are in effect methods, satisfactory to the Secretary, for the collection and reporting of reliable data regarding the enrollment of children described in subparagraphs (A) and (B) in order to accurately determine the commonwealth's or territory's eligibility for, and amount of payment, under this paragraph.''.

SEC. 104. CHIP PERFORMANCE BONUS PAYMENT TO OFFSET ADDITIONAL ENROLLMENT COSTS RESULTING FROM ENROLLMENT AND RETENTION EFFORTS.

Section 2105(a) (42 U.S.C. 1397ee(a)) is amended by adding at the end the following new paragraphs:

''(3) PERFORMANCE BONUS PAYMENT TO OFFSET ADDITIONAL MEDICAID AND CHIP CHILD ENROLLMENT COSTS RESULTING FROM ENROLLMENT AND RETENTION EFFORTS.—

''(A) IN GENERAL.—In addition to the payments made under paragraph (1), for each fiscal year (beginning with fiscal year 2009 and ending with fiscal year 2013), the Secretary shall pay from amounts made available under subparagraph (E), to each State that meets the condition under paragraph (4) for the fiscal year, an amount equal to the amount described in subparagraph (B) for the State and fiscal year. The payment under this paragraph shall be made, to a State for a fiscal year, as a single payment not later than the last day of the first calendar quarter of the following fiscal year.

''(B) AMOUNT FOR ABOVE BASELINE MEDICAID CHILD ENROLLMENT COSTS.—Subject to subparagraph (E), the amount described in this subparagraph for a State for a fiscal year is equal to the sum of the following amounts:

''(i) FIRST TIER ABOVE BASELINE MEDICAID ENROLLEES.—An amount equal to the number of first tier above baseline child enrollees (as determined under subparagraph (C)(i)) under title XIX for the State and fiscal year, multiplied by 15 percent of the projected per capita State Medicaid expenditures (as determined under subparagraph (D)) for the State and fiscal year under title XIX.

''(ii) SECOND TIER ABOVE BASELINE MEDICAID ENROLLEES.—An amount equal to the number of second tier above baseline child enrollees (as determined under subparagraph (C)(ii)) under title XIX for the State and fiscal year, multiplied by 62.5 percent of the projected per capita State Medicaid expenditures (as determined under subparagraph (D)) for the State and fiscal year under title XIX.

''(C) NUMBER OF FIRST AND SECOND TIER ABOVE BASELINE CHILD ENROLLEES; BASELINE NUMBER OF CHILD ENROLLEES.—For purposes of this paragraph:

''(i) FIRST TIER ABOVE BASELINE CHILD ENROLLEES.—The number of first tier above baseline child enrollees for a State for a fiscal year under title XIX is equal to the number (if any, as determined by the Secretary) by which—

''(I) the monthly average unduplicated number of qualifying children (as defined in subparagraph (F)) enrolled during the fiscal year under the State plan under title XIX, respectively; exceeds

''(II) the baseline number of enrollees described in clause (iii) for the State and fiscal year under title XIX, respectively;

but not to exceed 10 percent of the baseline number of enrollees described in subclause (II).

''(ii) SECOND TIER ABOVE BASELINE CHILD ENROLLEES.—The number of second tier above baseline child enrollees for a State for a fiscal year under title XIX is equal to the number (if any, as determined by the Secretary) by which—

''(I) the monthly average unduplicated number of qualifying children (as defined in subparagraph (F)) enrolled during the fiscal year under title XIX as described in clause (i)(I); exceeds

''(II) the sum of the baseline number of child enrollees described in clause (iii) for the State and fiscal year under title XIX, as described in clause (i)(II), and the maximum number of first tier above baseline child enrollees for the State and fiscal year under title XIX, as determined under clause (i).

''(iii) BASELINE NUMBER OF CHILD ENROLLEES.—Subject to subparagraph (H), the baseline number of child enrollees for a State under title XIX—

''(I) for fiscal year 2009 is equal to the monthly average unduplicated number of qualifying children enrolled in the State plan under title XIX during fiscal year 2007 increased by the population growth for children in that State from 2007 to 2008 (as estimated by the Bureau of the Census) plus 4 percentage points, and further increased by the population growth for children in that State from 2008 to 2009 (as estimated by the Bureau of the Census) plus 4 percentage points;

''(II) for each of fiscal years 2010, 2011, and 2012, is equal to the baseline number of child enrollees for the State for the previous fiscal year under title XIX, increased by the population growth for children in that State from the calendar year in which the respective fiscal year begins to the succeeding calendar year (as estimated by the Bureau of the Census) plus 3.5 percentage points;

''(III) for each of fiscal years 2013, 2014, and 2015, is equal to the baseline number of child enrollees for the State for the previous fiscal year under title XIX, increased by the population growth for children in that State from the calendar year in which the respective fiscal year begins to the succeeding calendar year (as estimated by the Bureau of the Census) plus 3 percentage points; and

''(IV) for a subsequent fiscal year is equal to the baseline number of child enrollees for the State for the previous fiscal year under title XIX, increased by the population growth for children in that State from the calendar year in which the fiscal year involved begins to the succeeding calendar year (as estimated by the Bureau of the Census) plus 2 percentage points.

''(D) PROJECTED PER CAPITA STATE MEDICAID EXPENDITURES.—For purposes of subparagraph (B), the projected per capita State Medicaid expenditures for a State and fiscal year under title XIX is equal to the average per capita expenditures (including both State and Federal financial participation) for children under the State plan under such title, including under waivers but not including such children eligible for assistance by virtue of the receipt of benefits under title XVI, for the most recent fiscal year for which actual data are available (as determined by the Secretary), increased (for each subsequent fiscal year up to and including the fiscal year involved) by the annual percentage increase in per capita amount of National Health Expenditures (as estimated by the Secretary) for the calendar year in which the respective subsequent fiscal year ends and multiplied by a State matching percentage equal to 100 percent minus the Federal medical assistance percentage (as defined in section 1905(b)) for the fiscal year involved.

''(E) AMOUNTS AVAILABLE FOR PAYMENTS.—

''(i) INITIAL APPROPRIATION.—Out of any money in the Treasury not otherwise appropriated, there are appropriated $3,225,000,000 for fiscal year 2009 for making payments under this paragraph, to be available until expended.

''(ii) TRANSFERS.—Notwithstanding any other provision of this title, the following amounts

shall also be available, without fiscal year limitation, for making payments under this paragraph:

''(I) UNOBLIGATED NATIONAL ALLOTMENT.—

''(aa) FISCAL YEARS 2009 THROUGH 2012.—As of December 31 of fiscal year 2009, and as of December 31 of each succeeding fiscal year through fiscal year 2012, 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 (m) 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 2013.—As of December 31 of fiscal year 2013, the portion, if any, of the sum of the amounts appropriated under subsection (a)(16)(A) and under section 108 of the Children's Health Insurance Reauthorization Act of 2009 for the period beginning on October 1, 2012, and ending on March 31, 2013, that is unobligated for allotment to a State under subsection (m) for such fiscal year or set aside under subsection (b)(2) of section 2111 for such fiscal year.

''(cc) SECOND HALF OF FISCAL YEAR 2013.—As of June 30 of fiscal year 2013, the portion, if any, of the amount appropriated under subsection (a)(16)(B) for the period beginning on April 1, 2013, and ending on September 30, 2013, that is unobligated for allotment to a State under subsection (m) for such fiscal year or set aside under subsection (b)(2) of section 2111 for such fiscal year.

''(II) UNEXPENDED ALLOTMENTS NOT USED FOR REDISTRIBUTION.—As of November 15 of each of fiscal years 2010 through 2013, the total amount of allotments made to States under section 2104 for the second preceding fiscal year (third preceding fiscal year in the case of the fiscal year 2006, 2007, and 2008 allotments) that is not expended or redistributed under section 2104(f) during the period in which such allotments are available for obligation.

''(III) EXCESS CHILD ENROLLMENT CONTINGENCY FUNDS.—As of October 1 of each of fiscal years 2010 through 2013, any amount in excess of the aggregate cap applicable to the Child Enrollment Contingency Fund for the fiscal year under section 2104(n).

''(IV) UNEXPENDED TRANSITIONAL COVERAGE BLOCK GRANT FOR NONPREGNANT CHILDLESS ADULTS.—As of October 1, 2011, any amounts set aside under section 2111(a)(3) that are not expended by September 30, 2011.

''(iii) PROPORTIONAL REDUCTION.—If the sum of the amounts otherwise payable under this paragraph for a fiscal year exceeds the amount available for the fiscal year under this subparagraph, the amount to be paid under this paragraph to each State shall be reduced proportionally.

''(F) QUALIFYING CHILDREN DEFINED.—

''(i) IN GENERAL.—For purposes of this subsection, subject to clauses (ii) and (iii), the term 'qualifying children' means children who meet the eligibility criteria (including income, categorical eligibility, age, and immigration status criteria) in effect as of July 1, 2008, for enrollment under title XIX, taking into account criteria applied as of such date under title XIX pursuant to a waiver under section 1115.

''(ii) LIMITATION.—A child described in clause (i) who is provided medical assistance during a presumptive eligibility period under section 1920A shall be considered to be a 'qualifying child' only if the child is determined to be eligible for medical assistance under title XIX.

''(iii) EXCLUSION.—Such term does not include any children for whom the State has made an election to provide medical assistance under paragraph (4) of section 1903(v).

''(G) APPLICATION TO COMMONWEALTHS AND TERRITORIES.—The provisions of subparagraph (G) of section 2104(n)(3) shall apply with respect to payment under this paragraph in the same manner as such provisions apply to payment under such section.

''(H) APPLICATION TO STATES THAT IMPLEMENT A MEDICAID EXPANSION FOR CHILDREN AFTER FISCAL YEAR 2008.—In the case of a State that provides coverage under section 115 of the Children's Health Insurance Program Reauthorization Act of 2009 for any fiscal year after fiscal year 2008—

''(i) any child enrolled in the State plan under title XIX through the application of such an election shall be disregarded from the determination for the State of the monthly average unduplicated number of qualifying children enrolled in such plan during the first 3 fiscal years in which such an election is in effect; and

''(ii) in determining the baseline number of child enrollees for the State for any fiscal year subsequent to such first 3 fiscal years, the baseline number of child enrollees for the State under title XIX for the third of such fiscal years shall be the monthly average unduplicated number of qualifying children enrolled in the State plan under title XIX for such third fiscal year.

''(4) ENROLLMENT AND RETENTION PROVISIONS FOR CHILDREN.—For purposes of paragraph (3)(A), a State meets the condition of this paragraph for a fiscal year if it is implementing at least 5 of the following enrollment and retention provisions (treating each subparagraph as a separate enrollment and retention provision) throughout the entire fiscal year:

''(A) CONTINUOUS ELIGIBILITY.—The State has elected the option of continuous eligibility for a full 12 months for all children described in section 1902(e)(12) under title XIX under 19 years of age, as well as applying such policy under its State child health plan under this title.

''(B) LIBERALIZATION OF ASSET REQUIREMENTS.—The State meets the requirement specified in either of the following clauses:

''(i) ELIMINATION OF ASSET TEST.—The State does not apply any asset or resource test for eligibility for children under title XIX or this title.

''(ii) ADMINISTRATIVE VERIFICATION OF ASSETS.—The State—

''(I) permits a parent or caretaker relative who is applying on behalf of a child for medical assistance under title XIX or child health assistance under this title to declare and certify by signature under penalty of perjury information relating to family assets for purposes of determining and redetermining financial eligibility; and

''(II) takes steps to verify assets through means other than by requiring documentation from parents and applicants except in individual cases of discrepancies or where otherwise justified.

''(C) ELIMINATION OF IN-PERSON INTERVIEW REQUIREMENT.—The State does not require an application of a child for medical assistance under title XIX (or for child health assistance under this title), including an application for renewal of such assistance, to be made in person nor does the State require a face-to-face interview, unless there are discrepancies or individual circumstances justifying an in-person application or face-to-face interview.

''(D) USE OF JOINT APPLICATION FOR MEDICAID AND CHIP.—The application form and supplemental forms (if any) and information verification process is the same for purposes of establishing and renewing eligibility for children for medical assistance under title XIX and child health assistance under this title.

''(E) AUTOMATIC RENEWAL (USE OF ADMINISTRATIVE RENEWAL).—

''(i) IN GENERAL.—The State provides, in the case of renewal of a child's eligibility for medical assistance under title XIX or child health assistance under this title, a pre-printed form completed by the State based on the information available to the State and notice to the parent or caretaker relative of the child that eligibility of the child will be renewed and continued based on such information unless the State is provided other information. Nothing in this clause shall be construed as preventing a State from verifying, through electronic and other means, the information so provided.

''(ii) SATISFACTION THROUGH DEMONSTRATED USE OF EX PARTE PROCESS.—A State shall be treated as satisfying the requirement of clause (i) if renewal of eligibility of children under title XIX or this title is determined without any requirement for an in-person interview, unless sufficient information is not in the State's possession and cannot be acquired from other sources (including other State agencies) without the participation of the applicant or the applicant's parent or caretaker relative.

''(F) PRESUMPTIVE ELIGIBILITY FOR CHILDREN.—The State is implementing section 1920A under title XIX as well as, pursuant to section 2107(e)(1), under this title.

''(G) EXPRESS LANE.—The State is implementing the option described in section 1902(e)(13) under title XIX as well as, pursuant to section 2107(e)(1), under this title.

''(H) PREMIUM ASSISTANCE SUBSIDIES.—The State is implementing the option of providing premium assistance subsidies under section 2105(c)(10) or section 1906A.''.

SEC. 105. TWO-YEAR INITIAL AVAILABILITY OF CHIP 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 paragraph (2), amounts allotted to a State pursuant to this section—

''(A) for each of fiscal years 1998 through 2008, shall remain available for expenditure by the State through the end of the second succeeding fiscal year; and

''(B) for fiscal year 2009 and each fiscal year thereafter, shall remain available for expenditure by the State through the end of the succeeding fiscal year.

''(2) AVAILABILITY OF AMOUNTS REDISTRIBUTED.—Amounts redistributed to a State under subsection (f) shall be available for expenditure by the State through the end of the fiscal year in which they are redistributed.''.

SEC. 106. REDISTRIBUTION OF UNUSED ALLOTMENTS.

(a) BEGINNING WITH FISCAL YEAR 2007.—

(1) IN GENERAL.—Section 2104(f) (42 U.S.C. 1397dd(f)) is amended—

(A) by striking ''The Secretary'' and inserting the following:

''(1) IN GENERAL.—The Secretary'';

(B) by striking ''States that have fully expended the amount of their allotments under this section.'' and inserting ''States that the Secretary determines with respect to the fiscal year for which unused allotments are available for redistribution under this subsection, are shortfall States described in paragraph (2) for such fiscal year, but not to exceed the amount of the shortfall described in paragraph (2)(A) for each such State (as may be adjusted under paragraph (2)(C)).''; and

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

''(2) SHORTFALL STATES DESCRIBED.—

''(A) IN GENERAL.—For purposes of paragraph (1), with respect to a fiscal year, a shortfall State described in this subparagraph is a State with a State child health plan approved under this title for which the Secretary estimates on the basis of the most recent data available to the Secretary, that the projected expenditures under such plan for the State for the fiscal year will exceed the sum of—

''(i) the amount of the State's allotments for any preceding fiscal years that remains available for expenditure and that will not be expended by the end of the immediately preceding fiscal year;

''(ii) the amount (if any) of the child enrollment contingency fund payment under subsection (n); and

''(iii) the amount of the State's allotment for the fiscal year.

''(B) PRORATION RULE.—If the amounts available for redistribution under paragraph (1) for a fiscal year are less than the total amounts of the estimated shortfalls determined for the year

under subparagraph (A), the amount to be redistributed under such paragraph for each shortfall State shall be reduced proportionally.

''(C) RETROSPECTIVE ADJUSTMENT.—The Secretary may adjust the estimates and determinations made under paragraph (1) and this paragraph with respect to a fiscal year as necessary on the basis of the amounts reported by States not later than November 30 of the succeeding fiscal year, as approved by the Secretary.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to redistribution of allotments made for fiscal year 2007 and subsequent fiscal years.

(b) REDISTRIBUTION OF UNUSED ALLOTMENTS FOR FISCAL YEAR 2006.—Section 2104(k) (42 U.S.C. 1397dd(k)) is amended—

(1) in the subsection heading, by striking ''THE FIRST 2 QUARTERS OF'';

(2) in paragraph (1), by striking ''the first 2 quarters of''; and

(3) in paragraph (6)—

(A) by striking ''the first 2 quarters of''; and

(B) by striking ''March 31'' and inserting ''September 30''.

SEC. 107. OPTION FOR QUALIFYING STATES TO RECEIVE THE ENHANCED PORTION OF THE CHIP MATCHING RATE FOR MEDICAID COVERAGE OF CERTAIN CHILDREN.

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

(1) in paragraph (1)(A), as amended by section 201(b)(1) of Public Law 110–173—

(A) by inserting ''subject to paragraph (4),'' after ''Notwithstanding any other provision of law,''; and

(B) by striking ''2008, or 2009'' and inserting ''or 2008''; and

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

''(4) OPTION FOR ALLOTMENTS FOR FISCAL YEARS 2009 THROUGH 2013.—

''(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 2009 through 2013 (insofar as the allotment is available to the State under subsections (e) and (m) 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.''.

(b) REPEAL OF LIMITATION ON AVAILABILITY OF FISCAL YEAR 2009 ALLOTMENTS.—Paragraph (2) of section 201(b) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173) is repealed.

SEC. 108. ONE-TIME APPROPRIATION.

There is appropriated to the Secretary, out of any money in the Treasury not otherwise appropriated, $11,706,000,000 to accompany the allotment made for the period beginning on October 1, 2012, and ending on March 31, 2013, under section 2104(a)(16)(A) of the Social Security Act (42 U.S.C. 1397dd(a)(16)(A)) (as added by section 101), to remain available until expended. Such amount shall be used to provide allotments to States under paragraph (3) of section 2104(m) of the Social Security Act (42 U.S.C. 1397dd(i)), as added by section 102, for the first 6 months of fiscal year 2013 in the same manner as allotments are provided under subsection (a)(16)(A) of such section 2104 and subject to the same terms and conditions as apply to the allotments provided from such subsection (a)(16)(A).

SEC. 109. IMPROVING FUNDING FOR THE TERRITORIES UNDER CHIP AND MEDICAID.

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 2009, 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.''.

Subtitle B—Focus on Low-Income Children and Pregnant Women

SEC. 111. 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 112(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) MINIMUM INCOME ELIGIBILITY LEVELS FOR PREGNANT WOMEN AND CHILDREN.—The State has established an income eligibility level—

''(A) for pregnant women under subsection (a)(10)(A)(i)(III), (a)(10)(A)(i)(IV), or (l)(1)(A) of section 1902 that is at least 185 percent (or such higher percent as the State has in effect with regard to pregnant women under this title) of the poverty line applicable to a family of the size involved, but in no case lower than the percent in effect under any such subsection as of July 1, 2008; and

''(B) for children under 19 years of age under this title (or title XIX) that is at least 200 percent of the poverty line applicable to a family of the size involved.

''(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 (l)(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.

''(7) NO WAITING LIST FOR CHILDREN.—The State does not impose, with respect to the enrollment under the State child health plan of targeted low-income children during the quarter, any enrollment cap or other numerical limitation on enrollment, any waiting list, any procedures designed to delay the consideration of applications for enrollment, or similar limitation with respect to enrollment.

''(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) with respect to an individual during the period described in paragraph (2)(A).

''(2) TARGETED LOW-INCOME PREGNANT WOMAN.—The term 'targeted low-income pregnant woman' means an individual—

''(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 exceeds 185 percent (or, if higher, the percent applied under subsection (b)(1)(A)) of the poverty line applicable to a family of the size involved, but 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, 2008).

''(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. 112. 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 2009.—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 2009, 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 paragraph (2) shall apply for purposes of any period beginning on or after January 1, 2010, 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 2009.—

''(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 December 31, 2009.

''(B) EXTENSION UPON STATE REQUEST.—If an applicable existing waiver described in subparagraph (A) would otherwise expire before January 1, 2010, notwithstanding the requirements of subsections (e) and (f) of section 1115, a State may submit, not later than September 30, 2009, a request to the Secretary for an extension of the waiver. The Secretary shall approve a request for an extension of an applicable existing waiver submitted pursuant to this subparagraph, but only through December 31, 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 nonpregnant childless adult during the period beginning on the date of the enactment of this subsection and ending on December 31, 2009.

''(3) 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 September 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 a '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 December 31, 2009, on the application of a State for a Medicaid nonpregnant childless adults waiver that was submitted to the Secretary by September 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 (2)(B) for fiscal year 2009, increased by the percentage increase (if any) in the projected nominal per capita amount of National Health Expenditures for 2010 over 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 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 PERIOD; AUTOMATIC EXTENSION AT STATE OPTION THROUGH FISCAL YEAR 2011.—

''(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 2009 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, 2011, 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, 2011, 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, 2011.

''(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 the third and fourth quarters of fiscal year 2009 and during fiscal years 2010 and 2011.

''(2) RULES FOR FISCAL YEARS 2012 THROUGH 2013.—

''(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 2012 or 2013, 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 2013, the set aside for any State shall be computed separately for each period described in subparagraphs (A) and (B) of section 2104(a)(16) and any reduction in the allotment for either such period under section 2104(m)(4) 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 2012 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 2012 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 subparagraph (A), (B), or (C) of paragraph (3) for fiscal year 2011; 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 2013.—For purposes of clause (ii), the applicable percentage for any quarter of fiscal year 2013 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 2012; and

''(bb) the State met either of the coverage benchmarks described in subparagraph (B) or (C) of paragraph (3) for fiscal year 2012; 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 2009.

''(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 2011;

''(ii) implemented 1 or more of the enrollment and retention provisions described in section 2105(a)(4) 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 ⅓ 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 performance bonus payment under section 2105(a)(3)(B) for the most recent fiscal year 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 2009.

''(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 ''.

''(1) The Secretary'';

(ii) in the first sentence, by inserting ''or a parent (as defined in section 2111(c)(2)(A)), who is not pregnant, of a targeted low-income child'' before the period;

(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 2009 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 112 of the Children's Health Insurance Program Reauthorization Act of 2009, 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 Committee on Finance of the Senate and the Committee on Energy and Commerce of the House of Representatives, including recommendations (if any) for changes in legislation.

SEC. 113. ELIMINATION OF COUNTING MEDICAID CHILD PRESUMPTIVE ELIGIBILITY COSTS AGAINST TITLE XXI ALLOTMENT.

(a) IN GENERAL.—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]''.

(b) AMENDMENTS TO MEDICAID.—

(1) ELIGIBILITY OF A NEWBORN.—Section 1902(e)(4) (42 U.S.C. 1396a(e)(4)) is amended in the first sentence by striking ''so long as the child is a member of the woman's household and the woman remains (or would remain if pregnant) eligible for such assistance''.

(2) APPLICATION OF QUALIFIED ENTITIES TO PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN UNDER MEDICAID.—Section 1920(b) (42 U.S.C. 1396r–1(b)) is amended by adding after paragraph (2) the following flush sentence:

''The term 'qualified provider' also includes a qualified entity, as defined in section 1920A(b)(3).''.

SEC. 114. 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 2009, 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 2009, 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) RULE OF CONSTRUCTION.—Nothing in the amendments made by this section shall be construed as—

(1) changing any income eligibility level for children under title XXI of the Social Security Act; or

(2) changing the flexibility provided States under such title to establish the income eligibility level for targeted low-income children under a State child health plan and the methodologies used by the State to determine income or assets under such plan.

SEC. 115. STATE AUTHORITY UNDER MEDICAID.

Notwithstanding any other provision of law, including 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, at State option, the Secretary shall provide the State with the Federal medical assistance percentage determined for the State for Medicaid with respect to expenditures described in section 1905(u)(2)(A) of such Act or otherwise made to provide medical assistance under Medicaid to a child who could be covered by the State under CHIP.

TITLE II—OUTREACH AND ENROLLMENT

Subtitle A—Outreach and Enrollment Activities

SEC. 201. GRANTS AND ENHANCED ADMINISTRATIVE FUNDING FOR OUTREACH AND ENROLLMENT.

(a) GRANTS.—Title XXI (42 U.S.C. 1397aa et seq.), as amended by section 111, 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 2009 through 2013 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 MATCH REQUIRED FOR ANY ELIGIBLE ENTITY AWARDED A GRANT.—

''(1) STATE MAINTENANCE OF EFFORT.—In the case of a State that is awarded a grant under this section, 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.

''(2) NO MATCHING REQUIREMENT.—No eligible entity awarded a grant under subsection (a) shall be required to provide any matching funds as a condition for receiving the grant.

''(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. 300x–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 2009 through 2013, 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)(iii) 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 AND MEDICAID.—

(1) CHIP.—Section 2105(a)(1) (42 U.S.C. 1397ee(a)(1)), as amended by section 113, is amended—

(A) 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

(B) in subparagraph (D)—

(i) in clause (iii), by striking ''and'' at the end;

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

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

''(iv) for translation or interpretation services in connection with the enrollment of, retention of, 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''.

(2) MEDICAID.—

(A) USE OF MEDICAID FUNDS.—Section 1903(a)(2) (42 U.S.C. 1396b(a)(2)) is amended by adding at the end the following new subparagraph:

''(E) an amount equal to 75 percent 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 translation or interpretation services in connection with the enrollment of, retention of, and use of services under this title by, children of families for whom English is not the primary language; plus''.

(B) USE OF COMMUNITY HEALTH WORKERS FOR OUTREACH ACTIVITIES.—

(i) IN GENERAL.—Section 2102(c)(1) of such Act (42 U.S.C. 1397bb(c)(1)) is amended by inserting ''(through community health workers and others)'' after ''Outreach''.

(ii) IN FEDERAL EVALUATION.—Section 2108(c)(3)(B) of such Act (42 U.S.C. 1397hh(c)(3)(B)) is amended by inserting ''(such as through community health workers and others)'' after ''including practices''.

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) (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 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. STATE OPTION TO RELY ON FINDINGS FROM AN EXPRESS LANE AGENCY TO CONDUCT SIMPLIFIED ELIGIBILITY DETERMINATIONS.

(a) APPLICATION UNDER MEDICAID AND CHIP PROGRAMS.—

(1) MEDICAID.—Section 1902(e) (42 U.S.C. 1396a(e)) is amended by adding at the end the following:

''(13) EXPRESS LANE OPTION.—

''(A) IN GENERAL.—

''(i) OPTION TO USE A FINDING FROM AN EXPRESS LANE AGENCY.—At the option of the State, the State plan may provide that in determining eligibility under this title for a child (as defined in subparagraph (G)), the State may rely on a finding made within a reasonable period (as determined by the State) from an Express Lane agency (as defined in subparagraph (F)) when it determines whether a child satisfies one or more components of eligibility for medical assistance under this title. The State may rely on a finding from an Express Lane agency notwithstanding sections 1902(a)(46)(B) and 1137(d) or any differences in budget unit, disregard, deeming or other methodology, if the following requirements are met:

''(I) PROHIBITION ON DETERMINING CHILDREN INELIGIBLE FOR COVERAGE.—If a finding from an Express Lane agency would result in a determination that a child does not satisfy an eligibility requirement for medical assistance under this title and for child health assistance under title XXI, the State shall determine eligibility for assistance using its regular procedures.

''(II) NOTICE REQUIREMENT.—For any child who is found eligible for medical assistance under the State plan under this title or child health assistance under title XXI and who is subject to premiums based on an Express Lane agency's finding of such child's income level, the State shall provide notice that the child may qualify for lower premium payments if evaluated by the State using its regular policies and of the procedures for requesting such an evaluation.

''(III) COMPLIANCE WITH SCREEN AND ENROLL REQUIREMENT.—The State shall satisfy the requirements under subparagraphs (A) and (B) of section 2102(b)(3) (relating to screen and enroll) before enrolling a child in child health assistance under title XXI. At its option, the State may fulfill such requirements in accordance with either option provided under subparagraph (C) of this paragraph.

''(IV) VERIFICATION OF CITIZENSHIP OR NATIONALITY STATUS.—The State shall satisfy the requirements of section 1902(a)(46)(B) or 2105(c)(9), as applicable for verifications of citizenship or nationality status.

''(V) CODING.—The State meets the requirements of subparagraph (E).

''(ii) OPTION TO APPLY TO RENEWALS AND REDETERMINATIONS.—The State may apply the provisions of this paragraph when conducting initial determinations of eligibility, redeterminations of eligibility, or both, as described in the State plan.

''(B) RULES OF CONSTRUCTION.—Nothing in this paragraph shall be construed—

''(i) to limit or prohibit a State from taking any actions otherwise permitted under this title or title XXI in determining eligibility for or enrolling children into medical assistance under this title or child health assistance under title XXI; or

''(ii) to modify the limitations in section 1902(a)(5) concerning the agencies that may make a determination of eligibility for medical assistance under this title.

''(C) OPTIONS FOR SATISFYING THE SCREEN AND ENROLL REQUIREMENT.—

''(i) IN GENERAL.—With respect to a child whose eligibility for medical assistance under this title or for child health assistance under title XXI has been evaluated by a State agency using an income finding from an Express Lane agency, a State may carry out its duties under subparagraphs (A) and (B) of section 2102(b)(3) (relating to screen and enroll) in accordance with either clause (ii) or clause (iii).

''(ii) ESTABLISHING A SCREENING THRESHOLD.—

''(I) IN GENERAL.—Under this clause, the State establishes a screening threshold set as a percentage of the Federal poverty level that exceeds the highest income threshold applicable under this title to the child by a minimum of 30 percentage points or, at State option, a higher number of percentage points that reflects the value (as determined by the State and described in the State plan) of any differences between income methodologies used by the program administered by the Express Lane agency and the methodologies used by the State in determining eligibility for medical assistance under this title.

''(II) CHILDREN WITH INCOME NOT ABOVE THRESHOLD.—If the income of a child does not exceed the screening threshold, the child is deemed to satisfy the income eligibility criteria for medical assistance under this title regardless of whether such child would otherwise satisfy such criteria.

''(III) CHILDREN WITH INCOME ABOVE THRESHOLD.—If the income of a child exceeds the screening threshold, the child shall be considered to have an income above the Medicaid applicable income level described in section 2110(b)(4) and to satisfy the requirement under section 2110(b)(1)(C) (relating to the requirement that CHIP matching funds be used only for children not eligible for Medicaid). If such a child is enrolled in child health assistance under title XXI, the State shall provide the parent, guardian, or custodial relative with the following:

''(aa) Notice that the child may be eligible to receive medical assistance under the State plan under this title if evaluated for such assistance under the State's regular procedures and notice of the process through which a parent, guardian, or custodial relative can request that the State evaluate the child's eligibility for medical assistance under this title using such regular procedures.

''(bb) A description of differences between the medical assistance provided under this title and child health assistance under title XXI, including differences in cost-sharing requirements and covered benefits.

''(iii) TEMPORARY ENROLLMENT IN CHIP PENDING SCREEN AND ENROLL.—

''(I) IN GENERAL.—Under this clause, a State enrolls a child in child health assistance under title XXI for a temporary period if the child appears eligible for such assistance based on an income finding by an Express Lane agency.

''(II) DETERMINATION OF ELIGIBILITY.—During such temporary enrollment period, the State shall determine the child's eligibility for child health assistance under title XXI or for medical assistance under this title in accordance with this clause.

''(III) PROMPT FOLLOW UP.—In making such a determination, the State shall take prompt action to determine whether the child should be enrolled in medical assistance under this title or child health assistance under title XXI pursuant to subparagraphs (A) and (B) of section 2102(b)(3) (relating to screen and enroll).

''(IV) REQUIREMENT FOR SIMPLIFIED DETERMINATION.—In making such a determination, the State shall use procedures that, to the maximum feasible extent, reduce the burden imposed on the individual of such determination. Such procedures may not require the child's parent, guardian, or custodial relative to provide or verify information that already has been provided to the State agency by an Express Lane agency or another source of information unless the State agency has reason to believe the information is erroneous.

''(V) AVAILABILITY OF CHIP MATCHING FUNDS DURING TEMPORARY ENROLLMENT PERIOD.—Medical assistance for items and services that are provided to a child enrolled in title XXI during a temporary enrollment period under this clause shall be treated as child health assistance under such title.

''(D) OPTION FOR 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 in writing, by telephone, orally, through electronic signature, or through any other means specified by the Secretary or by signature on an Express Lane agency application, if the requirement of clause (ii) is met.

''(ii) INFORMATION REQUIREMENT.—The requirement of this clause is that the State informs the parent, guardian, or custodial relative

of the child of the services that will be covered, appropriate methods for using such services, premium or other cost sharing charges (if any) that apply, medical support obligations (under section 1912(a)) created by enrollment (if applicable), and the actions the parent, guardian, or relative must take to maintain enrollment and renew coverage.

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

''(i) IN GENERAL.—For purposes of subparagraph (A)(iv), the requirement of this subparagraph for a State is that 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 election under this paragraph;

''(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 (as described in clause (iv)) with respect to the enrollment of such children (and shall not include such children in any data or samples used for purposes of complying with a Medicaid Eligibility Quality Control (MEQC) review or a payment error rate measurement (PERM) requirement);

''(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 elects to apply this paragraph, 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 elects to apply this paragraph, a reduction in the amount otherwise payable to the State under section 1903(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 paragraph shall be construed as relieving a State that elects to apply this paragraph from being subject to a penalty under section 1903(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)).

''(iv) ERROR RATE DEFINED.—In this subparagraph, the term 'error rate' means the rate of erroneous excess payments for medical assistance (as defined in section 1903(u)(1)(D)) for the period involved, except that such payments shall be limited to individuals for which eligibility determinations are made under this paragraph and except that in applying this paragraph under title XXI, there shall be substituted for references to provisions of this title corresponding provisions within title XXI.

''(F) EXPRESS LANE AGENCY.—

''(i) IN GENERAL.—In this paragraph, 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 one or more eligibility requirements described in subparagraph (A)(i);

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

''(III) notifies the child's family—

''(aa) of the information which shall be disclosed in accordance with this paragraph;

''(bb) 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

''(cc) 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.

''(ii) INCLUSION OF SPECIFIC PUBLIC AGENCIES.—Such term includes the following:

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

''(aa) The temporary assistance for needy families program funded under part A of title IV.

''(bb) A State program funded under part D of title IV.

''(cc) The State Medicaid plan.

''(dd) The State CHIP plan.

''(ee) The Food and Nutrition Act of 2008 (7 U.S.C. 2011 et seq.).

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

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

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

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

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

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

''(ll) 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.

''(iii) 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 or a private, for-profit organization.

''(iv) RULES OF CONSTRUCTION.—Nothing in this paragraph shall be construed as—

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

''(II) authorizing a State Medicaid agency that elects to use Express Lane agencies under this subparagraph to use the Express Lane option to avoid complying with such requirements for purposes of making eligibility determinations under the State Medicaid plan.

''(v) ADDITIONAL DEFINITIONS.—In this paragraph:

''(I) STATE.—The term 'State' means 1 of the 50 States or the District of Columbia.

''(II) STATE CHIP AGENCY.—The term 'State CHIP agency' means the State agency responsible for administering the State CHIP plan.

''(III) STATE CHIP PLAN.—The term 'State CHIP plan' means the State child health plan established under title XXI and includes any waiver of such plan.

''(IV) STATE MEDICAID AGENCY.—The term 'State Medicaid agency' means the State agency responsible for administering the State Medicaid plan.

''(V) STATE MEDICAID PLAN.—The term 'State Medicaid plan' means the State plan established under title XIX and includes any waiver of such plan.

''(G) CHILD DEFINED.—For purposes of this paragraph, the term 'child' means an individual under 19 years of age, or, at the option of a State, such higher age, not to exceed 21 years of age, as the State may elect.

''(H) STATE OPTION TO RELY ON STATE INCOME TAX DATA OR RETURN.—At the option of the State, a finding from an Express Lane agency may include gross income or adjusted gross income shown by State income tax records or returns.

''(I) APPLICATION.—This paragraph shall not apply with respect to eligibility determinations made after September 30, 2013.''.

(2) CHIP.—Section 2107(e)(1) (42 U.S.C. 1397gg(e)(1)) is amended by redesignating subparagraphs (B), (C), and (D) as subparagraphs (C), (D), and (E), respectively, and by inserting after subparagraph (A) the following new subparagraph:

''(B) Section 1902(e)(13) (relating to the State option to rely on findings from an Express Lane agency to help evaluate a child's eligibility for medical assistance).''.

(b) EVALUATION AND REPORT.—

(1) EVALUATION.—The Secretary shall conduct, by grant, contract, or interagency agreement, a comprehensive, independent evaluation of the option provided under the amendments made by subsection (a). Such evaluation shall include an analysis of the effectiveness of the option, 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 under paragraph (1).

(3) FUNDING.—

(A) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary to carry out the evaluation under this subsection $5,000,000 for the period of fiscal years 2009 through 2012.

(B) BUDGET AUTHORITY.—Subparagraph (A) constitutes budget authority in advance of appropriations Act and represents the obligation of the Federal Government to provide for the payment of such amount to conduct the evaluation under this subsection.

(c) ELECTRONIC TRANSMISSION OF INFORMATION.—Section 1902 (42 U.S.C. 1396a) is amended by adding at the end the following new subsection:

''(dd) ELECTRONIC TRANSMISSION OF INFORMATION.—If the State agency determining eligibility for medical assistance under this title or child health assistance under title XXI verifies an element of eligibility based on information

from an Express Lane Agency (as defined in subsection (e)(13)(F)), or from another public agency, then the applicant's signature under penalty of perjury shall not be required as to such element. Any signature requirement for an application for medical assistance may be satisfied through an electronic signature, as defined in section 1710(1) of the Government Paperwork Elimination Act (44 U.S.C. 3504 note). The requirements of subparagraphs (A) and (B) of section 1137(d)(2) may be met through evidence in digital or electronic form.''.

(d) AUTHORIZATION OF INFORMATION DISCLOSURE.—

(1) IN GENERAL.—Title XIX is amended by adding at the end the following new section:

''SEC. 1942. AUTHORIZATION TO RECEIVE RELEVANT INFORMATION.

''(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 maintained by Express Lane agencies described in section 1902(e)(13)(F), 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, to the extent such conveyance meets the requirements of subsection (b).

''(b) REQUIREMENTS FOR CONVEYANCE.—Data or information may be conveyed pursuant to subsection (a) only if the following requirements are met:

''(1) The individual whose circumstances are described in the data or information (or such individual'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 individuals who are eligible or potentially eligible for medical assistance under this title and enrolling or attempting to enroll such individuals in the State plan; and

''(B) verifying the eligibility of individuals 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 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 individuals in the plan.

''(c) PENALTIES FOR IMPROPER DISCLOSURE.—

''(1) CIVIL MONEY PENALTY.—A private entity described in the subsection (a) that publishes, discloses, or makes known in any manner, or to any extent not authorized by Federal law, any information obtained under this section is subject to a civil money penalty in an amount equal to $10,000 for each such unauthorized publication or disclosure. The provisions of section 1128A (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to a civil money penalty under this paragraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

''(2) CRIMINAL PENALTY.—A private entity described in the subsection (a) that willfully publishes, 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 $10,000 or imprisoned not more than 1 year, or both, for each such unauthorized publication or disclosure.

''(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).''.

(2) CONFORMING AMENDMENT TO TITLE XXI.—Section 2107(e)(1) (42 U.S.C. 1397gg(e)(1)), as amended by subsection (a)(2), is amended by adding at the end the following new subparagraph:

''(F) Section 1942 (relating to authorization to receive data directly relevant to eligibility determinations).''.

(3) CONFORMING AMENDMENT TO PROVIDE ACCESS TO DATA ABOUT ENROLLMENT IN INSURANCE FOR PURPOSES OF EVALUATING APPLICATIONS AND FOR CHIP.—Section 1902(a)(25)(I)(i) (42 U.S.C. 1396a(a)(25)(I)(i)) is amended—

(A) by inserting ''(and, at State option, individuals who apply or whose eligibility for medical assistance is being evaluated in accordance with section 1902(e)(13)(D))'' after ''with respect to individuals who are eligible''; and

(B) by inserting ''under this title (and, at State option, child health assistance under title XXI)'' after ''the State plan''.

(e) AUTHORIZATION FOR STATES ELECTING EXPRESS LANE OPTION TO RECEIVE CERTAIN DATA DIRECTLY RELEVANT TO DETERMINING ELIGIBILITY AND CORRECT AMOUNT OF ASSISTANCE.—The Secretary shall enter into such agreements as are necessary to permit a State that elects the Express Lane option under section 1902(e)(13) of the Social Security Act to receive data directly relevant to eligibility determinations and determining the correct amount of benefits under a State child health plan under CHIP or a State plan under Medicaid 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.

(f) EFFECTIVE DATE.—The amendments made by this section are effective on the date of the enactment of this Act.

Subtitle B—Reducing Barriers to Enrollment

SEC. 211. VERIFICATION OF DECLARATION OF CITIZENSHIP OR NATIONALITY FOR PURPOSES OF ELIGIBILITY FOR MEDICAID AND CHIP.

(a) ALTERNATIVE STATE PROCESS FOR VERIFICATION OF DECLARATION OF CITIZENSHIP OR NATIONALITY FOR PURPOSES OF ELIGIBILITY FOR MEDICAID.—

(1) ALTERNATIVE TO DOCUMENTATION REQUIREMENT.—

(A) IN GENERAL.—Section 1902 (42 U.S.C. 1396a), as amended by section 203(c), 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 (ee);''; and

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

''(ee)(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 program established under paragraph (2).

''(B) If the State receives notice from the Commissioner of Social Security that the name or social security number, or the declaration of citizenship or nationality, of the individual is inconsistent with information in the records maintained by the Commissioner—

''(i) the State makes a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors, by contacting the individual to confirm the accuracy of the name or social security number submitted or declaration of citizenship or nationality and by taking such additional actions as the Secretary, through regulation or other guidance, or the State may identify, and continues to provide the individual with medical assistance while making such effort; and

''(ii) in the case such inconsistency is not resolved under clause (i), 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 subclause (I) is received by the individual to either present satisfactory documentary evidence of citizenship or nationality (as defined in section 1903(x)(3)) or resolve the inconsistency with the Commissioner of Social Security (and continues to provide the individual with medical assistance during such 90-day period); 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 or if such inconsistency is not resolved.

''(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 at least monthly to the Commissioner of Social Security for comparison of the name and social security number, of each individual newly enrolled in the State plan under this title that month who is not described in section 1903(x)(2) and who declares to be a United States citizen or national, with information in records maintained by the Commissioner.

''(B) In establishing the State program under this paragraph, the State may enter into an agreement with the Commissioner of Social Security—

''(i) to provide, through an on-line system or otherwise, for the electronic submission of, and response to, the information submitted under subparagraph (A) for an individual enrolled in the State plan under this title who declares to be citizen or national on at least a monthly basis; or

''(ii) to provide for a determination of the consistency of the information submitted with the information maintained in the records of the Commissioner through such other method as agreed to by the State and the Commissioner and approved by the Secretary, provided that such method is no more burdensome for individuals to comply with than any burdens that may apply under a method described in clause (i).

''(C) The program established under this paragraph shall provide that, in the case of any individual who is required to submit a social security number to the State under subparagraph (A) and who is unable to provide the State with such number, shall be provided with at least the reasonable opportunity to present satisfactory documentary evidence of citizenship or nationality (as defined in section 1903(x)(3)) 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)(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 inconsistent submissions

bears to the total submissions made for comparison for such month. For purposes of this subparagraph, a name, social security number, or declaration of citizenship or nationality of an individual shall be treated as inconsistent and included in the determination of such percentage only if—

''(i) the information submitted by the individual is not consistent with information in records maintained by the Commissioner of Social Security;

''(ii) the inconsistency is not resolved by the State;

''(iii) the individual was provided with a reasonable period of time to resolve the inconsistency with the Commissioner of Social Security or provide satisfactory documentation of citizenship status and did not successfully resolve such inconsistency; and

''(iv) payment has been made for an item or service furnished to the individual under this title.

''(B) If, for any fiscal year, the average monthly percentage determined under subparagraph (A) is greater than 3 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 inconsistent information as the number of individuals with inconsistent information in excess of 3 percent of such total submitted bears to the total number of individuals with inconsistent 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) Subparagraphs (A) and (B) 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 that provides for the submission on a real-time basis of the information described in such paragraph.

''(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(ee) (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)''.

(4) APPROPRIATION.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated to the Commissioner of Social Security $5,000,000 to remain available until expended to carry out the Commissioner's responsibilities under section 1902(ee) of the Social Security Act, as added by subsection (a).

(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''; and

(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 114(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 subparagraph (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:

''(ii) 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 January 1, 2010.

(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, 2009, 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. 212. 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.''.

SEC. 213. MODEL OF INTERSTATE COORDINATED ENROLLMENT AND COVERAGE PROCESS.

(a) IN GENERAL.—In order to assure continuity of coverage of low-income children under the Medicaid program and the State Children's Health Insurance Program (CHIP), not later than 18 months after the date of the enactment of this Act, the Secretary of Health and Human Services, in consultation with State Medicaid and CHIP directors and organizations representing program beneficiaries, shall develop a model process for the coordination of the enrollment, retention, and coverage under such programs of children who, because of migration of families, emergency evacuations, natural or other disasters, public health emergencies, educational needs, or otherwise, frequently change their State of residency or otherwise are temporarily located outside of the State of their residency.

(b) REPORT TO CONGRESS.—After development of such model process, the Secretary of Health and Human Services shall submit to Congress a report describing additional steps or authority needed to make further improvements to coordinate the enrollment, retention, and coverage under CHIP and Medicaid of children described in subsection (a).

SEC. 214. PERMITTING STATES TO ENSURE COVERAGE WITHOUT A 5-YEAR DELAY OF CERTAIN CHILDREN AND PREGNANT WOMEN UNDER THE MEDICAID PROGRAM AND CHIP.

(a) MEDICAID PROGRAM.—Section 1903(v) (42 U.S.C. 1396b(v)) is amended—

(1) in paragraph (1), by striking ''paragraph (2)'' and inserting ''paragraphs (2) and (4)''; and

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

''(4)(A) A State may elect (in a plan amendment under this title) to provide medical assistance under this title, notwithstanding sections 401(a), 402(b), 403, and 421 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, to children and pregnant women who are lawfully residing in the United States (including battered individuals described in section 431(c) of such Act) and who are otherwise eligible for such assistance, within either or both of the following eligibility categories:

''(i) PREGNANT WOMEN.—Women during pregnancy (and during the 60-day period beginning on the last day of the pregnancy).

''(ii) CHILDREN.—Individuals under 21 years of age, including optional targeted low-income children described in section 1905(u)(2)(B).

''(B) In the case of a State that has elected to provide medical assistance to a category of aliens under subparagraph (A), no debt shall accrue under an affidavit of support against any sponsor of such an alien on the basis of provision of assistance to such category and the cost of such assistance shall not be considered as an unreimbursed cost.

''(C) As part of the State's ongoing eligibility redetermination requirements and procedures for an individual provided medical assistance as a result of an election by the State under subparagraph (A), a State shall verify that the individual continues to lawfully reside in the United States using the documentation presented to the State by the individual on initial enrollment. If the State cannot successfully verify that the individual is lawfully residing in the United States in this manner, it shall require that the individual provide the State with further documentation or other evidence to verify that the individual is lawfully residing in the United States.''.

(b) CHIP.—Section 2107(e)(1) (42 U.S.C. 1397gg(e)(1)), as amended by sections 203(a)(2) and 203(d)(2), is amended by redesignating subparagraphs (E) and (F) as subparagraphs (F) and (G), respectively and by inserting after subparagraph (D) the following new subparagraph:

''(E) Paragraph (4) of section 1903(v) (relating to optional coverage of categories of lawfully residing immigrant children or pregnant women), but only if the State has elected to apply such paragraph with respect to such category of children or pregnant women under title XIX.''.

TITLE III—REDUCING BARRIERS TO PROVIDING PREMIUM ASSISTANCE

Subtitle A—Additional State Option for Providing Premium Assistance

SEC. 301. ADDITIONAL STATE OPTION FOR PROVIDING PREMIUM ASSISTANCE.

(a) CHIP.—

(1) IN GENERAL.—Section 2105(c) (42 U.S.C. 1397ee(c)), as amended by sections 114(a) and 211(c), is amended by adding at the end the following:

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

''(A) IN GENERAL.—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. No subsidy shall be provided to a targeted low-income child under this paragraph unless the child (or the child's parent) voluntarily elects to receive such a subsidy. A State may not require such an election as a condition of receipt of child health assistance.

''(B) QUALIFIED EMPLOYER-SPONSORED COVERAGE.—

''(i) IN GENERAL.—Subject to clause (ii), 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) that is offered 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), without regard to whether the plan is purchased in conjunction with a health savings account (as defined under section 223(d) of such Code).

''(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).

''(iii) CLARIFICATION OF PAYMENT FOR ADMINISTRATIVE EXPENDITURES.—Nothing in this subparagraph shall be construed as permitting payment under this section for administrative expenditures attributable to the establishment or operation of such pool, except to the extent that such payment would otherwise be permitted under this title.

''(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 or 1906A, 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 2009.

''(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).

''(M) SATISFACTION OF COST-EFFECTIVENESS TEST.—Premium assistance subsidies for qualified employer-sponsored coverage offered under this paragraph shall be deemed to meet the requirement of subparagraph (A) of paragraph (3).

''(N) COORDINATION WITH MEDICAID.—In the case of a targeted low-income child who receives child health assistance through a State plan under title XIX and who voluntarily elects to receive a premium assistance subsidy under this section, the provisions of section 1906A shall apply and shall supersede any other provisions of this paragraph that are inconsistent with such section.''.

(2) DETERMINATION OF COST-EFFECTIVENESS FOR PREMIUM ASSISTANCE OR PURCHASE OF FAMILY COVERAGE.—

(A) IN GENERAL.—Section 2105(c)(3)(A) (42 U.S.C. 1397ee(c)(3)(A)) is amended by striking ''relative to'' and all that follows through the comma and inserting ''relative to

''(i) the amount of expenditures under the State child health plan, including administrative expenditures, that the State would have made to provide comparable coverage of the targeted low-income child involved or the family involved (as applicable); or

''(ii) the aggregate amount of expenditures that the State would have made under the State child health plan, including administrative expenditures, for providing coverage under such plan for all such children or families.''.

(B) NONAPPLICATION TO PREVIOUSLY APPROVED COVERAGE.—The amendment made by subparagraph (A) shall not apply to coverage the purchase of which has been approved by the Secretary under section 2105(c)(3) of the Social Security Act prior to the date of enactment of this Act.

(b) MEDICAID.—Title XIX is amended by inserting after section 1906 the following new section:

''PREMIUM ASSISTANCE OPTION FOR CHILDREN

''SEC. 1906A. (a) IN GENERAL.—A State may elect to offer a premium assistance subsidy (as defined in subsection (c)) for qualified employer-sponsored coverage (as defined in subsection (b)) to all individuals under age 19 who are entitled to medical assistance under this title (and to the parent of such an individual) who have access to such coverage if the State meets the requirements of this section.

''(b) QUALIFIED EMPLOYER-SPONSORED COVERAGE.—

''(1) IN GENERAL.—Subject to paragraph (2)), in this paragraph, the term 'qualified employer-sponsored coverage' means a group health plan or health insurance coverage offered through an employer—

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

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

''(C) that is offered 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).

''(2) EXCEPTION.—Such term does not include coverage consisting of—

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

''(B) a high deductible health plan (as defined in section 223(c)(2) of such Code), without regard to whether the plan is purchased in conjunction with a health savings account (as defined under section 223(d) of such Code).

''(3) TREATMENT AS THIRD PARTY LIABILITY.—The State shall treat the coverage provided under qualified employer-sponsored coverage as a third party liability under section 1902(a)(25).

''(c) PREMIUM ASSISTANCE SUBSIDY.—In this section, the term 'premium assistance subsidy' means the amount of the employee contribution for enrollment in the qualified employer-sponsored coverage by the individual under age 19 or by the individual's family. Premium assistance subsidies under this section shall be considered, for purposes of section 1903(a), to be a payment for medical assistance.

''(d) VOLUNTARY PARTICIPATION.—

''(1) EMPLOYERS.—Participation by an employer in a premium assistance subsidy offered by a State under this section shall be voluntary. 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.

''(2) BENEFICIARIES.—No subsidy shall be provided to an individual under age 19 under this section unless the individual (or the individual's parent) voluntarily elects to receive such a subsidy. A State may not require such an election as a condition of receipt of medical assistance. State may not require, as a condition of an individual under age 19 (or the individual's parent) being or remaining eligible for medical assistance under this title, apply for enrollment in qualified employer-sponsored coverage under this section.

''(3) OPT-OUT PERMITTED FOR ANY MONTH.—A State shall establish a process for permitting the parent of an individual under age 19 receiving a premium assistance subsidy to disenroll the individual from the qualified employer-sponsored coverage.

''(e) REQUIREMENT TO PAY PREMIUMS AND COST-SHARING AND PROVIDE SUPPLEMENTAL COVERAGE.—In the case of the participation of an individual under age 19 (or the individual's parent) in a premium assistance subsidy under this section for qualified employer-sponsored coverage, the State shall provide for payment of all enrollee premiums for enrollment in such coverage and all deductibles, coinsurance, and other cost-sharing obligations for items and services otherwise covered under the State plan under this title (exceeding the amount otherwise permitted under section 1916 or, if applicable, section 1916A). The fact that an individual under age 19 (or a parent) elects to enroll in qualified employer-sponsored coverage under this section shall not change the individual's (or parent's) eligibility for medical assistance under the State plan, except insofar as section

1902(a)(25) provides that payments for such assistance shall first be made under such coverage.''.

(c) GAO STUDY AND REPORT.—Not later than January 1, 2010, 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 Committee on Finance of the Senate and the Committee on Energy and Commerce of the House of Representatives on the results of such study.

SEC. 302. 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.—In the case of a State that provides for premium assistance subsidies under the State child health plan in accordance with paragraph (2)(B), (3), or (10) of section 2105(c), or a waiver approved under section 1115, outreach, education, and enrollment assistance for families of children likely to be eligible for such subsidies, 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 211(c)(2), is amended by adding at the end the following new clause:

''(iii) 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 paragraph (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), but not to exceed an amount equal to 1.25 percent of the maximum amount permitted to be expended under subparagraph (A) for items described in subsection (a)(1)(D).''.

Subtitle B—Coordinating Premium Assistance With Private Coverage

SEC. 311. 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 PLAN MATERIALS TO EMPLOYEE.—An employer may provide the model notice applicable to the State in which an employee resides concurrent with the furnishing of materials notifying the employee of health plan eligibility, concurrent with materials provided to the employee in connection with an open season or election process conducted under the plan, or 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 311(b)(1)(C) of the Children's Health Insurance Program Reauthorization Act of 2009, 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 2009, 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 PLAN MATERIALS TO EMPLOYEE.—An employer may provide the model notice applicable to the State in which an employee resides concurrent with the furnishing of materials notifying the employee of health plan eligibility, concurrent with materials provided to the employee in connection with an open season or election process conducted under the plan, or 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 311(b)(1)(C) of the Children's Health Insurance Program Reauthorization Act of 2009, 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 PLAN MATERIALS TO EMPLOYEE.—An employer may provide the model notice applicable to the State in which an employee resides concurrent with the furnishing of materials notifying the employee of health plan eligibility, concurrent with materials provided to the employee in connection with an open season or election process conducted under the plan, or 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 311(b)(1)(C) of the Children's Health Insurance Reauthorization Act of 2009, 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 IV—STRENGTHENING QUALITY OF CARE AND HEALTH OUTCOMES

SEC. 401. 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, 2010, 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 and effectiveness of a full range of—

''(i) preventive services, treatments, and services for acute conditions, including services to promote healthy birth, prevent and treat premature birth, and detect the presence or risk of physical or mental conditions that could adversely affect growth and development; and

''(ii) treatments to correct or ameliorate the effects of physical and mental conditions, including chronic 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, including children with special needs, 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 2009, 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, 2011, 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, 2011, 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 children, including children with disabilities and children with chronic conditions;

''(F) national organizations representing consumers and purchasers of children's health care;

''(G) national organizations and individuals with expertise in pediatric health quality measurement; and

''(H) 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, 2013, 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.

''(7) CONSTRUCTION.—Nothing in this section shall be construed as supporting the restriction of coverage, under title XIX or XXI or otherwise, to only those services that are evidence-based.

''(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, 2010, 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 2009 through 2013, 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 2009, 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 2009, 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 2009 through 2013.

''(f) DEVELOPMENT OF MODEL ELECTRONIC HEALTH RECORD FORMAT FOR CHILDREN ENROLLED IN MEDICAID OR CHIP.—

''(1) IN GENERAL.—Not later than January 1, 2010, 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, 2010, 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 2009 through 2013, $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. 402. IMPROVED AVAILABILITY OF PUBLIC INFORMATION REGARDING ENROLLMENT OF CHILDREN IN CHIP AND MEDICAID.

(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''; and

(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 assistance 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) STANDARDIZED REPORTING FORMAT.—

(1) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary shall specify a standardized format for States to use for reporting the information required under section 2108(e) of the Social Security Act, as added by subsection (a)(2).

(2) TRANSITION PERIOD FOR STATES.—Each State that is required to submit a report under subsection (a) of section 2108 of the Social Security Act that includes the information required under subsection (e) of such section may use up to 3 reporting periods to transition to the reporting of such information in accordance with the standardized format specified by the Secretary under paragraph (1).

(c) 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 2009 for the purpose of improving the timeliness of the data reported and analyzed from the Medicaid Statistical Information System (MSIS) for purposes of providing more timely data on enrollment and eligibility of children under Medicaid and CHIP 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 to report such information in a complete and expeditious manner) so that, beginning no later than October 1, 2009, 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.

(d) GAO STUDY AND REPORT ON ACCESS TO PRIMARY AND SPECIALITY 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 Committee on Finance of the Senate and the Committee on Energy and Commerce of the House of Representatives 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. 403. APPLICATION OF CERTAIN MANAGED CARE QUALITY SAFEGUARDS TO CHIP.

(a) IN GENERAL.—Section 2103(f) of Social Security Act (42 U.S.C. 1397bb(f)) is amended by adding at the end the following new paragraph:

''(3) COMPLIANCE WITH MANAGED CARE REQUIREMENTS.—The State child health plan shall provide for the application of subsections (a)(4), (a)(5), (b), (c), (d), and (e) of section 1932 (relating to requirements for managed care) to coverage, State agencies, enrollment brokers, managed care entities, and managed care organizations under this title in the same manner as such subsections apply to coverage and such entities and organizations under title XIX.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to contract years for health plans beginning on or after July 1, 2009.

TITLE V—IMPROVING ACCESS TO BENEFITS

SEC. 501. DENTAL BENEFITS.

(a) COVERAGE.—

(1) IN GENERAL.—Section 2103 (42 U.S.C. 1397cc) is amended—

(A) in subsection (a)—

(i) in the matter before paragraph (1), by striking ''subsection (c)(5)'' and inserting ''paragraphs (5) and (7) of subsection (c)''; and

(ii) in paragraph (1), by inserting ''at least'' after ''that is''; and

(B) in subsection (c)—

(i) by redesignating paragraph (5) as paragraph (7); and

(ii) by inserting after paragraph (4), the following:

''(5) DENTAL BENEFITS.—

''(A) IN GENERAL.—The child health assistance provided to a targeted low-income child shall include coverage of dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions.

''(B) PERMITTING USE OF DENTAL BENCHMARK PLANS BY CERTAIN STATES.—A State may elect to meet the requirement of subparagraph (A) through dental coverage that is equivalent to a benchmark dental benefit package described in subparagraph (C).

''(C) BENCHMARK DENTAL BENEFIT PACKAGES.—The benchmark dental benefit packages are as follows:

''(i) FEHBP CHILDREN'S DENTAL COVERAGE.—A dental benefits plan under chapter 89A of title 5, United States Code, that has been selected most frequently by employees seeking dependent coverage, among such plans that provide such dependent coverage, in either of the previous 2 plan years.

''(ii) STATE EMPLOYEE DEPENDENT DENTAL COVERAGE.—A dental benefits plan that is offered and generally available to State employees in the State involved and that has been selected most frequently by employees seeking dependent coverage, among such plans that provide such dependent coverage, in either of the previous 2 plan years.

''(iii) COVERAGE OFFERED THROUGH COMMERCIAL DENTAL PLAN.—A dental benefits plan that has the largest insured commercial, non-medicaid enrollment of dependent covered lives of such plans that is offered in the State involved.''.

(2) ASSURING ACCESS TO CARE.—Section 2102(a)(7)(B) (42 U.S.C. 1397bb(c)(2)) is amended by inserting ''and services described in section 2103(c)(5)'' after ''emergency services''.

(3) EFFECTIVE DATE.—The amendments made by paragraphs (1) and (2) shall apply to coverage of items and services furnished on or after October 1, 2009.

(b) STATE OPTION TO PROVIDE DENTAL-ONLY SUPPLEMENTAL COVERAGE.—

(1) IN GENERAL.—Section 2110(b) (42 U.S.C. 1397jj(b)) is amended—

(A) in paragraph (1)(C), by inserting '', subject to paragraph (5),'' after ''under title XIX or''; and

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

''(5) OPTION FOR STATES WITH A SEPARATE CHIP PROGRAM TO PROVIDE DENTAL-ONLY SUPPLEMENTAL COVERAGE.—

''(A) IN GENERAL.—Subject to subparagraphs (B) and (C), in the case of any child who is enrolled in a group health plan or health insurance coverage offered through an employer who would, but for the application of paragraph (1)(C), satisfy the requirements for being a targeted low-income child under a State child health plan that is implemented under this title, a State may waive the application of such paragraph to the child in order to provide—

''(i) dental coverage consistent with the requirements of subsection (c)(5) of section 2103; or

''(ii) cost-sharing protection for dental coverage consistent with such requirements and the requirements of subsection (e)(3)(B) of such section.

''(B) LIMITATION.—A State may limit the application of a waiver of paragraph (1)(C) to children whose family income does not exceed a level specified by the State, so long as the level so specified does not exceed the maximum income level otherwise established for other children under the State child health plan.

''(C) CONDITIONS.—A State may not offer dental-only supplemental coverage under this paragraph unless the State satisfies the following conditions:

''(i) INCOME ELIGIBILITY.—The State child health plan under this title—

''(I) has the highest income eligibility standard permitted under this title (or a waiver) as of January 1, 2009;

''(II) does not limit the acceptance of applications for children or impose any numerical limitation, waiting list, or similar limitation on the eligibility of such children for child health assistance under such State plan; and

''(III) provides benefits to all children in the State who apply for and meet eligibility standards.

''(ii) NO MORE FAVORABLE TREATMENT.—The State child health plan may not provide more favorable dental coverage or cost-sharing protection for dental coverage to children provided dental-only supplemental coverage under this paragraph than the dental coverage and cost-sharing protection for dental coverage provided to targeted low-income children who are eligible for the full range of child health assistance provided under the State child health plan.''.

(2) STATE OPTION TO WAIVE WAITING PERIOD.—Section 2102(b)(1)(B) (42 U.S.C. 1397bb(b)(1)(B)), as amended by section 111(b)(2), is amended—

(A) in clause (ii), by striking ''and'' at the end;

(B) in clause (iii), by striking the period and inserting ''; and''; and

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

''(iv) at State option, may not apply a waiting period in the case of a child provided dental-only supplemental coverage under section 2110(b)(5).''.

(c) DENTAL EDUCATION FOR PARENTS OF NEWBORNS.—The Secretary shall develop and implement, through entities that fund or provide perinatal care services to targeted low-income children under a State child health plan under title XXI of the Social Security Act, a program to deliver oral health educational materials that inform new parents about risks for, and prevention of, early childhood caries and the need for a dental visit within their newborn's first year of life.

(d) PROVISION OF DENTAL SERVICES THROUGH FQHCS.—

(1) MEDICAID.—Section 1902(a) (42 U.S.C. 1396a(a)) is amended—

(A) by striking ''and'' at the end of paragraph (70);

(B) by striking the period at the end of paragraph (71) and inserting ''; and''; and

(C) by inserting after paragraph (71) the following new paragraph:

''(72) provide that the State will not prevent a Federally-qualified health center from entering into contractual relationships with private practice dental providers in the provision of Federally-qualified health center services.''.

(2) CHIP.—Section 2107(e)(1) (42 U.S.C. 1397g(e)(1)), as amended by subsections (a)(2)

and (d)(2) of section 203, is amended by inserting after subparagraph (B) the following new subparagraph (and redesignating the succeeding subparagraphs accordingly):

''(C) Section 1902(a)(72) (relating to limiting FQHC contracting for provision of dental services).''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on January 1, 2009.

(e) REPORTING INFORMATION ON DENTAL HEALTH.—

(1) MEDICAID.—Section 1902(a)(43)(D)(iii) (42 U.S.C. 1396a(a)(43)(D)(iii)) is amended by inserting ''and other information relating to the provision of dental services to such children described in section 2108(e)'' after ''receiving dental services,''.

(2) CHIP.—Section 2108 (42 U.S.C. 1397hh) is amended by adding at the end the following new subsection:

''(e) INFORMATION ON DENTAL CARE FOR CHILDREN.—

''(1) IN GENERAL.—Each annual report under subsection (a) shall include the following information with respect to care and services described in section 1905(r)(3) provided to targeted low-income children enrolled in the State child health plan under this title at any time during the year involved:

''(A) The number of enrolled children by age grouping used for reporting purposes under section 1902(a)(43).

''(B) For children within each such age grouping, information of the type contained in questions 12(a)–(c) of CMS Form 416 (that consists of the number of enrolled targeted low income children who receive any, preventive, or restorative dental care under the State plan).

''(C) For the age grouping that includes children 8 years of age, the number of such children who have received a protective sealant on at least one permanent molar tooth.

''(2) INCLUSION OF INFORMATION ON ENROLLEES IN MANAGED CARE PLANS.—The information under paragraph (1) shall include information on children who are enrolled in managed care plans and other private health plans and contracts with such plans under this title shall provide for the reporting of such information by such plans to the State.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall be effective for annual reports submitted for years beginning after date of enactment.

(f) IMPROVED ACCESSIBILITY OF DENTAL PROVIDER INFORMATION TO ENROLLEES UNDER MEDICAID AND CHIP.—The Secretary shall—

(1) work with States, pediatric dentists, and other dental providers (including providers that are, or are affiliated with, a school of dentistry) to include, not later than 6 months after the date of the enactment of this Act, on the Insure Kids Now website (http://www.insurekidsnow.gov/) and hotline (1–877–KIDS–NOW) (or on any successor websites or hotlines) a current and accurate list of all such dentists and 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, not later than 6 months after the date of the enactment of this Act, 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, and shall ensure that such list is updated at least annually.

(g) 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), as added by section 401(a), is amended—

(1) in paragraph (3)(B)(ii), by inserting ''and, with respect to dental care, conditions requiring the restoration of teeth, relief of pain and infection, and maintenance of dental health'' after ''chronic conditions''; and

(2) in paragraph (6)(A)(ii), by inserting ''dental care,'' after ''preventive health services,''.

(h) GAO STUDY AND REPORT.—

(1) STUDY.—The Comptroller General of the United States shall provide for a study that examines—

(A) access to dental services by children in underserved areas;

(B) children's access to oral health care, including preventive and restorative services, under Medicaid and CHIP, including—

(i) the extent to which dental providers are willing to treat children eligible for such programs;

(ii) information on such children's access to networks of care, including such networks that serve special needs children; and

(iii) geographic availability of oral health care, including preventive and restorative services, under such programs; and

(C) the feasibility and appropriateness of using qualified mid-level dental health providers, in coordination with dentists, to improve access for children to oral health services and public health overall.

(2) REPORT.—Not later than 18 months year after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1). The report shall include 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.

SEC. 502. MENTAL HEALTH PARITY IN CHIP PLANS.

(a) ASSURANCE OF PARITY.—Section 2103(c) (42 U.S.C. 1397cc(c)), as amended by section 501(a)(1)(B), is amended by inserting after paragraph (5), the following:

''(6) 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 use disorder benefits, such plan shall ensure that the financial requirements and treatment limitations applicable to such mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health 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), as amended by section 501(a)(1)(A)(i), in the matter preceding paragraph (1), by inserting '', (6),'' after ''(5)''; and

(2) in subsection (c)(2), by striking subparagraph (B) and redesignating subparagraphs (C) and (D) as subparagraphs (B) and (C), respectively.

SEC. 503. 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 section 501(c)(2) is amended by inserting after subparagraph (C) the following new subparagraph (and redesignating the succeeding subparagraphs accordingly):

''(D) 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, 2009.

(b) TRANSITION GRANTS.—

(1) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary for fiscal year 2009, $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)(D) 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, 2011, 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. 504. PREMIUM GRACE PERIOD.

(a) IN GENERAL.—Section 2103(e)(3) (42 U.S.C. 1397cc(e)(3)) is amended by adding at the end the following new subparagraph:

''(C) PREMIUM GRACE PERIOD.—The State child health plan—

''(i) shall afford individuals enrolled under the plan a grace period of at least 30 days from the beginning of a new coverage period to make premium payments before the individual's coverage under the plan may be terminated; and

''(ii) shall provide to such an individual, not later than 7 days after the first day of such grace period, notice—

''(I) that failure to make a premium payment within the grace period will result in termination of coverage under the State child health plan; and

''(II) of the individual's right to challenge the proposed termination pursuant to the applicable Federal regulations.

For purposes of clause (i), the term 'new coverage period' means the month immediately following the last month for which the premium has been paid.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to new coverage periods beginning on or after the date of the enactment of this Act.

SEC. 505. CLARIFICATION OF COVERAGE OF SERVICES PROVIDED THROUGH SCHOOL-BASED HEALTH CENTERS.

(a) IN GENERAL.—Section 2103(c) (42 U.S.C. 1397cc(c)), as amended by section 501(a)(1)(B), is amended by adding at the end the following new paragraph:

''(8) AVAILABILITY OF COVERAGE FOR ITEMS AND SERVICES FURNISHED THROUGH SCHOOL-BASED HEALTH CENTERS.—Nothing in this title shall be construed as limiting a State's ability to provide child health assistance for covered items and services that are furnished through school-based health centers (as defined in section 2110(c)(9)).''.

(b) DEFINITION.—Section 2110(c) (42 U.S.C. 1397jj) is amended by adding at the end the following:

''(9) SCHOOL-BASED HEALTH CENTER.—

''(A) IN GENERAL.—The term 'school-based health center' means a health clinic that—

''(i) is located in or near a school facility of a school district or board or of an Indian tribe or tribal organization;

''(ii) is organized through school, community, and health provider relationships;

''(iii) is administered by a sponsoring facility;

''(iv) provides through health professionals primary health services to children in accordance with State and local law, including laws relating to licensure and certification; and

''(v) satisfies such other requirements as a State may establish for the operation of such a clinic.

''(B) SPONSORING FACILITY.—For purposes of subparagraph (A)(iii), the term 'sponsoring facility' includes any of the following:

''(i) A hospital.

''(ii) A public health department.

''(iii) A community health center.

''(iv) A nonprofit health care agency.

''(v) A school or school system.

''(vi) A program administered by the Indian Health Service or the Bureau of Indian Affairs or operated by an Indian tribe or a tribal organization.''.

SEC. 506. MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION.

(a) IN GENERAL.—Title XIX (42 U.S.C. 1396 et seq.) is amended by inserting before section 1901 the following new section:

''MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION

''SEC. 1900. (a) ESTABLISHMENT.—There is hereby established the Medicaid and CHIP Payment and Access Commission (in this section referred to as 'MACPAC').

''(b) DUTIES.—

''(1) REVIEW OF ACCESS POLICIES AND ANNUAL REPORTS.—MACPAC shall—

''(A) review policies of the Medicaid program established under this title (in this section referred to as 'Medicaid') and the State Children's Health Insurance Program established under title XXI (in this section referred to as 'CHIP') affecting children's access to covered items and services, including topics described in paragraph (2);

''(B) make recommendations to Congress concerning such access policies;

''(C) by not later than March 1 of each year (beginning with 2010), submit a report to Congress containing the results of such reviews and MACPAC's recommendations concerning such policies; and

''(D) by not later than June 1 of each year (beginning with 2010), submit a report to Congress containing an examination of issues affecting Medicaid and CHIP, including the implications of changes in health care delivery in the United States and in the market for health care services on such programs.

''(2) SPECIFIC TOPICS TO BE REVIEWED.—Specifically, MACPAC shall review and assess the following:

''(A) MEDICAID AND CHIP PAYMENT POLICIES.—Payment policies under Medicaid and CHIP, including—

''(i) the factors affecting expenditures for items and services in different sectors, including the process for updating hospital, skilled nursing facility, physician, Federally-qualified health center, rural health center, and other fees;

''(ii) payment methodologies; and

''(iii) the relationship of such factors and methodologies to access and quality of care for Medicaid and CHIP beneficiaries.

''(B) INTERACTION OF MEDICAID AND CHIP PAYMENT POLICIES WITH HEALTH CARE DELIVERY GENERALLY.—The effect of Medicaid and CHIP payment policies on access to items and services for children and other Medicaid and CHIP populations other than under this title or title XXI and the implications of changes in health care delivery in the United States and in the general market for health care items and services on Medicaid and CHIP.

''(C) OTHER ACCESS POLICIES.—The effect of other Medicaid and CHIP policies on access to covered items and services, including policies relating to transportation and language barriers.

''(3) CREATION OF EARLY-WARNING SYSTEM.—MACPAC shall create an early-warning system to identify provider shortage areas or any other problems that threaten access to care or the health care status of Medicaid and CHIP beneficiaries.

''(4) COMMENTS ON CERTAIN SECRETARIAL REPORTS.—If the Secretary submits to Congress (or a committee of Congress) a report that is required by law and that relates to access policies, including with respect to payment policies, under Medicaid or CHIP, the Secretary shall transmit a copy of the report to MACPAC. MACPAC shall review the report and, not later than 6 months after the date of submittal of the Secretary's report to Congress, shall submit to the appropriate committees of Congress written comments on such report. Such comments may include such recommendations as MACPAC deems appropriate.

''(5) AGENDA AND ADDITIONAL REVIEWS.—MACPAC shall consult periodically with the chairmen and ranking minority members of the appropriate committees of Congress regarding MACPAC's agenda and progress towards achieving the agenda. MACPAC may conduct additional reviews, and submit additional reports to the appropriate committees of Congress, from time to time on such topics relating to the program under this title or title XXI as may be requested by such chairmen and members and as MACPAC deems appropriate.

''(6) AVAILABILITY OF REPORTS.—MACPAC shall transmit to the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

''(7) APPROPRIATE COMMITTEE OF CONGRESS.—For purposes of this section, the term 'appropriate committees of Congress' means the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.

''(8) VOTING AND REPORTING REQUIREMENTS.—With respect to each recommendation contained in a report submitted under paragraph (1), each member of MACPAC shall vote on the recommendation, and MACPAC shall include, by member, the results of that vote in the report containing the recommendation.

''(9) EXAMINATION OF BUDGET CONSEQUENCES.—Before making any recommendations, MACPAC shall examine the budget consequences of such recommendations, directly or through consultation with appropriate expert entities.

''(c) MEMBERSHIP.—

''(1) NUMBER AND APPOINTMENT.—MACPAC shall be composed of 17 members appointed by the Comptroller General of the United States.

''(2) QUALIFICATIONS.—

''(A) IN GENERAL.—The membership of MACPAC shall include individuals who have had direct experience as enrollees or parents of enrollees in Medicaid or CHIP and individuals with national recognition for their expertise in Federal safety net health programs, health finance and economics, actuarial science, health facility management, health plans and integrated delivery systems, reimbursement of health facilities, health information technology, pediatric physicians, dentists, and other providers of health services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives.

''(B) INCLUSION.—The membership of MACPAC shall include (but not be limited to) physicians and other health professionals, employers, third-party payers, and individuals with expertise in the delivery of health services. Such membership shall also include consumers representing children, pregnant women, the elderly, and individuals with disabilities, current or former representatives of State agencies responsible for administering Medicaid, and current or former representatives of State agencies responsible for administering CHIP.

''(C) MAJORITY NONPROVIDERS.—Individuals who are directly involved in the provision, or management of the delivery, of items and services covered under Medicaid or CHIP shall not constitute a majority of the membership of MACPAC.

''(D) ETHICAL DISCLOSURE.—The Comptroller General of the United States shall establish a system for public disclosure by members of MACPAC of financial and other potential conflicts of interest relating to such members. Members of MACPAC shall be treated as employees of Congress for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95–521).

''(3) TERMS.—

''(A) IN GENERAL.—The terms of members of MACPAC shall be for 3 years except that the Comptroller General of the United States shall designate staggered terms for the members first appointed.

''(B) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in MACPAC shall be filled in the manner in which the original appointment was made.

''(4) COMPENSATION.—While serving on the business of MACPAC (including travel time), a member of MACPAC shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code; and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of MACPAC. Physicians serving as personnel of MACPAC may be provided a physician comparability allowance by MACPAC in the same manner as Government physicians may be provided such an allowance by an agency under section 5948 of title 5, United States Code, and for such purpose subsection (i) of such section shall apply to MACPAC in the same manner as it applies to the Tennessee Valley Authority. For purposes of pay (other than pay of members of MACPAC) and employment benefits, rights, and privileges, all personnel of MACPAC shall be treated as if they were employees of the United States Senate.

''(5) CHAIRMAN; VICE CHAIRMAN.—The Comptroller General of the United States shall designate a member of MACPAC, at the time of appointment of the member as Chairman and a member as Vice Chairman for that term of appointment, except that in the case of vacancy of the Chairmanship or Vice Chairmanship, the Comptroller General of the United States may designate another member for the remainder of that member's term.

''(6) MEETINGS.—MACPAC shall meet at the call of the Chairman.

''(d) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Comptroller General of the United States deems necessary to assure the efficient administration of MACPAC, MACPAC may—

''(1) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General of the United States) and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

''(2) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

''(3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of MACPAC (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

''(4) make advance, progress, and other payments which relate to the work of MACPAC;

''(5) provide transportation and subsistence for persons serving without compensation; and

''(6) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of MACPAC.

''(e) POWERS.—

''(1) OBTAINING OFFICIAL DATA.—MACPAC may secure directly from any department or agency of the United States information necessary to enable it to carry out this section. Upon request of the Chairman, the head of that department or agency shall furnish that information to MACPAC on an agreed upon schedule.

''(2) DATA COLLECTION.—In order to carry out its functions, MACPAC shall—

''(A) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section;

''(B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate; and

''(C) adopt procedures allowing any interested party to submit information for MACPAC's use in making reports and recommendations.

''(3) ACCESS OF GAO TO INFORMATION.—The Comptroller General of the United States shall have unrestricted access to all deliberations, records, and nonproprietary data of MACPAC, immediately upon request.

''(4) PERIODIC AUDIT.—MACPAC shall be subject to periodic audit by the Comptroller General of the United States.

''(f) AUTHORIZATION OF APPROPRIATIONS.—

''(1) REQUEST FOR APPROPRIATIONS.—MACPAC shall submit requests for appropriations in the same manner as the Comptroller General of the United States submits requests for appropriations, but amounts appropriated for MACPAC shall be separate from amounts appropriated for the Comptroller General of the United States.

''(2) AUTHORIZATION.—There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section.''.

(b) DEADLINE FOR INITIAL APPOINTMENTS.—Not later than January 1, 2010, the Comptroller General of the United States shall appoint the initial members of the Medicaid and CHIP Payment and Access Commission established under section 1900 of the Social Security Act (as added by subsection (a)).

(c) ANNUAL REPORT ON MEDICAID.—Not later than January 1, 2010, and annually thereafter, the Secretary, in consultation with the Secretary of the Treasury, the Secretary of Labor, and the States (as defined for purposes of Medicaid), shall submit an annual report to Congress on the financial status of, enrollment in, and spending trends for, Medicaid for the fiscal year ending on September 30 of the preceding year.

TITLE VI—PROGRAM INTEGRITY AND OTHER MISCELLANEOUS PROVISIONS

Subtitle A—Program Integrity and Data Collection

SEC. 601. 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 301(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 302(b)), is amended by adding at the end the following:

''(iv) 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 new final rule (in this section referred to as the ''new final rule'') promulgated after the date of the enactment of this Act and 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 new final rule in effect for all States may only be inclusive of errors, as defined in such new final rule or in guidance issued within a reasonable time frame after the effective date for such new final rule that includes detailed guidance for the specific methodology for error determinations.

(c) REQUIREMENTS FOR NEW FINAL RULE.—For purposes of subsection (b), the requirements of this subsection are that the new final rule implementing the PERM requirements shall—

(1) include—

(A) clearly defined criteria for errors for both States and providers;

(B) a clearly defined process for appealing error determinations by—

(i) review contractors; or

(ii) the agency and personnel described in section 431.974(a)(2) of title 42, Code of Federal Regulations, as in effect on September 1, 2007, responsible for the development, direction, implementation, and evaluation of eligibility reviews and associated activities; and

(C) clearly defined responsibilities and deadlines for States in implementing any corrective action plans; and

(2) provide that the payment error rate determined for a State shall not take into account payment errors resulting from the State's verification of an applicant's self-declaration or self-certification of eligibility for, and the correct amount of, medical assistance or child health assistance, if the State process for verifying an applicant's self-declaration or self-certification satisfies the requirements for such process applicable under regulations promulgated by the Secretary or otherwise approved by the Secretary.

(d) OPTION FOR APPLICATION OF DATA FOR STATES IN FIRST APPLICATION CYCLE UNDER THE INTERIM FINAL RULE.—After the new 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 or under a 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 2010 or 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 new 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.

(3) STATE OPTION TO APPLY MEQC DATA.—For purposes of satisfying the requirements of subpart Q of part 431 of title 42, Code of Federal Regulations, relating to Medicaid eligibility reviews, a State may elect to substitute data obtained through MEQC reviews conducted in accordance with section 1903(u) of the Social Security Act (42 U.S.C. 1396b(u)) for data required for purposes of PERM requirements, but only if the State MEQC reviews are based on a broad, representative sample of Medicaid applicants or enrollees in the States.

(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 the first fiscal year that begins on or after the date on which the new final rule is in effect for all States, 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.

(g) TIME FOR PROMULGATION OF FINAL RULE.—The final rule implementing the PERM requirements under subsection (b) shall be promulgated not later than 6 months after the date of enactment of this Act.

SEC. 602. 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 2000'' and inserting ''$20,000,000 for fiscal year 2009''.

(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 2009, 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 determine the child population growth factor under section 2104(m)(5)(B) and any other data necessary for carrying out this title.

''(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, in consultation with the States, 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. 603. UPDATED FEDERAL EVALUATION OF CHIP.

Section 2108(c) (42 U.S.C. 1397hh(c)) is amended by striking paragraph (5) and inserting the following:

''(5) SUBSEQUENT EVALUATION USING UPDATED INFORMATION.—

''(A) IN GENERAL.—The Secretary, directly or through contracts or interagency agreements, shall conduct an independent subsequent evaluation of 10 States with approved child health plans.

''(B) SELECTION OF STATES AND MATTERS INCLUDED.—Paragraphs (2) and (3) shall apply to such subsequent evaluation in the same manner as such provisions apply to the evaluation conducted under paragraph (1).

''(C) SUBMISSION TO CONGRESS.—Not later than December 31, 2011, the Secretary shall submit to Congress the results of the evaluation conducted under this paragraph.

''(D) FUNDING.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated $10,000,000 for fiscal year 2010 for the purpose of conducting the evaluation authorized under this paragraph. Amounts appropriated under this subparagraph shall remain available for expenditure through fiscal year 2012.''.

SEC. 604. ACCESS TO RECORDS FOR IG AND GAO AUDITS AND EVALUATIONS.

Section 2108(d) (42 U.S.C. 1397hh(d)) is amended to read as follows:

''(d) ACCESS TO RECORDS FOR IG AND GAO AUDITS AND EVALUATIONS.—For the purpose of evaluating and auditing the program established under this title, or title XIX, the Secretary, the Office of Inspector General, and the Comptroller General shall have access to any books, accounts, records, correspondence, and other documents that are related to the expenditure of Federal funds under this title and that are in the possession, custody, or control of States receiving Federal funds under this title or political subdivisions thereof, or any grantee or contractor of such States or political subdivisions.''.

SEC. 605. NO FEDERAL FUNDING FOR ILLEGAL ALIENS; DISALLOWANCE FOR UNAUTHORIZED EXPENDITURES.

Nothing in this Act allows Federal payment for individuals who are not legal residents. Titles XI, XIX, and XXI of the Social Security Act provide for the disallowance of Federal financial participation for erroneous expenditures under Medicaid and under CHIP, respectively.

Subtitle B—Miscellaneous Health Provisions

SEC. 611. DEFICIT REDUCTION ACT TECHNICAL CORRECTIONS.

(a) CLARIFICATION OF REQUIREMENT TO PROVIDE EPSDT SERVICES FOR ALL CHILDREN IN BENCHMARK BENEFIT PACKAGES UNDER MEDICAID.—Section 1937(a)(1) (42 U.S.C. 1396u–7(a)(1)), as inserted by section 6044(a) of the Deficit Reduction Act of 2005 (Public Law 109–171, 120 Stat. 88), is amended—

(1) in subparagraph (A)—

(A) in the matter before clause (i)—

(i) by striking ''Notwithstanding any other provision of this title'' and inserting ''Notwithstanding section 1902(a)(1) (relating to statewideness), section 1902(a)(10)(B) (relating to comparability) and any other provision of this title which would be directly contrary to the authority under this section and subject to subsection (E)''; and

(ii) by striking ''enrollment in coverage that provides'' and inserting ''coverage that'';

(B) in clause (i), by inserting ''provides'' after ''(i)''; and

(C) 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).'';

(2) in subparagraph (C)—

(A) in the heading, by striking ''**WRAP-AROUND**'' and inserting ''**ADDITIONAL**''; and

(B) by striking ''wrap-around or''; and

(3) 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)(ii) through an issuer of benchmark coverage described in subsection (b)(1) or benchmark equivalent coverage described in subsection (b)(2);

''(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); or

''(iii) affecting a child's entitlement to care and services described in subsections (a)(4)(B) and (r) of section 1905 and provided in accordance with section 1902(a)(43) whether provided through benchmark coverage, benchmark equivalent coverage, or otherwise.''.

(b) 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''.

(c) 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.—With respect to a State plan amendment to provide benchmark benefits in accordance with subsections (a) and (b) that is approved by the Secretary, the Secretary shall publish 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 the plan amendment and the reason for each such determination on the date such approval is made, and shall publish such list in the Federal Register and not later than 30 days after such date of approval.''.

(d) EFFECTIVE DATE.—The amendments made by subsections (a), (b), and (c) of this section shall take effect as if included in the amendment made by section 6044(a) of the Deficit Reduction Act of 2005.

SEC. 612. REFERENCES TO TITLE XXI.

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. 613. PROHIBITING INITIATION OF NEW HEALTH OPPORTUNITY ACCOUNT DEMONSTRATION PROGRAMS.

After the date of the enactment of this Act, the Secretary of Health and Human Services may not approve any new demonstration programs under section 1938 of the Social Security Act (42 U.S.C. 1396u–8).

SEC. 614. ADJUSTMENT IN COMPUTATION OF MEDICAID FMAP TO DISREGARD AN EXTRAORDINARY EMPLOYER PENSION CONTRIBUTION.

(a) IN GENERAL.—Only for purposes of computing the FMAP (as defined in subsection (e)) for a State for a fiscal year (beginning with fiscal year 2006) and applying the FMAP under title XIX of the Social Security Act, any significantly disproportionate employer pension or insurance fund contribution described in subsection (b) shall be disregarded in computing the per capita income of such State, but shall not be disregarded in computing the per capita income for the continental United States (and Alaska) and Hawaii.

(b) SIGNIFICANTLY DISPROPORTIONATE EMPLOYER PENSION AND INSURANCE FUND CONTRIBUTION.—

(1) IN GENERAL.—For purposes of this section, a significantly disproportionate employer pension and insurance fund contribution described in this subsection with respect to a State is any identifiable employer contribution towards pension or other employee insurance funds that is estimated to accrue to residents of such State for a calendar year (beginning with calendar year 2003) if the increase in the amount so estimated exceeds 25 percent of the total increase in personal income in that State for the year involved.

(2) DATA TO BE USED.—For estimating and adjustment a FMAP already calculated as of the date of the enactment of this Act for a State with a significantly disproportionate employer pension and insurance fund contribution, the Secretary shall use the personal income data set originally used in calculating such FMAP.

(3) SPECIAL ADJUSTMENT FOR NEGATIVE GROWTH.—If in any calendar year the total personal income growth in a State is negative, an employer pension and insurance fund contribution for the purposes of calculating the State's FMAP for a calendar year shall not exceed 125 percent of the amount of such contribution for the previous calendar year for the State.

(c) HOLD HARMLESS.—No State shall have its FMAP for a fiscal year reduced as a result of the application of this section.

(d) REPORT.—Not later than May 15, 2009, the Secretary shall submit to the Congress a report on the problems presented by the current treatment of pension and insurance fund contributions in the use of Bureau of Economic Affairs calculations for the FMAP and for Medicaid and on possible alternative methodologies to mitigate such problems.

(e) FMAP DEFINED.—For purposes of this section, the term ''FMAP'' means the Federal medical assistance percentage, as defined in section

1905(b) of the Social Security Act (42 U.S.C. 1396(d)).

SEC. 615. CLARIFICATION TREATMENT OF REGIONAL MEDICAL CENTER.

(a) IN GENERAL.—Nothing in section 1903(w) of the Social Security Act (42 U.S.C. 1396b(w)) shall be construed by the Secretary of Health and Human Services as prohibiting a State's use of funds as the non-Federal share of expenditures under title XIX of such Act where such funds are transferred from or certified by a publicly-owned regional medical center located in another State and described in subsection (b), so long as the Secretary determines that such use of funds is proper and in the interest of the program under title XIX.

(b) CENTER DESCRIBED.—A center described in this subsection is a publicly-owned regional medical center that—

(1) provides level 1 trauma and burn care services;

(2) provides level 3 neonatal care services;

(3) is obligated to serve all patients, regardless of ability to pay;

(4) is located within a Standard Metropolitan Statistical Area (SMSA) that includes at least 3 States;

(5) provides services as a tertiary care provider for patients residing within a 125-mile radius; and

(6) meets the criteria for a disproportionate share hospital under section 1923 of such Act (42 U.S.C. 1396r–4) in at least one State other than the State in which the center is located.

SEC. 616. EXTENSION OF MEDICAID DSH ALLOTMENTS FOR TENNESSEE AND HAWAII.

Section 1923(f)(6) (42 U.S.C. 1396r–4(f)(6)), as amended by section 202 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275) is amended—

(1) in the paragraph heading, by striking ''2009 AND THE FIRST CALENDAR QUARTER OF FISCAL YEAR 2010'' and inserting ''2011 AND THE FIRST CALENDAR QUARTER OF FISCAL YEAR 2012'';

(2) in subparagraph (A)—

(A) in clause (i)—

(i) in the second sentence—

(I) by striking ''and 2009'' and inserting '', 2009, 2010, and 2011''; and

(II) by striking ''such portion of''; and

(ii) in the third sentence, by striking ''2010 for the period ending on December 31, 2009'' and inserting ''2012 for the period ending on December 31, 2011'';

(B) in clause (ii), by striking ''or for a period in fiscal year 2010'' and inserting ''2010, 2011, or for period in fiscal year 2012''; and

(C) in clause (iv)—

(i) in the clause heading, by striking ''2009 AND THE FIRST CALENDAR QUARTER OF FISCAL YEAR 2010'' and inserting ''2011 AND THE FIRST CALENDAR QUARTER OF FISCAL YEAR 2012''; and

(ii) in each of subclauses (I) and (II), by striking '' or for a period in fiscal year 2010'' and inserting ''2010, 2011, or for a period in fiscal year 2012''; and

(3) in subparagraph (B)—

(A) in clause (i)—

(i) in the first sentence, by striking ''2009'' and inserting ''2011''; and

(ii) in the second sentence, by striking ''2010 for the period ending on December 31, 2009'' and inserting ''2012 for the period ending on December 31, 2011''.

SEC. 617. GAO REPORT ON MEDICAID MANAGED CARE PAYMENT RATES.

Not later than 18 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit a report to the Committee on Finance of the Senate and the Committee on Energy and Commerce of the House of Representatives analyzing the extent to which State payment rates for medicaid managed care organizations under Medicaid are actuarially sound.

Subtitle C—Other Provisions

SEC. 621. 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.

SEC. 622. SENSE OF THE 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.

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 ''$50.33 per thousand'',

(2) by striking ''20.719 percent (18.063 percent on cigars removed during 2000 or 2001)'' in paragraph (2) and inserting ''52.75 percent'', and

(3) by striking ''$48.75 per thousand ($42.50 per thousand on cigars removed during 2000 or 2001)'' in paragraph (2) and inserting ''40.26 cents 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 ''$50.33 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 ''$105.69 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 ''3.15 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 ''6.30 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 ''$1.51'', and

(2) by striking ''19.5 cents (17 cents on chewing tobacco removed during 2000 or 2001)'' in paragraph (2) and inserting ''50.33 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 ''$2.8311 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 ''$24.78''.

(h) FLOOR STOCKS TAXES.—

(1) IMPOSITION OF TAX.—On tobacco products (other than cigars described in section 5701(a)(2) of the Internal Revenue Code of 1986) and cigarette papers and tubes manufactured in or imported into the United States which are removed before April 1, 2009, 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 such Code 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 April 1, 2009, 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 April 1, 2009, 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 August 1, 2009.

(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 April 1, 2009, 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 March 31, 2009.

SEC. 702. ADMINISTRATIVE IMPROVEMENTS.

(a) PERMIT, INVENTORIES, REPORTS, AND RECORDS REQUIREMENTS FOR MANUFACTURERS AND IMPORTERS OF PROCESSED TOBACCO.—

(1) PERMIT.—

(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, REPORTS, AND PACKAGES.—

(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''.

(C) PACKAGES, MARKS, LABELS, AND NOTICES.—Section 5723 of such Code is amended by inserting '', processed tobacco,'' after ''tobacco products'' each place it appears.

(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 AMENDMENTS.—

(A) Section 5702(h) of such Code is amended by striking ''tobacco products and cigarette papers and tubes'' and inserting ''tobacco products or cigarette papers or tubes or any processed tobacco''.

(B) Sections 5702(j) and 5702(k) of such Code are each amended by inserting '', or any processed tobacco,'' after ''tobacco products or cigarette papers or tubes''.

(6) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on April 1, 2009.

(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, processed tobacco, 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, processed tobacco, 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, processed tobacco, 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, processed tobacco, 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.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on the date of the enactment of this Act.

(c) APPLICATION OF INTERNAL REVENUE CODE STATUTE OF LIMITATIONS FOR ALCOHOL AND TOBACCO EXCISE TAXES.—

(1) IN GENERAL.—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)''.

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply to articles imported after the date of the enactment of this Act.

(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 March 31, 2009.

(e) TIME OF TAX FOR UNLAWFULLY MANUFACTURED TOBACCO PRODUCTS.—

(1) IN GENERAL.—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 manufactured 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.''.

(2) EFFECTIVE DATE.—The amendment made by this subsection shall take effect on the date of the enactment of this Act.

(f) DISCLOSURE.—

(1) IN GENERAL.—Paragraph (1) of section 6103(o) of such Code is amended by designating

the text as subparagraph (A), moving such text 2 ems to the right, striking ''Returns'' and inserting ''(A) IN GENERAL.—Returns'', and by inserting after subparagraph (A) (as so redesignated) the following new subparagraph:

''(B) USE IN CERTAIN PROCEEDINGS.—Returns and return information disclosed to a Federal agency under subparagraph (A) may be used in an action or proceeding (or in preparation for such action or proceeding) brought under section 625 of the American Jobs Creation Act of 2004 for the collection of any unpaid assessment or penalty arising under such Act.''.

(2) CONFORMING AMENDMENT.—Section 6103(p)(4) of such Code is amended by striking ''(o)(1)'' both places it appears and inserting ''(o)(1)(A)''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply on or after the date of the enactment of this Act.

(g) TRANSITIONAL RULE.—Any person who—

(1) on April 1, 2009 is engaged in business as a manufacturer of processed tobacco or as an importer of processed tobacco, and

(2) before the end of the 90-day period beginning on such date, submits an application under subchapter B of chapter 52 of such Code to engage in such business, may, notwithstanding such subchapter B, continue to engage in such business pending final action on such application. Pending such final action, all provisions of such chapter 52 shall apply to such applicant in the same manner and to the same extent as if such applicant were a holder of a permit under such chapter 52 to engage in such business.

SEC. 703. TREASURY STUDY CONCERNING MAGNITUDE OF TOBACCO SMUGGLING IN THE UNITED STATES.

Not later than one year after the date of the enactment of this Act, the Secretary of the Treasury shall conduct a study concerning the magnitude of tobacco smuggling in the United States and submit to Congress recommendations for the most effective steps to reduce tobacco smuggling. Such study shall also include a review of the loss of Federal tax receipts due to illicit tobacco trade in the United States and the role of imported tobacco products in the illicit tobacco trade in the United States.

SEC. 704. TIME FOR PAYMENT OF CORPORATE ESTIMATED TAXES.

The percentage under subparagraph (C) of section 401(1) of the Tax Increase Prevention and Reconciliation Act of 2005 in effect on the date of the enactment of this Act is increased by 0.5 percentage point.

MOTION OFFERED BY MR. WAXMAN

The text of the motion is as follows:

Mr. Waxman moves to concur in the Senate amendment.

The SPEAKER pro tempore. Pursuant to House Resolution 107, the motion shall be debatable for 1 hour equally divided and controlled by the Chair and ranking minority member of the Committee on Energy and Commerce and the Chair and ranking minority member of the Committee on Ways and Means.

The gentleman from California (Mr. WAXMAN), the gentleman from Texas (Mr. BARTON), the gentleman from New York (Mr. RANGEL), and the gentleman from Michigan (Mr. CAMP) each will control 15 minutes.

The Chair recognizes the gentleman from California.

Mr. WAXMAN. Madam Speaker, I yield myself 1½ minutes.

I rise in strong support of H.R. 2, as amended by the Senate. This is the same bill, by and large, that we passed in the House by an overwhelming bipartisan majority a few weeks ago.

The opportunity before us today is to make basic health insurance available to 11 million low-income children who would otherwise have no insurance.

We know that without health insurance many children go without the health care they need to grow, to learn, to compete, and to contribute.

The bill before us will extend the current program for 4½ years, ensuring that States will be able to maintain coverage for the 7 million kids now enrolled and to extend coverage to an additional 4.1 million uninsured low-income children.

The bill is fully paid for. It will cost $33 billion over the next 5 years, fully offset by a 62-cent per pack increase in the cigarette tax.

The Senate made a few minor changes, adding a new option for CHIP to provide dental care for privately insured children and creating a new commission to evaluate provider payments and access in CHIP and Medicaid.

The Senate did not retain the House provision closing a loophole in Medicare that allows physicians to refer patients to hospitals where they have ownership interest. We will continue to work on that matter.

While this bill is short of our ultimate goal of health reform, it is a down payment, and it is an essential start. We need to pass this bill. We need to do so now.

I urge my colleagues to vote for this bill and send it to the President for his signature.

I reserve the balance of my time.

Mr. BARTON of Texas. Madam Speaker, I recognize myself for 1 minute.

Madam Speaker, we're here today to have another debate about SCHIP, another incidence of where we have a bill that's come over from the Senate slightly different than came from the House. In the case of this SCHIP bill, I don't recall there being a hearing on it. I don't recall there being a hearing last year before we had the vote.

So, let us simply say from the Republican perspective that we're very supportive of continuing the State Children's Health Insurance Program. We do think that it should be limited to families that are under 200 percent of poverty. We do think this is a children's health program. It ought to be for children. And we do think that there should be a verification to make sure that the program benefits go to citizens of the United States.

None of those things are in this bill. So we would oppose the bill and hope at the appropriate time the House would also oppose it.

With that, I reserve the balance of my time.

Mr. WAXMAN. Madam Speaker, I still continue to reserve our time.

Mr. BARTON of Texas. Madam Speaker, I yield 3 minutes to the distinguished ranking member of the Subcommittee on Health in the Energy and Commerce Committee, the Honorable NATHAN DEAL from Georgia.

Mr. DEAL of Georgia. Madam Speaker, I thank the gentleman for yielding.

I think it would be appropriate for us to review what the SCHIP program is designed and was originally designed to do and where it is in light of what this bill attempts to do.

First of all, it stands for the State Children's Health Insurance Program. States call it by a variety of different names at the State level. In my State, it is called PeachCare. You would imagine that we would do that in Georgia, but it was originally designed in 1997 as a 10-year program—it was a block grant program—designed to fill in the need of children who live in families that are above the Medicaid poverty level eligibility but are still below 200 percent of poverty, and that in that capacity was a worthwhile and useful program.

During its 10-year initial lifespan as it moved forward, there were times when States had shortfalls. In other words, the allocation under the Federal matching rate formula for the SCHIP program, coupled with the State's contribution, was not sufficient to meet the demand and the cost of eligible children to be enrolled, and Congress stepped up to the plate, appropriated additional funds, and allowed those States to continue with their legitimate enrollment programs.

When it came to the 10-year time frame expiring, we were faced with, well, what is the future of SCHIP going to be. After much debate, vetoes by the President, about a program that was going to take a huge step in the area of expanding government control of health care, we did an 18-month extension, and that 18 months will expire this next month.

And what it did was it said let's take the legitimate needs of the 200 percent of poverty and below, recognizing that some States had already far exceeded that limit, but nevertheless allowing them to be grandfathered in and provide enough money so that no State runs out of money to cover the eligible children.

Unfortunately, the bill before us today continues to take a step, in my opinion, in the wrong direction.

We talk about the millions of children that are supposedly going to be enrolled as new enrollees in the program, and yet when we look at those figures, we find that about 2.5 million of those so-called new enrollees will be children who are already enrolled in private health insurance plans, but because their family is now eligible for the government to pay for their health care, it is anticipated that their families will simply take them off of the private insurance and put them on the taxpayer-paid program of SCHIP. I don't think that's what most Americans in this country want this program to be.

Couple that with the fact that we have no provision in this bill that requires States—

The SPEAKER pro tempore. The time of the gentleman has expired.

Mr. BARTON of Texas. I yield the gentleman 1 additional minute.

Mr. DEAL of Georgia. There is no provision in this bill that requires States to go out and make the extra effort to enroll children who are eligible for either Medicaid or the current SCHIP program under its current authorization of up to 200 percent of poverty but are still unenrolled.

In fact, it is estimated that about a quarter of the children who are eligible are simply not enrolled in the current program. These are the children that are at the lowest levels of poverty but are not covered. They should be the part that are our first incentive. The Republican version of this incentivizes States to take that extra effort to enroll those children first before they started going up the poverty level and enrolling children in higher income families, many of whom already have private insurance.

I thank the gentleman for yielding to me.

Mr. WAXMAN. Madam Speaker, I'm pleased at this time to yield 3 minutes to the gentleman from Washington State (Mr. MCDERMOTT).

Mr. MCDERMOTT. Madam Speaker, I rise in strong support of the SCHIP reauthorization legislation and want to thank the Speaker, Ms. PELOSI, for her leadership in bringing this bill to the floor. H.R. 2 clearly says that change has arrived for our country and our children.

Instead of the veto pen that was used last year by the outgoing President to deny health care to children, our new President will sign this legislation and, in so doing, will write a new chapter in America's commitment to our children and our future.

H.R. 2 is a real down payment on our efforts to ensure universal access to affordable health care for all Americans. It builds on successful models that have expanded access to millions of children nationwide.

Health care should be a right, not a privilege for the rich in America. This legislation affirms the commitment of a new Congress to serve all the people, not merely those who have the means to pay any price for health care while the Nation pays a steep price by not covering its children.

H.R. 2 represents an additional 4 million children that will have access to health care, and it will provide access to preventive health care, and this alone means America will raise healthier children who grow to become healthier and more productive adults.

The American people have spoken. They want a more compassionate response to our Nation's problems. Today, we are voting with our heads and our hearts to do just that. This is not about ideology or party. It is about providing health care to children. H.R. 2 represents real change.

I am proud of my own State that took the lead before SCHIP was put in place in 1994. Three years before the enactment of SCHIP, Washington State expanded coverage to children up to 200 percent of the Federal poverty line. That was a huge commitment, and clearly, my State took the lead. As a result, we have fewer children uninsured, we have a healthier population, and more integrated primary care. It's a commitment that worked for us in our State, and it recognizes that what worked for Washington State will work across the country.

Thirty million dollars was the commitment we made. H.R. 2 rewards States like Washington who knew early on that providing quality affordable health care to children was a sound, humane investment, but also, it expands a successful program to cover more uninsured children and working families.

The present economic difficulties in this country are going to make this program even more important than they've ever been in the past. This bill provides greater flexibility and will allow States to meet the needs of low-income working families.

I'm grateful also that this legislation includes important access for legal immigrant children who are currently denied coverage, children who are born in the United States and are U.S. legal citizens. In Washington State, we have provided coverage for these children, but the State is doing this alone without the full partnership of the Federal Government. H.R. 2 corrects this error and will allow Washington State to maintain coverage for more than 3,000 children.

Madam Speaker, we need to do the right thing. Providing universal coverage for children is an objective that we should all support. This legislation takes us one step closer to meeting this goal. I urge my colleagues to support this bill.

□ 1130

Mr. BARTON of Texas. Madam Speaker, I yield 2 minutes to a distinguished member of the committee, Dr. GINGREY of Georgia.

Mr. GINGREY of Georgia. Madam Speaker, I appreciate the gentleman yielding, and I regretfully rise to oppose H.R. 2, not because I oppose the original legislation—which I think the bill was a very good bill and as a physician Member and a compassion for wanting to extend health care to our children—my concern with the bill with the reauthorization is that it doesn't really limit it to those children that need it the most, those, say, under 200 percent or between 100 and 200 percent of the Federal poverty level. This new bill actually allows that to go up to 300 percent.

But, Madam Speaker, there is an even bigger problem. This is a situation that some States use called—well, they're loopholes, really, and they call them income disregards. I think there are about 13 States, Madam Speaker, who utilize that loophole that just simply says to couples or families, If you're not eligible, that is, you make more than 300 percent of the Federal poverty level—well, what is that, about $65,000 a year for a family of 4—then we will just simply disregard the income that you make between 300 and 400 percent of the Federal poverty level and say, We're not going to count that. Let's count—a wink, wink, wink, nod, smoke and mirrors, shell game—not count a certain block of income.

And I had an amendment—which I thought was a very good amendment; unfortunately it's a closed rule—but this amendment would simply say that there will be income disregards only in the amount of a maximum of $3,000 a year or $250 a month. Only income disregards may be something like childcare or something of that sort.

But to completely disregard, that's where we get into this crowd-out situation, Madam Speaker, where people whose children are already covered in the private market, they're going to drop that, clearly they're going to drop it even though they can afford it so they can get on the government dole. And as was pointed out earlier, a lot of physicians are not going to take the SCHIP patient because of the reimbursement.

The SPEAKER pro tempore. The time of the gentleman has expired.

Mr. BARTON of Texas. Madam Speaker, I am going to be magnanimous and give the gentleman 1 additional minute.

Mr. GINGREY of Georgia. I thank my ranking member of the Energy and Commerce Committee for his generosity. He knows that this Georgia brogue is a little bit slow.

But clearly it makes no sense, it makes no sense to crowd them out and put them into this program and then physicians are going to be less inclined to provide the service because their reimbursement under SCHIP or Medicaid is probably 30 percent less than it is in the private market.

So while in trying to enroll more children and help more children, I think, unfortunately, you're going to get less coverage and less service for those children.

So again, that was a good amendment. I'm sorry I didn't have a chance, Madam Speaker, to offer it. I think we could have made a good bill a whole lot better.

And for that reason, I'm going to oppose this bill.

Mr. WAXMAN. Madam Speaker, I am pleased at this time to yield 1 minute to the distinguished majority leader of the House of Representatives, the gentleman from Maryland (Mr. HOYER).

Mr. HOYER. I thank the gentleman for yielding.

Madam Speaker, I thank the chairman for bringing this bill to the floor in a timely fashion. I'm pleased that we're going to pass this bill, we're going to send it to the President, and he's going to sign it.

Atul Gawande, a surgeon and writer on health care policy, recently described our medical system like this:

''American health care is an appallingly patched-together ship, with . . . fifteen percent of the passengers thrown over the rails just to keep it afloat.''

If you can afford health care in America, there is no better place in the world to get sick. You will be treated to the best hospitals by the most skilled doctors with the latest technology. However, if you're one of the Americans thrown overboard, if you're one of the 45 million uninsured Americans for whom even a checkup is a luxury, you might be better off in some other places in the world. Every other developed nation has figured out how to cover all of its citizens. Every one but ours.

We're here today to start fixing that. Actually, we've been fixing that in a number of ways—Medicaid, Medicare, other programs that we've adopted—to patch the holes, however, that still exist in the leaking ship to make it into a vessel capable of carrying every passenger, every American.

We can't patch every hole today, but if I could pick just one leak to stop, it would be the hold where we keep our sick children. If you asked me for the most efficient use of a single health care dollar, I would put it towards covering more children.

I don't say that out of a misplaced sentimentality; I say it because it's well-established that childhood is the most medically pivotal time of life. A child who lives through the first years without a doctor's care, without regular checkups, without immunizations, and without booster shots is in for a lifetime of health danger. That child will live sicker and die sooner. In adulthood, he or she will be a less productive worker. And in old age, he or she will help swell the costs of our entitlement programs.

That is the logic behind the final passage of this bill, which brings into the State Children's Health Insurance Program, as has been said already, four million children who are eligible but not yet enrolled.

Very frankly, as a result of the veto of the legislation we passed in the last Congress, four million children went to bed last night with their parents worried if they got sick, what were they going to do, with the alternative being the emergency room: the most expensive, and in some cases least efficient, intervention in the health care system in our country.

It does what President Bush promised to do when he ran for re-election in 2004 accepting the Republican nomination. As I've said before, President Bush said this, ''In a new term''—that meant the 2005 to the 2009 term that just expired—''In a new term, we will lead an aggressive effort to enroll millions of poor children who are eligible but not signed up for government health insurance programs.''

Those millions of children of which President Bush spoke will be added by this bill. President Bush failed to deliver on his promise, but today, we will redeem that commitment. Today, the objective of years of work will be substantially advanced.

With this vote, and with President Obama's immediate signature, this bill will at long last be law.

Backed by overwhelming majorities of Americans, we can pass this bill and help raise a healthier generation of Americans. That's good for our country, it's good for our economy, and it's good for the international community.

And in this recession, we can lend some vital assistance to the millions of family budgets that are stretched, literally stretched, to the breaking point and the point of letting the health care of our children be further at risk.

Madam Speaker, renewing American health care, bringing the best care in the world, which we have right here—as Dr. GINGREY knows, we have right here—bringing it to all of our people is a hugely complex job. That work, of course, does not end today, as Chairman WAXMAN would emphasize. But this important inclusion of more than four million of our children and the guarantee of access to health care is a victory for America's values and its health care future.

I urge my colleagues, each and every one of us, to vote for this legislation, vote for our children, vote for our families, vote for a healthier America.

Mr. BARTON of Texas. Madam Speaker, can I inquire of the time remaining on each side?

The SPEAKER pro tempore. The gentleman from Texas has 7 minutes remaining and the gentleman from California has 9½ minutes remaining.

Mr. BARTON of Texas. Madam Speaker, I yield myself 3 minutes.

Madam Speaker, my admiration for the majority leader knows no bounds. Mr. HOYER is a great man, and he is an institutionalist, and he was personally involved in the negotiations of the last Congress who tried to get a compromise. But sometimes he doesn't tell the entire facts of the matter. So I want to just point out a few things that our distinguished majority leader failed to mention.

Right now in America, the SCHIP law that we're operating under is a Barton-Deal bill—Mr. DEAL and myself, two Republicans—that extends the existing program. And to Mr. HOYER's credit and Ms. PELOSI's credit, they passed that extension in the last Congress when we couldn't get a political compromise.

Under current law, if you're low income, below 200 percent of poverty, your children are covered under Medicaid 100 percent, 100 percent. If you're a working family that's under 200 percent of the Federal poverty limit, you're automatically covered. In some States, they go up to 250 percent of poverty, and in some States they have asked for waivers to go even higher than that. I think Mr. PALLONE's State of New Jersey may be at 300 percent. I think the State of New York may be at 300 percent.

So it is a misnomer to say that there are all of these children out there that don't have health insurance. There are some.

Now, the bill before us today really doesn't have an income test. It officially takes it to 300 percent of poverty but allows the States to ask for waivers and do what are called income disregards, which basically means you could have families at 400 or 500 percent of poverty and if that State disregards their income, they can be covered. That was admitted on the House floor in last year's debate, and that provision is unchanged in the bill before us.

Now, President Obama has already scheduled a signing ceremony so there is no real suspense about whether this bill is going to pass with a Democrat majority of 258 votes and a Republican minority of 178 votes, we're pretty sure that this bill is going to prevail.

But the record should show that low-income children are covered, that children up to 200 percent of poverty are covered, and in some states it goes to 250 percent. This debate is about raising the level.

This debate is about do we want a children's health insurance program that covers every child in America with State and Federal dollars regardless of their ability to pay; do we want to freeze out the private sector for health insurance. That's what this debate is about.

Republicans are for children's health insurance. Republicans do believe, though, that we should target the help to those families that have less ability to help themselves.

And on the question of citizen verification, since we didn't have a legislative hearing, I'm not sure what the verification measurement is, but I think it's personal affirmation.

The SPEAKER pro tempore. The time of the gentleman has expired.

Mr. BARTON of Texas. Madam Speaker, I yield myself 15 seconds.

If it is personal affirmation, when you sign up for SCHIP they say, ''Are you U.S. citizen?'' And if your parent says you are, you are. That's what personal affirmation is.

So I hope we could somehow pull out a miracle and defeat this bill and then do the bipartisan compromise that we almost pulled off in the last Congress.

With that, I reserve the balance of my time.

Mr. WAXMAN. Madam Speaker, I yield to the chairman of the Health Subcommittee and the author of the SCHIP bill in the House, Mr. PALLONE from the State of New Jersey, 1 minute with an option for more.

Mr. PALLONE. I thank the gentleman from California.

Madam Speaker, on this historic day I'm reminded of a quote from the Pulitzer Prize winning American author, Pearl Buck, who said, ''If our American way of life fails the child, it fails us all.''

Well, this is a day worthy of celebration. It comes nearly 2 years after

Deamonte Driver, a young boy from suburban Maryland, lost his life because his family lost its health insurance. And this simply should not happen in America. And if Congress does not act today, I can't help but think of the millions of other children whose lives will be put at risk simply because they do not have access to health coverage.

There can be no greater cause or worthier goal than protecting the wellbeing of our Nation's children. I emphasize this point now because in a recession parents are forced to make tough financial decisions: do they keep their families' health insurance, or do they put food on the table at night?

And today we have an extraordinary opportunity to ensure that these children don't fall through the cracks. This is a very good bill. With its passage, 11 million children will have access to the health care coverage they need to lead healthy and strong lives. And these children are our Nation's future.

Let's support them today by voting ''yes.''

Mr. BARTON of Texas. Madam Speaker, I yield 1 minute to the gentleman from California, Congressman MCCLINTOCK.

□ 1145

Mr. MCCLINTOCK. I thank the gentleman for yielding, and I think it's a prime example of unintended consequences. Since its inception, we've watched as SCHIP has been slowly replacing employer health plans with government-paid plans—with spiraling costs to taxpayers. Employers discovered that they could avoid their own plans, knowing that their employees would be covered by SCHIP.

This was supposed to provide health insurance for poor and working-class families but, like all things bureaucratic, it's now morphed into one in which families earning as much as six-figure incomes and who would have good employer-paid health insurance are being pushed into the government program. And that is the fine point of it.

This is no longer a program for the children of poor people. It's being used to insinuate government into the medical care of every American. Frankly, we don't need the same people who run the TSA to run our health insurance.

Mr. WAXMAN. Madam Speaker, I yield 1 minute to a member of the Energy and Commerce Committee and a member as well of the Health Subcommittee, the gentlewoman from Illinois (Ms. SCHAKOWSKY).

Ms. SCHAKOWSKY. I am delighted to rise today in support of the Children's Health Insurance Program Reauthorization Act. I thank Chairman WAXMAN and Chairman PALLONE for their hard work on bringing it to us today.

As a mother and proud grandmother of four, I can think of no higher priority than ensuring that our children get the health care they need. Unfortunately, 7 million children nationally and 350,000 children in Illinois are at risk of losing their coverage if we don't reauthorize this program.

But this bill will not only prevent SCHIP from expiring on March 31, it will also expand coverage to 4 million uninsured children nationally and 300,000 children in Illinois. It makes many needed improvements, including dental coverage and providing mental health parity. I am particularly pleased that it gives States the discretion to cover more women and children by lifting the 5-year ban for legal immigrants.

I am also pleased that after many thwarted efforts, we finally have a President that will sign this bill into law. It represents a renewed commitment to health care. This is the first step in making sure that every child, woman, and man in the United States has health care that is affordable, accessible, and high quality.

Mr. BARTON of Texas. I yield 2 minutes to the gentleman from Georgia (Mr. DEAL).

Mr. DEAL of Georgia. I thank the gentleman for yielding.

Let me clear up a couple of things. First of all, the majority leader has said that this is an effort to provide universal coverage for citizens of this country to health care. It obviously is a major step in that direction of government control of health care.

The problem though is it may also include expanding and extending health care to citizens of other countries. In 2005, the Inspector General of HHS told us that some 46 States and the District of Columbia were using self-attestation of citizenship to enroll people in their Medicaid programs. Part of the reason was when they had asked for identification, they were accused of profiling or threatened with civil rights lawsuits. So most States backed off and said, Well, if you tell us you're a citizen, we'll take your word for it.

In the Deficit Reduction Act, we changed that. And we require that you now prove you're a citizen and prove who you are. This bill changes that. And we go back.

For those of us who think, Well, just tell us a name and a Social Security number—that means that if you believe that there are not people who are out there with fraudulent Social Security numbers, then I have some stories back home I'd like to tell you.

We take a huge step backwards—and it's not just in the SCHIP program. It applies to the Medicaid program as well. Now, that means then at a time when we are hearing people saying that we want you to secure our borders, we want you to protect us, we are saying we are going to open it up to anybody who just wants to tell you they are a citizen and, by the way, even if they tell you wrong, this bill has no sanctions for them telling you they are a citizen, when they are not, and this bill requires you to provide them with medical care during the time period when they have defrauded.

At a time when citizens are concerned about the economy of this country, we should not be taking a step in the direction of loosening up and encouraging fraud and abuse of this program.

Mr. WAXMAN. Madam Speaker, I yield 1 minute to the gentlelady from California (Ms. ESHOO).

Ms. ESHOO. Madam Speaker, I think today is really a great day in America because the legislation that is before us is one of the most important bills that we will pass in the 111th Congress, the Children's Health Insurance Program Reauthorization Act, or SCHIP.

As we know, the same legislation was vetoed not once, but twice by President Bush, forcing the Congress to pass short-term extensions and no improvements to the program. But, today, a promise is being kept to America's children. They will be insured with health insurance. And the total will be 11 million. We are adding 4 million children to be covered. I think that that is a victory.

The legislation invests more than $32 billion over 5 years, and it is fully paid for. So it is good fiscal policy, it is good health policy, and is good social policy.

Forty years ago today, I gave birth to my daughter, Karen. Today, more children are being born, and the little ones can look forward to what the Congress is providing. Bravo, bravo, bravo.

Mr. BARTON of Texas. May I inquire on the time remaining?

The SPEAKER pro tempore. The gentleman has 45 seconds remaining.

Mr. BARTON of Texas. How about my friends on the majority?

The SPEAKER pro tempore. There are 6½ minutes remaining for the gentleman from California.

Mr. BARTON of Texas. I reserve the balance of my time.

Mr. WAXMAN. Madam Speaker, I yield 1 minute to the Speaker of the House, without whom we would not have this legislation before us today, who has been tireless in pushing forward the agenda to make sure that no child in this country goes without health insurance, the gentlewoman from California (Ms. PELOSI).

Ms. PELOSI. This is a very happy day for me, for the Congress, and for the country, for all of America's children. I thank my colleagues for their extraordinary leadership in working on this very, very important legislation, which is strongly bipartisan, very carefully crafted, and again, a giant step forward for our children.

Almost 2 years ago, when we first talked about this legislation—we have been talking about it for years. Of course, it has been the law, and now we are expanding it. But when we first brought it into the previous Congress, on that day, it was late in the afternoon when I came to the floor, and while the sun was setting in the sky—coincidentally, I came at a time when

it was, in poetry, described as the ''children's hour.''

I quoted then Henry Wadsworth Longfellow's poem: Between the dark and the daylight, when the night is beginning to lower, comes a pause in the day's occupation that is known as the Children's Hour.

Today, the children's hour has come to pass. With the bipartisan vote of this House, and the signature of the new President of the United States, we will provide health care to 11 million children in America.

We owe a great deal of thanks to our chairman, Mr. WAXMAN, to the chairman emeritus, Mr. DINGELL, and Chairman FRANK PALLONE, of the Energy and Commerce Committee; Chairman RANGEL and PETE STARK of the Ways and Means Committee. So many women on the committees have worked for this. Congresswomen SCHAKOWSKY, BALDWIN, DEGETTE, ESHOO, and many others. This has been a product of many women focusing on this important issue that involves our children.

But our success really springs also from the outside mobilization that went with this. A compilation of more than 300 organizations—everyone from AARP to YMCA, March of Dimes, Easter Seals, and every organization in between—supported providing quality, affordable health care to America's children.

More than 80 percent of Americans support our bipartisan children's health insurance bill because they understand that with 2.6 million jobs lost last year, now even more children do not have health insurance. For every 1 percent increase in unemployment—for every 1 percent increase in unemployment—it is estimated as many as 1.5 million Americans will lose their health care coverage.

The American people know that preventive care is more cost effective than relying on our Nation's emergency rooms. That phrase was used in the debate over the past 2 years. Everyone in America has access to health care. All they have to do is go to the emergency room. What a ridiculous statement. What a disservice to the debate.

They know also that reducing smoking, which the Campaign for Tobacco-Free Kids says this legislation will do, means healthier children leading longer lives.

The bipartisan, fully paid for children's health insurance bill represents the new direction that Democrats have fought for that now, today, we join with our Republican colleagues to bring to the floor. This is the beginning of the change that the American people voted for in the last election and that we will achieve with President Barack Obama. We look forward to this afternoon when the President of the United States will sign this legislation.

I see some of our new Members of Congress on the floor. I see Congresswoman BETSY MARKEY and Congresswoman DAHLKEMPER on the floor. I don't know if others are here. But they have taken a major interest. TOM PERRIELLO of Virginia has taken a major interest in this legislation too. I commend them because their coming to Congress has already, only a few short weeks in the Congress, has already made a difference in the lives of the American people.

It's a very happy day for me because, as you know, each time I have been sworn in as Speaker, I have gaveled this House to order in honor and on behalf of all of America's children. Right now, we are observing a children's hour that signifies that we are a Congress for those children.

I urge all of my colleagues to support our effort to pass this with a tremendous, tremendous margin, and then also to celebrate the signing of the legislation this afternoon.

Mr. BARTON of Texas. I continue to reserve the balance of my time until they are ready to close. We have one speaker remaining.

Mr. WAXMAN. I yield 1 minute to a member of the Health Subcommittee and the full Energy and Commerce Committee who played a role in this legislation, the gentlelady from Wisconsin (Ms. BALDWIN).

Ms. BALDWIN. Thank you, Mr. Chairman.

I rise in strong support today of the Senate amendment to H.R. 2, the Children's Health Insurance Program Reauthorization Act. Achieving health care for all in this country is the reason why I got into politics. It is my goal, it is my passion, it is my motivation. And, for the first time during my tenure in Congress, I see real promise that the Obama administration and this Congress will work together to achieve that goal.

SCHIP takes an important first step in moving towards achieving this goal. I am proud to support this particular bill because it contains some key provisions. It provides increased Federal funding for States like my own State of Wisconsin that have proven successful in reducing the number of uninsured children. It also provides funding for outreach activities to find the children that are hardest to reach—the most in need of health care.

Madam Speaker, this legislation will give 4.1 million uninsured children meaningful access to health care. And now we must move forward to cover the millions more who suffer every day due to lack of health insurance. Today, we must enact SCHIP legislation. Tomorrow, we must move forward to bring health care coverage to every American.

Mr. WAXMAN. Madam Speaker, I yield 1 minute to the vice chairman of the Energy and Commerce Committee and a longtime member of the Health Subcommittee, the gentlelady from Colorado (Ms. DEGETTE).

Ms. DEGETTE. We will pass this bill today. And we will pass this bill for millions of women, like Susan Molina, who are trying to work and support their children and do the right thing for them. Susan is a single mother in my district. Her abusive husband left her, and she has struggled to work and pay for health insurance for her two children as she worked tirelessly to move from a janitor to an apartment manager position.

In 2006, Susan's two children lost their health insurance under SCHIP because her new job paid just slightly more than 200 percent of poverty level. Susan has tried to work her way up to be a responsible member of society. Eventually, she got her children in SCHIP, and they have health care, and she could work. But then after she lost her SCHIP coverage, as she testified to Congress, to our committee, she felt like a failure as a mom.

□ 1200

She was working, she was in school trying to get her GED, but she still had to take her kids to the emergency room when they got an ear infection. Frankly, Madam Speaker, it is about time that the most civilized country in the world give health care coverage to all of its children.

Mr. WAXMAN. Madam Speaker, I am pleased to yield to the gentleman from Washington State, a member of the Energy and Commerce Committee, Mr. INSLEE, for 1 minute.

(Mr. INSLEE asked and was given permission to revise and extend his remarks.)

Mr. INSLEE. Madam Speaker, I want to particularly commend this bill, because it honors the States that have been visionary and proactive in trying to get health insurance for their kids.

Eleven States have moved forward ahead of the country in providing health insurance for their kids up to 300 percent of poverty, and this bill finally, due to the great efforts of Mr. WAXMAN, Mr. DINGELL, and many others who have been working for years, Mr. PALLONE, to fashion a provision that will allow the children in those States to in fact enjoy health insurance. In my State of Washington, over 5,000 kids are going to have health insurance as a result of this; the State will have $94 million to help those families. This is long overdue.

And to my friends across the aisle who somehow do not understand that parents who become unemployed in the downturn we are now experiencing, whether they are at 100 percent of poverty or 200 percent or 300 percent, I don't know why they don't understand the pain of parents who can't provide health insurance for their kids. This does it today. Let's pass this bill.

Mr. WAXMAN. Madam Speaker, I am pleased to yield to the gentleman from North Carolina (Mr. BUTTERFIELD), a very important and distinguished member of the Energy and Commerce Committee, 1 minute.

Mr. BUTTERFIELD. Madam Speaker, I want to thank the chairman of the Ways and Means Committee for yielding this time. This is a very important subject in all of our States.

Madam Speaker, without question, the people of my State in North Carolina are hurting very badly. Unemployment figures show that the number of counties with double digit unemployment actually doubled to 34 during the month of December. That is more than one-third of the counties in my State now suffering from double digit unemployment.

When people lose their jobs, they lose access to affordable health care, and it is the children, just as the gentleman from Washington just said, it is the children who suffer most in these circumstances. Today, we have an opportunity to take another step toward ensuring that every American child has access to affordable health care regardless of family circumstances.

With the passage of this bill, my State of North Carolina will reduce the number of children who lack health insurance by 46 percent. That is 136,000 children. There will be similar impacts across the country. I urge my colleagues to join me in approving this important bill.

The SPEAKER pro tempore. The gentleman from Texas has 45 seconds remaining; the gentleman from California has 1½ minutes remaining.

Mr. WAXMAN. Madam Speaker, at this time it is my great honor to yield to speak on this legislation to the gentleman from Michigan (Mr. DINGELL), who has been the author of this bill for child health insurance in the last Congress. Unfortunately, the bill was vetoed by President Bush. But we all have to recognize his strong commitment and leadership on this issue, and so I want to yield to him 1 minute to be able to speak in favor of the legislation.

(Mr. DINGELL asked and was given permission to revise and extend his remarks.)

Mr. DINGELL. I thank my friend, the chairman of the committee. I rise to voice my support for the extension of the Children's Health Insurance Program. As a long-time supporter of the program, I am delighted that we are sending a bill to the President that will be signed into law. This time there will be no veto pen to stand in the way of providing health coverage for 11 million of our kids.

High health care costs are straining already strapped families nationwide. Nowhere is this truer than in my home State of Michigan, where unemployment now tops 10 percent. With families struggling to save for retirement, to save for college, to pay mortgages and bills, this legislation will help State governments provide health care to children who otherwise would be left out.

Recently, there has been much talk about investments, good and bad. The bad kind has pushed our financial system into the brink of insolvency and has caused economic crisis on a scale unseen since the depression. But good investments, such as SCHIP, invest in our children and our future.

This expansion is a bipartisan effort, a collaboration of my colleagues on both sides of the aisle. Of this, I am properly grateful, and I urge my colleagues to vote for this legislation. It will be signed into law, and I look forward to working with the administration on a program of national health reform.

As someone who has spent 50 years on this effort, I know that this is just the beginning of what needs to be done.

The SPEAKER pro tempore. The gentleman from Texas has 45 seconds remaining.

Mr. BARTON of Texas. I am going to yield my last potent 45 seconds to a distinguished member of the committee, MARSHA BLACKBURN of Tennessee, to close.

Mrs. BLACKBURN. Madam Speaker, I think that, I would hope, that not only my colleagues but the American people realize that this bill today contains a $72 billion tax increase on the American people, what Congressional Research Service calls the most regressive of taxes, because it is tobacco taxes. But this is a tax increase that is coming full steam ahead at us. And, Madam Speaker, it is not there to go into a program that we all originally supported the way SCHIP was originally set up. This expanded SCHIP goes to middle-income children; it does not focus on low income and uninsured children. That is a sad day for us. Indeed, part of the 900,000 children that are expected to be added already have access to health insurance.

I would encourage all of my colleagues to vote against the tax increase and vote ''no.''

Mr. WAXMAN. Madam Speaker, I wish to yield the balance of our time to the gentlelady from Colorado (Ms. MARKEY).

(Ms. MARKEY of Colorado asked and was given permission to revise and extend her remarks.)

Ms. MARKEY of Colorado. As working class families struggle to make ends meet in these tough economic times, we have the opportunity to ease their burden by providing health care for 11 million children. Currently, more than 1 out of 8 children in Colorado lacks health insurance because they can't afford it. As the mother of three, I understand the burden of caring for sick children and the relief of being able to take my children to the doctor without worrying about costs.

We need to expand access to children's health care, and make sure that every child has the ability to go to the doctor and receive treatment. This is not just the right thing to do; it makes fiscal sense to give children preventive health care.

As working class families struggle to make ends meet in these tough economic times, we have the opportunity to ease their burden by providing health care for 11 million children. In my state of Colorado, we had 84,649 children enrolled in SCHIP in 2007. This legislation would preserve coverage for them, and extend it to thousands more children in the state. (Currently, more than one out of every eight children in Colorado lacks health insurance.)

As a mother of three, I understand the burden of caring for sick children and the relief of being able to take my children to the doctor without worrying about costs.

We need to expand access to children's health care and make sure that every child has the ability to go to the doctor and receive treatment. Today's children are the next generation of leaders, and we need to insure our future. This is not only the right thing to do, it makes fiscal sense to give children preventive healthcare. I ask all of my colleagues on both sides of the aisle to pledge their support for our children and vote for this bill.

The SPEAKER pro tempore. The gentleman from New York (Mr. RANGEL) is recognized.

Mr. RANGEL. Madam Speaker, what a great opportunity for us in this august body, whether we are Republican or Democrat, to think in terms of the comfort that we are giving parents and grandparents by having assurances that, if anything happened to these very special people, that they would have health insurance.

There is hardly a weekend that goes by that I don't thank God for my three grandchildren, and not have to worry that if anything, God forbid, should happen to them, that at least we would know they have access to health care. It reminded me when I was a young father and how precious my son and daughter would be. And then you think, of course, of the so many millions of people that go to work every day not being able to concentrate on their jobs and being productive and competitive, but thinking what would happen if their child became ill.

And it is not just the compassionate and right thing to do, to know that all of us would be able to go to sleep at night and to know that we made our contribution to provide health care to 11 million kids, but even from a national security or fiscal point of view, as doctors and researchers indicate, the great burden of fiscal costs for diseases and ailments that could have been detected if the children had access to health care. So many kids drop out of school with people not even knowing that they couldn't hear, that they couldn't understand properly, that they couldn't see minor things that could have been detected if the child had the availability of health care. And, of course, in the long run I don't think any on the other side and certainly none of ours can challenge the fact that it is in the later years of life things that could have been prevented that increase the need for health care and of course increase the costs for health care. In other words, we can dramatically improve the quality of care and cut down the ever increasing costs of care by preventing these things from happening.

I sat here trying to listen to some argument about why anyone would be against this bill. Sure, no one likes taxes. I am opposed to excise taxes. But, my God, cigarettes? You almost

feel like you are doing the right thing by making it difficult for kids and others to smoke cigarettes. Indeed, from a Ways and Means point of view, it is a question of whether or not the bill could be adequately funded because last year we collected more taxes because there was more consumption. So something is really working in terms of curtailing of people from destroying the quality of their own lives.

And so I do hope that we continue to have this as a bipartisan bill, that we can walk out at least and go home and say that we worked together on one initiative that was good for our children, good for our community, and good for our country.

I now ask unanimous consent to yield the balance of my time to the chairman of our Health Subcommittee, and to have Dr. MCDERMOTT determine which Members he would like to yield to.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from New York?

There was no objection.

Mr. MCDERMOTT. I reserve the balance of my time.

Mr. LINDER. Madam Speaker, I yield myself such time as I may consume.

The State Children's Health Insurance Program, which started in 1997, was for children, for children who lived in families who did not qualify for Medicaid but still needed health insurance programs. Today, four States have more adults in the program than children. It is being abused.

The health insurance program for children also required, originally, those in this country to show that they lived in this country legally, to have documentation. This program removes that proof. You now need only to say, ''Yes, I am here legally.'' It also removes the 5-year requirement. When you are here legally and you are sponsored by someone, they have to be responsible for taking care of your needs for 5 years. This is removed. What will happen if we follow on with an amnesty bill for the 20 million illegals who would be immediately eligible for the SCHIP program? Would it then be fully funded?

The funding, by the way, mostly by tobacco, falls on low-income people. The burden on the lowest 20 percent with the tobacco program is 37 times more burdensome than were it funded by an income tax. It also requires 22 million new smokers just to pay the bill. I want to see the majority go recruit them.

It is estimated that 2.4 million people will drop private insurance; families will drop because they qualify. Employers paying employees less than $80,000 a year will drop it. This isn't mean-spirited; it is in their interest. We saw this happen before.

In 1965, every physician and dentist in America had a file drawer full of patients that they treated for free. It was their community responsibility. When Medicare and Medicaid came along, they said, ''Well, my taxes are going up to pay for that. The government will now do it.'' And they dropped that responsibility, and the burden fell on the taxpayer.

With the upper limit disregards in this program on income ceilings, we essentially make 75 percent of all Americans eligible for the program. Again, I repeat. I have heard it said many times it is fully funded. And Lyndon Johnson said that about Medicare and Medicaid. I was in dental school and watched his great society speech. He said, ''We know, using easily quantifiable user statistics that, by 1990, Medicare will only cost $9 billion and Medicaid will only cost $1 billion.'' He was wrong. Medicare costs over $100 billion; Medicaid costs over $75 billion, and those entitlements are breaking this country.

□ 1215

The same is going to happen when the ceilings are taken off incomes and other people are put into this program. It will not be fully funded by tobacco.

This program will pay less than one-half the reimbursement to providers through Medicare or SCHIP that currently Blue Cross pays. And those providers are going to disappear from the program. We are already seeing it in Medicare and Medicaid. Who is going to be left to treat these people?

There was a real bipartisan effort to reauthorize this program last year, to expand its income protections and to increase the money to pay for it. It wasn't enough for the majority. They wanted to make it for everybody all of the time. This will not work.

I will vote against it.

I reserve the balance of my time.

Mr. MCDERMOTT. Madam Speaker, I yield 1 minute to the gentleman from North Dakota (Mr. POMEROY).

Mr. POMEROY. I thank the gentleman for yielding.

A great country holds the interests of its children first and foremost. A great country responds to tough times and steep challenges by placing the interests of its children at the head of the line when it comes to advancing measures to help. Today we have a chance to reflect this dimension of America's greatness by passing this bill to extend vital health insurance to 11 million of our kids. We must take this action.

Like last year, we will have bipartisan support when it comes to moving this bill forward. But unlike last year, this time our efforts will receive a different reception at the White House. Our prior President vetoed this bill. But we now have a new President. And this bill will be received with a resounding ''yes.'' And the effort to get coverage to our children will at last succeed.

Mr. LINDER. Madam Speaker, at this time I yield 3 minutes to my friend from Texas (Mr. CULBERSON).

Mr. CULBERSON. I thank the gentleman from Georgia.

Each one of us as representatives of our districts have a fiduciary duty, the highest obligation of the law, to protect the Treasury of the United States to ensure that our children and grandchildren are not inheriting an unaffordable debt burden. Today the national debt exceeds $10 trillion. Today the national deficit, for the first time in history, exceeds $1 trillion. It is approaching $1.5 trillion. Today the unfunded liabilities of the United States exceed $60 trillion.

And in that set of circumstances, it is essential that this Congress, on every bill, on every issue, on every vote and in every debate think first and foremost about that debt burden that we are passing on to our children and analyze every bill before us from that perspective. Is it physically responsible? Is it financially prudent to pass the legislation before us?

Obviously the Federal Government has a longstanding existing obligation to provide health insurance for the very poorest of our citizens. But the key is, we fiscal conservatives want to see poor American children provided health insurance first and foremost. We fiscal conservatives want to limit the provision of health insurance coverage to those poor American children in circumstances where they can show that they are truly citizens, they are here legally—in our current law, they have to wait 5 years—and that they are truly poor.

Yet with the legislation this unleashed liberal leadership of the new Congress has put before us, you are hiding behind campaign slogans. Step back and let's forget the next election. Think about the next generation. Let's legislate for the next generation, not the next election. And when you look at the next generation, the legislation that this unleashed liberal leadership of Congress asked us to support would allow Arnold Schwarzenegger in California to implement his plan of providing health insurance, quoting from the Washington Post, Schwarzenegger's health insurance plan would require everyone living in California, even illegal immigrants, to have health insurance at an estimated cost of $12 billion. You're changing existing law which requires the applicant to confirm, to verify and to prove that I am a citizen of the United States, you're repealing the requirement that if you are here legally you wait 5 years to apply for public assistance. You're repealing the requirement that if you come here legally that you're not going to become a burden on American taxpayers. Today it is required that you have a sponsor. If you come into the United States legally, I have got to have a sponsor who will sign an oath confirming that I as the sponsor will make sure this person I am sponsoring does not become a burden on American taxpayers.

The SPEAKER pro tempore. The time of the gentleman from Texas has expired.

Mr. LINDER. I yield the gentleman 1 additional minute.

Mr. CULBERSON. Under current law, if I enter the United States legally, I must have a sponsor who signs an oath ''I confirm and I will pay for this new, this person entering the United States legally. I will make sure they don't become a burden on taxpayers.'' That requirement is repealed. When you look at the cost of this legislation to future generations, it's a staggering bill to pass on to our kids. It's an unaffordable burden to add to our children, grandchildren and great-grandchildren's obligation. For the sake of a sound-bite, for the sake of a cheap election slogan, you're passing on an unaffordable burden to our kids when we as fiduciaries, as trustees of the public Treasury, of the public dollar at a time of all these bailouts, the repeated bailouts of Wall Street, of rewarding bad behavior, something that the fiscal conservatives in the Congress have fought, you're now adding to the problem by repealing the citizenship verification requirement. You're repealing the 5-year waiting period. You're allowing States to provide health care coverage to people up to 400 percent of poverty. It's unaffordable. It's unacceptable. It's a dangerous trend. And I hope all of us vote against it.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Members are reminded to address their remarks to the Chair.

Mr. MCDERMOTT. Madam Speaker, I yield 1 minute to the gentleman from California (Mr. THOMPSON).

Mr. THOMPSON of California. Madam Speaker, investing in children's health care is one of the best investments our country can make. When kids see the doctor more regularly, they receive the preventive services that keep them healthier for longer. And they're less likely to end up in the emergency room, which saves everyone money.

The State Children's Health Insurance Program has been an extraordinary success. Over 1.5 million children in my home State of California get their health care through this program. However, today, we still have 1.25 million uninsured kids in California. That is unacceptable in the United States of America.

This bill will begin to address that tragedy by providing health care for almost 700,000 additional children in California alone. As a down payment toward health care reform, this legislation will reduce the percentage of uninsured children, just in California, by 55 percent. Our children deserve a healthy start. And this legislation ensures that 4 million more children across the country will get just that.

I ask for your ''aye'' vote.

Mr. LINDER. Madam Speaker, I yield 4 minutes to my friend from Iowa (Mr. KING).

Mr. KING of Iowa. Madam Speaker, I thank the gentleman from Georgia for yielding time, and I appreciate the privilege to address this issue of SCHIP. This has been a significant frustration to me to grow up in a society where we have respect for the rule of law and fiscal responsibility, or we identify the pillars of American exceptionalism and our charter is to go out and refurbish them. And what we have instead is a bill before us that apparently is a bill that is endorsed by the White House, Madam Speaker, that doesn't reflect these values at all.

And I start down through the issue that is my charge here more than any other in this Congress, and that is what this SCHIP does to undermine the integrity of the restraint that is shutting off, keeping the magnet shut off that attracts illegals into the United States. And it's clear. It's not a number that comes from my side. And it's not a number that comes from an activist group. These are numbers that come from the Congressional Budget Office. The requirement to verify the citizenship of Medicaid applicants by using a verified Social Security number has been taken out of this bill. And that amounts to a cost, according to the CBO, of $5.1 billion federally. It will bring an extra cost on to the States, according to CBO, of $3.85 billion. So just that component, lowering the standard to open the door for anybody that wants to walk in the door and say, well, here is a Social Security number for you, and they will sit there and say, well, we have a government program for you, even though your residence might well be in another state and you may have come across the border illegally, that number of illegals applying for and qualifying under this open rule comes to $8.95 billion between the State and the Federal portion of this.

And then another egregious affront to the standards that we have had since the beginning of immigration law in America was, when you come here, you're to be self-sustained. And Ellis Island, where they processed my grandmother, they sent about 2 percent back because either they weren't physically able to sustain themselves or they didn't have a sponsor. And we had passed a law back in several previous Congresses that sets the 5-year bar where you will have a sponsor and they will be accountable that you will not go on the government dole for 5 years if you are a lawful permanent resident here in the United States. That is gone. That is gone if this bill passes. That is $6.5 billion, Madam Speaker. So those two pieces of this altogether are $15.45 billion in costs that either increase the magnet for legal immigration to come on welfare, open the door and says on the first day you come here, you will qualify for welfare legally. If you come here illegally, you can do the same thing for Medicaid by simply attesting to a Social Security number. It is no longer required to sign a form even that the information is right. That has been waived as well.

If you add these costs all up, there is another huge cost to this, and that is this tax increase. Now, I remember, and I will go verbatim through the quote that came from then-candidate and now our President ''No matter what John McCain may claim, here are the facts. If you make under $250,000 a year, you will not see your taxes increase by a single dime, not your income taxes, not your payroll taxes, not your capital gains taxes, no taxes, because the last thing we should do in this economy is raise taxes on the middle class. And we have been saying that throughout this campaign.''

Now here is this policy that may well land on the President's desk. That is his quote. This is a tax increase on the middle class. It's a tax increase. Ninety-nine percent of this tax increase of the $72 billion that comes goes on the middle class, those people making, by his definition, under $250,000 a year, Madam Speaker. So this is a huge tax increase on the middle class.

And the final piece of this bill, and I think it is actually the biggest one, is that opening up the door beyond 200 percent of poverty and allowing waivers for States to go beyond 400 percent of poverty, in fact, Medicaid for millionaires, sets the stage. This is a foundation stone for socialized medicine in the United States. And I oppose the bill.

Mr. MCDERMOTT. Madam Speaker, I yield 1 minute to the gentlelady from Pennsylvania (Mrs. DAHLKEMPER).

Mrs. DAHLKEMPER. Madam Speaker, I rise in support of SCHIP legislation before us today.

As I have said before, perhaps the most important reason that I ran for Congress was to help ensure that all children in this Nation have access to quality health care. A healthy start in life is something that all children deserve. And I'm particularly pleased that this bill will offer coverage to pregnant women, because I often tell the story of how I could not get coverage during one of the most critical times in my life, the pregnancy of my second child, when it was deemed a preexisting condition by my private insurer.

This legislation, which will be signed by President Obama later today, will expand the SCHIP program to cover an additional 4 million children. This is an accomplishment that our Nation can be proud of.

I urge my colleagues' support of this legislation.

Mr. LINDER. Madam Speaker, I yield 1 minute to the gentleman from Texas (Mr. CULBERSON).

Mr. CULBERSON. I thank the gentleman from Georgia.

To summarize very quickly, 4 minutes goes so quickly, Madam Speaker, I want to make sure that every opportunity I have to speak on this floor and that we as fiscal conservatives remind the American people that this new liberal leadership in Congress has been spending money at the rate of $100 million per minute. Let me let that sink in, $100 million per minute. We've only

been here the first 17 days of this Congress, and this new leadership managed to spend about $1.3 trillion more than the entire annual budget of the United States. And our primary concern about this legislation is that we want to see health insurance for poor American kids first. And the bill you have dropped in front of us is going to open the door for fraud, for illegal aliens to apply, and for people who are here legally to walk in and get coverage. The minute they enter the United States, they become a burden on American taxpayers.

□ 1230

This legislation is going to allow people up to age 21 who earn $80,000 a year to apply for health insurance as if they were poor. It's fiscally irresponsible, particularly at a time of record debt and record deficit. Let us remember the next generation. Let's legislate for the next generation and not the next election.

Mr. MCDERMOTT. Madam Speaker, I yield to the gentleman from California (Mr. BECERRA) 1½ minutes.

Mr. BECERRA. Madam Speaker, 200 years ago America's children would perish from illnesses that today are easily preventable. We benefit from 21st century medical advances and the best trained doctors and providers in the world. Yet 2 years ago, 2 years ago, a young boy at the age of 12, not far from this Capitol died after an infection in an abscessed tooth, an infection that spread beyond that tooth to his brain. Because his family did not have the money to remain on Medicaid coverage, and that Medicaid coverage had lapsed, he was unable, his family was unable to afford the $80 it would have cost to extract that tooth. And so 2 years ago, a young man by the name of Diamonte Driver died in America.

Today we say this is the 21st century and America understands that no one should die of a preventable disease or illness. We have 11 million children in this country who are still uninsured. Today's legislation will make sure that about half of those kids, about 4 million of those kids will be insured, along with seven other million who today benefit on an ongoing basis from this SCHIP legislation.

We know what it was like 200 years ago in America and we know now what it could be like 2 years ago in America. We know that today we must do better for our kids and that is why we pass this legislation today.

Mr. LINDER. Madam Speaker, I reserve the balance of my time.

Mr. MCDERMOTT. Madam Speaker, I yield 1 minute to the gentleman from Virginia (Mr. PERRIELLO).

Mr. PERRIELLO. Madam Speaker, today I rise in support of H.R. 2, the State Children's Health Insurance Program Reauthorization Act of 2009.

At a time of growing unemployment, and when more Americans are losing employer-sponsored health care for their children, this bill is needed urgently for the 150,000 Virginia children currently insured by the program, and the 55,000 more who will be covered.

This approach makes good public health policy. It's morally the right thing to do by our children, and it's good economic policy because it rewards the very families and parents who are working their way out of poverty. At a time when the cost of health care is crushing America's families and America's businesses, this is an important lifeline to extend to children in Virginia and children throughout the country.

While I am in full support of the underlying legislation, I am disappointed to learn that the Senate bill includes a disproportionate increase in the excise tax rate on tobacco products. The proposed tobacco tax could impact jobs and State revenues in already tight times.

The SPEAKER pro tempore. The time of the gentleman has expired.

Mr. MCDERMOTT. Madam Speaker, I yield the gentleman an extra 30 seconds.

Mr. PERRIELLO. In these very difficult times, we are in this together as a matter of public health and as a matter of economic growth.

As the son of a pediatrician, I am pleased to have the opportunity to vote in favor of this critical legislation and in favor of children in the Fifth District.

I urge my colleagues on both sides of the aisle to join me in putting America's children first and cast a vote in favor of this important bipartisan legislation.

Mr. LINDER. Madam Speaker, I reserve the balance of the time.

Mr. MCDERMOTT. Madam Speaker, I yield 1 minute to the gentlewoman from Texas (Ms. JACKSON-LEE).

(Ms. JACKSON-LEE of Texas asked and was given permission to revise and extend her remarks.)

Ms. JACKSON-LEE of Texas. Let me thank the chairman of the full Energy and Commerce Committee, Mr. WAXMAN. Let me thank the manager, Dr. MCDERMOTT, and the chairman of the Full Committee on Ways and Means.

This is a miraculous accomplishment. The children of America are shouting today. It's important to know that there are 8.9 million uninsured children in America. Overall, 11.3 percent of children in the United States are uninsured. That is unacceptable, and it is not befitting of this great Nation.

In Texas we have close to 1.5 million children that are uninsured. Today we say to them that they are a priority, and that their health care and their preventative health care is crucial; that it is not a waste of money. When 74 percent of uninsured children eligible for CHIP, for Medicaid are not enrolled, this is not a waste of money.

I am gratified that pregnant women will have access. I am gratified that they will also have access for certain adults that meet certain criteria; and I am delighted that we still have an opportunity to protect certain hospitals owned by physicians that will continue to serve children that are uninsured as well.

This is a great bill. We should vote on it enthusiastically and continue to work again to enroll more children for this great medical service.

Madam Speaker, I rise today in strong support for the Senate Amendment to H.R. 2—"The Children's Health Insurance Program Reauthorization Act". We stand today, closer to helping 4 million children without health insurance. No longer will these children be forced to live with fear of getting sick. Today is a great day. Today we are able to bring 4 million children in to the fold. Finally, we can tell those 4 million children that are begging for help that Yes We Can!

NATIONALLY AND IN TEXAS

There are an estimated 8.9 million uninsured children in America. Overall, about 11.3 percent of children in the United States are uninsured, but the percentage of uninsured children in each state varies widely. Based on a 3–year average, there were an estimated 20.9% of uninsured children (under 19 years of age) in the State of Texas representing 1,454,000 of the State's children.

According to the Institute of Medicine, uninsured people are less likely to use preventive services and receive regular care. They are also more likely to delay care resulting in poorer health and outcomes. Texas has the highest uninsured rates of all 50 States and the District of Columbia (2005–2007). Almost one-quarter (24.4%) of Texans are uninsured compared to 15.3% of the general U.S. population.

Recent studies estimate that for every 1 percent increase in U.S. unemployment, 1.1 million Americans lose health insurance and more than a million enroll in Medicaid and CHIP. While Texas' 6 percent December unemployment rate remains better than the national average of 7.2 percent, the State rate is up from just 4.2 percent in December 2007. Widespread job losses continue, and leading economists predict that absent dramatic government action, the national unemployment rate could reach 10 percent by 2010. Many states, including Texas, already experience much higher Medicaid enrollment than projected due to job loss and lower incomes, and will be unable to support the higher demand without this relief.

HOW DOES CHIP HELP TEXAS FAMILIES?

According to 2004 U.S. Census data, Texas has the highest rate of uninsured children in the country with 21.6% of children in Texas lacking health insurance coverage.

Nearly 90% of uninsured children in Texas have at least one working parent. The high cost of health insurance means that it is unaffordable for many Texas families. According to the Milliman Medical Index, the annual cost of health insurance for a family of four is $13,382.

Although many Texans have employer sponsored health care insurance, many cannot get affordable coverage for dependents through an employer.

National data shows that virtually all the net reduction in SCHIP enrollment has been among children in families with incomes below 150% FPL. I want to share with you just some of the scary health statistics that are affecting children:

74% of uninsured children eligible for SCHIP or Medicaid but not enrolled.

11% of uninsured children in families not eligible for Medicaid or SCHIP with incomes below.

15% of uninsured children in families with incomes over 300 percent of the federal poverty-level who are ineligible for Medicaid and SCHIP.

90% of uninsured children that come from families where at least one parent works.

50% of two-parent families of uninsured children in which both parents work.

3.4 million uninsured children who are white, non-Hispanic.

1.6 million uninsured children who are African American.

3.3 million uninsured children who are Hispanic.

670,000 uninsured children of other racial and ethnic backgrounds.

PHYSICIAN-OWNED HOSPITALS

I am very pleased to see that this new version does not include the restrictions on physician owned hospitals. Along with many of my colleagues, I have been very concerned that we had with the prohibition on physician-owned hospitals. Which is why I worked with my colleagues to ensure that this language was not included.

In my district of Houston, Texas the population has grown close to 4.5 million people and there are only approximately 16,000 beds available in the city. Physician-owned hospitals like St. Joseph Medical Center in my district provide essential emergency, maternity, and psychiatric care for their patients. They delivered over 6,000 babies in 2008, of which 3,700 were insured by Medicaid. Currently they provide $14M in uninsured care in the Houston Market. A Houston Institution for 120 years, St. Joseph Medical Center is also a major provider of psychiatric beds as it currently operates 102 of the 800 licensed beds in Houston.

In 2006, St. Joseph Medical Center, downtown Houston's first and only teaching hospital was on the verge of closing its doors. When I learned that they were going to shut down this hospital and turn it into high-end condominiums, I personally worked with the hospital board, community leaders, and local government to ensure this did not take place.

Eventually, after I was assured that it would be responsibly managed and it's doors would remain open, I was able to help a hospital corporation, which, in partnership with physicians, purchased the hospital and has made it the premier hospital in the region to keep open St. Joseph's doors including its qualified emergency room responsive to a heavily populated downtown Houston. This formerly troubled medical center is now in the process of reopening Houston Heights Hospital, the fourth oldest acute care hospital in Houston.

ROBIN FROM TEXAS—HER STORY

Her daughter has a developmental disorder, known as autism. She was not certain of the extent or the prognosis diagnosis of her disorder due to her lack of funds being a single mother, and lack of quality health insurance. She is one of the many uninsured in Texas.

She scraped together money to take her daughter to the doctor when she gets sick and does not pay her electricity bill so she can pay for 30 minutes of private speech therapy a week to complement what the school system provides.

She cannot qualify for SSI or Medicaid, they say she makes just over the maximum allowable income. She had trouble qualifying for CHIP in the past as well. Sadly once this mother has paid for daycare, speech therapy, clothing, car insurance, food, shelter , transportation, the rising cost of gasoline etc., she can barely afford to pay her monthly bills let alone quality insurance on her salary.

Robin wants the American dream for her and her daughter, but she is unable to obtain it. She is stuck in an old apartment building, with an even older car, and inadequate health coverage for her sweet 7 year old daughter. God help us, Robin and the many like her and her daughter deserve better.

THE ECONOMIC AFFECT ON HEALTHCARE

The economy has now lost 1.2 million jobs since the beginning of the year, with nearly half of those losses occurring in the last three months alone, pointing to acceleration in the pace of erosion in labor markets. It is more important than ever in this economy that children's healthcare is not sacrificed.

Madam Speaker, my faith is renewed in the process that is so often maligned in the media. Thoughtful and deliberate negotiations were taken to advance this legislation—and through your leadership we have succeeding in bringing this to the floor for passage.

I look forward to a day when every child is covered and can play on football fields and jungle gyms without their parents fearing a bankrupting injury to their child. This legislation is piece of mind to 4 million families and I will joyfully cast my vote for passage of this important legislation.

Mr. LINDER. Madam Speaker, can I inquire as to the time remaining on each side?

The SPEAKER pro tempore. The gentleman from Georgia (Mr. LINDER) has 2 minutes remaining. The gentleman from Washington (Mr. MCDERMOTT) has 4½ minutes remaining.

Mr. LINDER. Madam Speaker, I reserve.

Mr. MCDERMOTT. Madam Speaker, I listened to fiscal conservatives rail against this bill, and I think about an article I read in this morning's Washington Post. Over in Arlington, which is just across the river, they have a clinic where people go who don't have health insurance and hope that their number is drawn from a lottery so that they can get to see a doctor. Our health care system is in serious problems, from the seniors all the way down to the young people in this country.

Now, this bill says to the States, here's some additional money for you to expand coverage to your youngsters. Through no fault of their own, they're born into a home where there is no way to pay for health care. And we are giving the States, in this time of economic collapse brought on by the fiscal conservatives in this body, who said that we could spend and spend and spend, and never have to meet the day of reckoning, the people who are now going to suffer from that will be women and children.

Children have nobody to speak for them but us. And for us to put that money out there and give them the opportunity to have health care is humane in the very strongest sense of that word.

How anybody could vote against this, I have no idea, after you've wasted a trillion dollars on a war in Iraq, and have the real estate industry totally out of control, and then you say to the children, you can't see a doctor. What kind of body is this if we don't take care of children?

I yield the remaining 3 minutes of my time to Mr. WAXMAN.

Mr. WAXMAN. Madam Speaker, we wish to reserve our time to close the debate.

Mr. LINDER. Madam Speaker, I would like to point out that nobody on this side opposes children. The SCHIP program was started under the Republican majority in 1997, principal sponsor being Republican Senator ORRIN HATCH.

We believe the program was a good start in allowing for the health coverage of children whose parents did not qualify for Medicaid. What will destroy this program is a lack of restraint and irresponsible expansion of it.

It is true we are in the midst of a global economic collapse. And what has caused that? Abuse, lack of restraint, corporate leaders spending other people's money, shareholders, ignored limitations, ignored risks, ignored warning signs, and gave us the problem we have in the economy.

What makes us different? We are spending other people's money and we're spending more and more of it. We have a GAO study that says that if we continue to spend in our discretionary spending at the current percentage of the overall economy, and if we continue to tax at 19 percent of GDP, which is about the average since 1945, that in just 31 years from today, the entire Federal revenue stream will be insufficient to pay the interest on the debt because of entitlements, Social Security, Medicare, which is much worse than Social Security, Medicaid.

And to solve those programs in the face of President Obama's desire to get a handle on entitlements, we stand here today proposed to add a new one. It is true that this is designed as a block grant program. But there are no limitations on it. This will go out of control just like all of the other programs have, and our children will pay.

Madam Speaker, I hope we all oppose this.

Mr. WAXMAN. Madam Speaker, Members of the House of Representatives, this bill is going to pass by an overwhelming bipartisan majority, as it passed in the last Congress as well, at least twice. But the difference is, this bill will be signed tonight by the President of the United States.

President Bush vetoed this children's health bill twice. And it is interesting to review the arguments he gave for rejecting the legislation. First of all, he said, there's no problem for children getting health care when they need it. They can always go to an emergency

room of a hospital. Of course, the care in an emergency room of a hospital is the most expensive care, and it often means that the child has gotten sicker than otherwise would be the case and is forced to go to that emergency room as the only option.

And the second reason he gave for vetoing the bill is, to me, one of the most astounding. He said, why should taxpayers subsidize parents for their children's health insurance if the parents could afford to buy a private health insurance plan for their own children? Well, many parents just can't afford it or will not have that as an opportunity because of a pre-existing medical condition. But think of that argument.

Suppose the President of the United States said, we ought not to have public schools for children whose parents could afford to send them to private schools. I find that a remarkable argument for him to have made.

We, in this country, should value the opportunity for every child to succeed to the fullest extent of his or her ability, and that means education for all children and health care when those children need it.

We will see the President of the United States sign this bill tonight because election results make a difference. And we will have a President who will sign this bill into law, along with a bipartisan majority in the House and the Senate. And that will be a happy day for America's children.

Mr. ENGEL. Madam Speaker, today is another great day for American families. Later this afternoon, President Obama will sign the State Children's Health Insurance program Reauthorization into law.

Just one week ago, President Obama signed the Lilly Ledbetter Fair Pay Act into law—a bill which restores basic protection against pay discrimination. When women do better, families do better, and the Lilly Ledbetter Act will make it easier for families to pay for day-to-day expenses like groceries, child care and doctor's visits.

We build on the enactment of family security legislation today by providing health care coverage for 11 million children. In this commonsense legislation, we will preserve coverage for the roughly 7 million children currently covered by SCHIP and extend coverage to 4.1 million uninsured children who are currently eligible for, but not enrolled in, SCHIP and Medicaid.

As the third largest S-CHIP program in the nation, New York reduced the number of uninsured children in the State by 40%. We are only one of seven states to achieve a decline of that magnitude and I am so pleased that we will further strengthen children's access to health care today.

During this time of economic distress, we must remember that the S-CHIP program is a critical part of our health care safety net and more broadly our family security safety net. S-CHIP has served New York and our country well, and I commend the Speaker for working so diligently on behalf of our nation's kids.

Mr. TOWNS. Madam Speaker, esteemed colleagues on both sides of the aisle, I stand before you today, one happy man. I am happy that I have the opportunity to vote in favor and hopefully bear witness to the passage of this momentous bill, the State Children's Health Insurance Program Reauthorization Act.

Our great leader, Dr. Martin Luther King Jr., once famously remarked, "Of all the forms of inequality, injustice in health care is the most shocking and inhumane." I wholeheartedly agree with Reverend King's sentiments and I would like to take his statement one step further. I contend neglecting adequate health care for all of our children is perhaps the most disgraceful and appalling atrocity this nation faces.

Today we have an opportunity to take one step towards rectifying the wrongs of our past. Today we have the opportunity to vote in favor of a bipartisan piece of legislation that would expand health care to more than 11 million children nationwide and preserves the coverage of 7.1 million children through 2013.

This fine piece of legislation will reduce the number of uninsured children in my state by 66%; reducing the number from 400,000 to approximately 267,000. I don't know about you, but that's the type of change I can believe in.

The State Children's Health Insurance Program catches the most overlooked segment of our population—those families and children that earn too much to qualify for Medicaid but too little to afford private health insurance. This land-breaking and much needed piece of legislation will provide coverage to those families that are eligible for but not yet enrolled in SCHIP and Medicaid.

The legislation is truly bipartisan in nature, and is supported by numerous organizations including the American Hospital Association, AARP, and families USA.

My Democratic friends and Republican comrades, I urge you to take a stand against health injustices and take a stand for our children. I urge you to vote in support of the Children's Health Insurance Health Program Reauthorization Act.

Ms. HIRONO. Madam Speaker, I rise today in strong support of H.R. 2, the Children's Health Insurance Program (CHIP) Reauthorization Act. Our nation must show true compassion for the most vulnerable among us, and CHIP helps millions of low-income children receive healthcare.

The last time we had a floor debate on H.R. 2, there were references made by those in opposition to the bill to a program in my state called Keiki Care. It was suggested by those individuals that the Keiki Care program was cancelled due to perceived crowd-out, where parents drop their children's private insurance in order to enroll into a free government program.

That claim was entirely false, and I join Congressman ABERCROMBIE in correcting the misstatements made by the opposition. The Keiki Care program did not have an issue with crowd-out. It was intentionally designed so that those who wish to enroll in the program must be continuously uninsured for six months. There was also no spike in program enrollment that even suggests that parents were indeed dropping their private insurance to join. I would like to insert into the RECORD a fact sheet on Keiki Care published by the group Hawaii Covering Kids.

In Hawaiian, "keiki" means "child" or taken literally "little one." H.R. 2 is a bill that provides for the health and well-being of the keiki most in need of our help. I urge my colleagues to join me in voting in support of H.R. 2 today.

KEIKI CARE

GOAL

All children and youths living in Hawai'i are enrolled in health insurance.

CHILDREN'S HEALTH

Compelling national health care statistics drive Hawai'i Covering Kids' goal:

Children who are uninsured are twice as likely not to receive any medical care;

Only 45% of uninsured children had one or more well-child visits in the past year compared with more than 70% of insured children;

More than one in three uninsured children do not have a personal physician; and

Uninsured children are less likely to receive proper medical care for common childhood illnesses such as sore throats, earaches, and asthma.

BACKGROUND INFORMATION

Approximately five percent of Hawai'i's children and youths are uninsured statewide which means over 16,000 kids do not have health insurance. Hawai'i Covering Kids sponsored meetings in October 2006 and January 2007 to determine the "gap groups" and possible solutions. We concluded these children and youths are most likely uninsured:

Eligible for QUEST or Medicaid Fee-for-Service in households between 251–300% FPL but parents cannot afford monthly premium payments;

In families with incomes above 300% FPL and parents cannot afford private health insurance;

Have temporary visas (V, H, K, etc.);

Undocumented immigrants; and

Student dependents (F2 visa) whose parents cannot afford university health insurance plans.

2007 INITIATIVE

The Hawai'i State Legislature introduced HB1008, now Act 236, to help uninsured children and youths in the gap groups. It included paying QUEST and Medicaid Fee-for-Service monthly premiums for children between 251–300% FPL and establishing a free Keiki Care plan for children ages 31 days to 19 years old who are ineligible for public health insurance. The Keiki Care plan is modeled after the low-cost HMSA Children's Plan with limited benefits and some out-of-pocket expenses. It requires the child live in Hawai'i and be continuously uninsured for six months. Exceptions to the six-month uninsured provision include: (1) children who "income out" of QUEST or Medicaid Fee-for-Service, (2) children enrolled in a managed care children's plan on the effective date (one-time only exemption), (3) newborns uninsured since birth, and (4) children in families affected by Aloha Airline's bankruptcy.

TIMELINE

3 May 2007—HB1008 HD2 SD2 CD1 Passed by the Legislature;

30 June 2007—Signed by the Governor as Act 236;

1 March 2008—Enrollment Commenced;

1 April 2008—Keiki Care Effective Date.

ENROLLMENT

1 April 2008—1,827;

1 November 2008—2,021.

CROWD-OUT

Hawai'i has never experienced problems with parents dropping their children's private health insurance to enroll them in public-financed programs. Keiki Care specifically discourages this tactic (called "crowd-out") through an eligibility requirement that each child must be uninsured continuously for six months, limited benefit package, and some out-of-pocket expenses. The

fact enrollment in November 2008 isn't significantly greater than when Keiki Care began illustrates crowd-out prevention is working.

OUTREACH

Hawai'i Covering Kids has conducted intensive outreach through broadcast emails to state and community partners, mailouts to statewide outreach workers, web site information, 211 hotline referrals, and natural points of contact including community health centers, hospitals, public health nurses, Head Start, WIC, and schools.

ECONOMIC IMPACT

The modest investment in Keiki Care pays off in several significant ways. It supports healthier children, confident parents, and reliable payments to health care providers while preserving precious charity care and limited uninsured funds for those who are uninsurable. Keiki Care empowers parents by connecting their children to a pediatrician and regular preventive health care. Should a sudden illness or injury occur, the children are also insured for emergency care which averts personal and institutional financial crises. In fact, as the number of insured kids has increased in Hawai'i, hospital emergency department data for 2000–2006 show that visits by uninsured children and youths have declined from 5.25% to 3.79%.

KEIKI CARE HELPS HAWAI'I'S ECONOMY

(By Barbara Luksch)

Imagine your child awakens in the night with an asthma attack and needs health care. The coughing and breathing worsen, however your child has no health insurance. You struggle to pay for food, rent, and other basic living expenses and are fearful of the hospital emergency room because of potentially ruinous medical bills. What do you do?

This dilemma is familiar for thousands of parents and guardians of uninsured children and youths throughout Hawai'i. As state budgets face monetary shortfalls, taxpayers should know it is cheaper to cover kids with health insurance than cover expensive hospital costs for uninsured kids. That is why federal, state, and community organizations collaborated to create Keiki Care for uninsured children and youths in ''gap groups''—those who do not qualify for public health insurance and their parents cannot provide private health insurance. It should be clarified that specific provisions discourage parents from dropping their children's private health insurance to enroll in Keiki Care: (1) child must be continuously uninsured for six months, (2) limited health care benefits, and (3) out-of-pocket expenses.

A modest investment in Keiki Care helps Hawai'i's economy because should a sudden illness or injury occur, children are insured for emergency care which averts personal and institutional financial crises. In fact, as the number of insured kids has increased in Hawai'i, hospital emergency department data for 2000–2006 show that visits by uninsured children and youths have declined from 5.25% to 3.79%.

Keiki Care also empowers parents by connecting their children to a pediatrician and regular preventive health care. Compelling national health care statistics published in a recent Covering Kids & Families ''State of Coverage'' report support this: (1) children who are uninsured are twice as likely not to receive any medical care, (2) only 45% of uninsured children had one or more well-child visits in the past year compared with more than 70% of insured children, (3) more than one in three uninsured children do not have a personal physician, and (4) uninsured children are less likely to receive proper medical care for childhood illnesses such as sore throats, earaches, and asthma.

Parents with uninsured children often face hard choices . . . pay the electric bill or pay the doctor; fill the refrigerator or fill a prescription. That is why uninsured children often go to school without annual checkups and may not participate in co-curricular activities—not only because their parents fear an injury, but also because they fear the impact medical bills could have on their family budget.

Overall, Keiki Care supports healthier children, confident parents, and reliable payments to health care providers while allocating precious charity care and limited uninsured funds for others who are uninsurable.

Mr. HARE. Madam Speaker, I rise once again in strong support of the State Children's Health Insurance Program Reauthorization Act (also known as SCHIP). I commend the Senate for acting so promptly on the measure and the leadership of this House for bringing it to the floor for its final vote.

One of the biggest moral failures of our nation is the fact that we allow nine million children to go without health insurance every day in the United States. This is unacceptable. Our children are the future of this great nation—a future that is compromised every day we let a single child go without health care.

Since its inception, SCHIP has successfully filled the gap between those families qualifying for Medicaid and those who can afford private health insurance. In these times of economic hardship, SCHIP creates a fundamentally important safety net, providing health coverage for seven million low-income children; 345,000 children in Illinois.

The legislation before us today reauthorizes the SCHIP program through Fiscal Year 2013, enabling states to maintain their current programs and extend them to an additional 4 million children.

SCHIP is the first critical step to improving health coverage across the nation. I urge my colleagues to vote yes on H.R. 2 and finally send it to the President's desk.

Mr. VAN HOLLEN. Madam Speaker, I rise in strong support for the Children's Health Insurance Program Reauthorization Act of 2009.

This bipartisan legislation will improve the very successful State Children's Health Insurance Program (CHIP). The message and the substance of this bill is clear—we are going to preserve coverage for the 7 million children currently enrolled who otherwise have no access to health insurance while extending coverage to 4 million children who are from working families who earn too much to qualify for Medicaid, but do not earn enough to afford the very high costs of private health insurance.

By reauthorizing this important program through 2013, we will strengthen CHIP's financing, improve the quality of health care children receive, and increase health insurance coverage for low-income children. The Congressional Research Service projects that under this legislation, Maryland's CHIP allotment will increase by 162 percent. The bill is fully paid for by a 62 cent increase in federal excise taxes on cigarettes. Increasing the tobacco tax will save millions of children from tobacco addiction and save billions in health care costs. The 2000 U.S. Surgeon General's report found that increasing the price of tobacco products will decrease the prevalence of tobacco use, particularly among kids and young adults.

Just two weeks ago, a new President was sworn into office—President Obama. Passing this bill and sending it to his desk now sends a very important signal that change has come as a result of the last election. President Obama's predecessor twice vetoed this legislation. The new President will sign this legislation into law because he understands the hardships that American families are struggling under at a time when millions of Americans have lost their jobs and lost health coverage for their children.

Madam Speaker, let's look out for America's children by providing them the health insurance coverage they deserve. I urge my colleagues to vote for this much-needed legislation.

Mr. HASTINGS of Florida. Madam Speaker, for over a decade the State Children's Health Insurance Program (SCHIP) saved millions of America's low-income families from suffering the consequences of living without healthcare insurance, and exemplified our nation's commitment to equal opportunity.

Former President Bush twice prevented this critically important program from benefiting people who fell through the cracks of America's flawed healthcare system.

Thankfully, the new Congress and Administration exercised the power and political will to make a different choice. Finally, the American people can rest assured that Congress' vote to provide healthcare coverage to 11 million low-income children will not be in vain.

The Senate-amended SCHIP bill authorizes 32.8 billion dollars over 4½ years to cover the 7 million children who currently rely on SCHIP, and extends coverage to more than 4 million low-income children who are currently living without healthcare.

The bill also offers comprehensive and wide ranging care that includes mental, dental, prenatal and maternal health services, increases health insurance enrollment, and fights geographical health disparities by offering additional support to under-funded states.

Madam Speaker, the SCHIP program is known by different names around the country. But whether it's called Healthy Families, Health Wave, Healthy Steps, or Kid Care, SCHIP's mission remains the same—providing children from hard working low-income families with the care that they need and deserve.

Thirteen years of SCHIP has shown that this program helps to decrease costly emergency room visits and invasive medical procedures. We know that extending healthcare insurance helps to combat the social, economic, and health disparities that continue to divide our nation and hinder our progress. And, we know that healthy children are better equipped to compete in school and help America compete in the global market. The facts are clear. Missed school days from untreated asthma, tooth decay and mental health disorders and other illnesses are also missed opportunities for our children to reach their full potential and successfully compete.

However, some House and Senate Republicans were driven by ideological affiliation instead of economic prudence and moral obligation and attempted to halt the passage of this bill despite the fact that 19 states enacted budget cuts to SCHIP and Medicaid for 2009.

The 2008 financial crisis clearly exacerbated our long standing healthcare crisis and therefore failing to pass SCHIP would be disastrous in these hard economic times.

Last year, skyrocketing gas and food prices, and the plummeting job market made it difficult for low- and middle-income Americans to

finance their everyday needs—including healthcare. In 2008, one million additional children enrolled in Medicaid or SCHIP as a result of lost employment issued insurance.

In a country where a large portion of people receive healthcare insurance through their employer, it comes as no surprise that when the economy and job market plunge, the number of uninsured Americans soars. And children frequently pay the highest price.

This issue hits close to home. My state of Florida was recently ranked 45th in the nation in terms of overall health. Like other low ranking states, Florida has a large uninsured population and a high rate of child poverty. In fact, Florida has the second largest number of uninsured children in the country. What's more, a disproportionate number of Florida's uninsured and low-income children are black, Hispanic and reside in rural areas.

However, the targeted provisions in the 2009 SCHIP Reauthorization bill give us reason to be hopeful. Make no mistake. SCHIP and other emergency and supplemental programs cannot repair the problems that are intrinsic in America's healthcare system. State, local and federal entities must execute a coordinated effort to lessen the burden of uninsured people in this country as we embark on the road to long-term economic and healthcare development.

President Obama signing the 2009 SCHIP bill into law is a noble beginning to achieving healthcare reform, and sends a strong message to our nation's children.

In 1981, the member of the Select Panel for the Promotion of Child Health said, ''Children are one third of our population and all of our future''.

SCHIP is as much of an investment in addressing the issues of today as it is to ensure the welfare of our nation's economy and competitiveness tomorrow. I am pleased to see that we are giving millions of children the basic health benefits they rightly deserve.

Mr. BACA. Madam Speaker, I rise today in strong support concurring to the Senate Amendment to H.R. 2—The Children's Health Insurance Program Reauthorization Act.

In my District, home foreclosures and unemployment are devastating many families with no end in sight. A facility in my district, the Community Hospital of San Bernardino is being forced to eat the costs or turn children away.

This bill will provide needed health care to our most vulnerable, our most in need, America's children. With this bill, the state of California alone will be able to cover an additional 694,000 children who are currently uninsured.

SCHIP benefits will be further improved, providing for all children enrolled in SCHIP to receive dental coverage. Parents should not have to choose between putting food on the table or paying for health insurance.

For too long we've faced partisan debates that only hinder our efforts. We now have the ''change'' voters want.

I urge my colleagues to help these families, do the responsible thing and vote for S–CHIP.

Mr. MEEK of Florida. Madam Speaker, I rise in full support of H.R. 2 and am proud to cast this vote in favor of it.

Providing health care coverage for 11 million children has been a top priority of mine and the vast majority of both the 110th and 111th Congresses.

And, after several attempts, we are now only minutes away from sending this important legislation to a President that we know will sign it the moment it lands on his desk.

This is a great piece of the change promised in November and a win for the families of 4.1 million currently uninsured children. In my home state of Florida, passage into law of this bill will mean that 290,000 children will have affordable access to healthcare that they do not have right now. That will lessen the number of uninsured children in Florida by 36%.

This bipartisan legislation renews and improves SCHIP, providing health care coverage for 11 million children—preserving coverage for the roughly 7 million children currently covered by SCHIP and extending coverage to 4.1 million uninsured children who are currently eligible for, but not enrolled in, SCHIP and Medicaid.

Covering more eligible children is not only the right thing to do—it's also much more cost-effective for taxpayers than using the emergency room as a primary care provider. In addition, a healthy child is better prepared for learning and success.

I commend the willingness of those who are paying for this legislation, particularly the small businesses, local cigar importers, who showed a great willingness to do their part to see the SCHIP legislation passed despite the sacrifices they will have to make.

This is a proud day in the House of Representatives. I ask all of my colleagues to join me in voting for this important legislation.

Mr. GENE GREEN of Texas. Madam Speaker, I rise today in support of final passage of H.R. 2, the Children's Health Insurance Program Reauthorization Act of 2009.

This bill should have been passed last year, but after working on this bill for an entire Congress, I am pleased with the final version before us today.

This bill will extend the SCHIP program for four and a half years and provide SCHIP coverage for the 7 million children already enrolled in the SCHIP and will insure nearly 4 million additional children.

The bill also includes a provision that will give 400,000 to 600,000 legal immigrant children access to health care. These children are currently barred from SCHIP coverage because of a five year waiting period for Medicaid for legal immigrants.

This provision, which was originally in H.R. 465, the Immigrant Children's Health Improvement Act, will give states the option to cover children and pregnant women lawfully residing in the United States.

Current law requires these legal immigrants to endure a five year waiting period before they have access to Medicaid coverage when they would otherwise be eligible.

The waiting period actually costs more than covering these children because they often have no health insurance and end up in emergency rooms for primary care treatment.

The SCHIP reauthorization bill also includes language from a bill I originally introduced and will give one year of emergency Medicaid coverage for children born in the U.S. and their mothers, which is crucial in protecting the health and wellness of newborns born in this country.

I hope my colleagues will join me in supporting this legislation and reauthorize the SCHIP program to extend coverage to nearly 11 million low-income children.

Mr. SMITH of Texas. Madam Speaker, I oppose this bill for many reasons. In my role as the Ranking Member of the Judiciary Committee, though, I want to point out a few immigration provisions that undermine personal responsibility and burden American taxpayers.

In 1996, Congress required that legal immigrants wait five years after coming to the United States before receiving welfare benefits.

It's only fair that American taxpayers not foot the medical bills of foreign nationals who arrive with a sponsor's pledge not to let them become a ''public charge.''

This bill, H.R. 2, changes current law and allows immigrants to get medical benefits at the expense of U.S. taxpayers.

The five-year waiting period for immigrants to receive government benefits is the last line of defense for the U.S. taxpayer. It should not be repealed or altered.

Prior to 1996, the cost of welfare for immigrants had jumped to $8 billion a year. The number of noncitizens on Supplemental Security Income increased more than 600 percent between 1982 and 1995. Both of those numbers will be much higher if H.R. 2 is enacted.

At a time when government spending is out of control, and when states, cities and American citizens are struggling to make ends meet, the last thing we need is to change good policy and further burden U.S. taxpayers.

This legislation should be opposed.

Mrs. CAPPS. Madam Speaker, I rise today in support of this bill and in support of America's children.

As someone who spent over 20 years of my life as a school nurse dedicated to the betterment of children's healthcare, I can think of nothing greater than fulfilling the promise of quality healthcare for all deserving children.

It was with great frustration I watched as President Bush repeatedly vetoed our proposals to improve the Children's Health Insurance Program.

And I could not be prouder to know that the bill we pass today will be signed into law thanks to the commitment of President Obama to our nation's children.

Signing this bill into law will mean 4 million more children get the care they need.

Four million more children won't have to unnecessarily miss days of school because of preventable illness.

Four million more children's parents won't have to wait in the emergency room for their daughters and sons to receive routine care.

Earlier today I met with a school nurse who relayed to me that a child in her school district was injured on the playground and they can't find a doctor to perform a necessary MRI because the child is uninsured.

I wish this was an isolated incident and that no other parent had to take their son from doctor to doctor and pray that someone will perform the procedure for free.

But it is all too common.

Passage of this legislation today may not help this one child's family in time, but we can be sure that four million more children's parents can take comfort that they will not ever face this situation in the future.

I urge my colleagues to vote for this legislation and in favor of our children's future.

Mr. MARKEY. Madam Speaker, I rise today in strong support of the Senate-amended version of the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009.

I am proud to be an original cosponsor of this important legislation to expand the highly

successful State Children's Health Insurance Program (SCHIP). This bill will provide health insurance to an additional 4 million low-income children on top of the nearly 7 million who already benefit from the program. CHIPRA also improves access to dental care and mental health services and includes provisions to improve quality of care and utilize health information technology for children.

In my home state, SCHIP enrollment is part of the reason why Massachusetts has the lowest rate of uninsured children in the country. More than 180,000 Massachusetts children receive health coverage through SCHIP, and this reauthorization will allow the state to cover about 56,000 more Massachusetts children who currently do not have health insurance.

It is unfortunate that the previous two attempts to reauthorize SCHIP were vetoed by President Bush, who chose to side with big corporations over children. With the current economic crisis causing significant job losses, millions of Americans also are losing their health coverage, making today's vote even more urgent.

While President Bush twice dashed the hopes of millions of low-income families in need of health care for their children, the Obama administration recognizes the value of ensuring that all low-income children get the health care they need.

Three weeks ago this chamber approved CHIPRA by a larger margin than the two votes on SCRIP bills in the 110th Congress. I urge my colleagues to once again stand with the hard working families who want to provide their children with the health care they need. Vote yes on this critical legislation.

Mr. ETHERIDGE. Madam Speaker, I am a strong supporter of the Children's Health Insurance Program, and I rise in support of this legislation. With one out of eight children in North Carolina lacking health insurance, and with the economic downturn making it even more difficult for families to afford health care, this legislation is more important than ever.

At the same time, I feel it is important to say a few words about fairness. Time and time again, Congress has singled out tobacco to pay for benefits that are spread across this country's economy. North Carolina's tobacco farmers grow a legal crop. These hard working farm families who work hard to be able to pay their bills and provide a better life for their children have suffered greatly from transformations in the global economy. Because my district is the second largest tobacco producing district in the country, H.R. 2 disproportionately affects my constituents. It is unfair for North Carolina's farm families to pay the entire cost of this bill, which has benefits that accrue to the entire country. We must find more equitable ways to pay for worthy initiatives like the Children's Health Insurance Program, and I urge my colleagues to work together to be fiscally responsible without placing the burden on one region of the country or one segment of the economy.

In these difficult economic times, North Carolina will need additional help to bear the economic effects of reduced farming and manufacturing. According to researchers at North Carolina State University, increased taxes and decreased revenues due to the provisions in this bill may be more than $1 billion. Other analysis shows that North Carolina's citizens pay over four percent of the costs of this legislation while receiving only two percent of the benefit. This will mean lost jobs in a region that is already one of the top ten in the nation in unemployment, and is one of the top five fastest areas in unemployment growth. I am hopeful that we can work together to get my home State the economic support it needs to weather both the national economic downturn and the effects of this bill.

At the same, it is vital that we expand and extend CHIP to provide much-needed health care to our most vulnerable citizens. North Carolina has 296,000 uninsured children, the sixth-largest number in the country, and nearly half of these children would be able to get insurance under the provisions of this bill. Together with the 240,000 children currently served by NC Health Choice for Children, the new enrollees would be able to get the health care they need. Preventative care and timely treatment of disease ensures that children are healthy and productive, able to fulfill their potential. Access to health care also saves money for our health system in the long term, because it is more cost-effective to get primary care at a doctor's office than to go to the emergency room.

The bill improves the benefits available under CHIP, including by ensuring dental coverage and mental health parity. It improves the quality of care, and prioritizes coverage for the lowest-income children. Together these provisions will enhance children's lives and keep children from suffering from preventable disease.

As North Carolina's former Superintendent of Public Instruction, I have seen first hand that healthy children are better prepared for learning and success. My life's work has been to help children make the most of their God-given abilities, and CHIP plays a key role in giving children the environment they need to grow. Therefore, despite my misgivings about the funding mechanism, I will cast my vote in favor of H.R. 2.

Madam Speaker, as we work together to provide health care to America's children, we should all remember the family farmers who grow tobacco. I ask that we take steps in future legislation to help all of those who are negatively impacted by provisions of this bill, especially including families in the Second District of North Carolina. However, today, for our children's health, I urge my colleagues to join me in supporting this bill.

Mr. REYES. Madam Speaker, I rise in strong support of H.R. 2, the State Children's Health Insurance Program (SCHIP) Reauthorization Act of 2009, as amended by the Senate.

At this time, the reauthorization of SCHIP is critically important for the nation and particularly my district of El Paso, Texas, where over 20,000 children in El Paso County are enrolled in the program. My district has one of the highest rates of uninsured children in the country, and the current economic recession is making it even harder for many more families to afford health insurance.

I am deeply troubled that Texas has the highest number of uninsured children in the United States. It is simply unacceptable to have one in five children in my state without health insurance, and this legislation will expand coverage for millions who are uninsured.

The current economic recession is affecting many families across our nation. Recent studies estimate that for every one percent increase in our national unemployment rate, 1.1 million Americans lose health insurance and more than a million enroll in Medicaid and SCHIP.

Having a large number of uninsured children in our communities places a tremendous financial burden on parents and local hospitals, as families are forced to send their children to the emergency room because they cannot afford a regular doctor's visit. For the families of the children in El Paso and throughout our country who rely on SCHIP for scheduled checkups, prescriptions, eyeglasses, this program is vitally important. The cost of health care is ever-rising, and reauthorizing SCHIP for the next four and a half years is an important first step in stemming the rising tide of the uninsured.

Today's bill provides sufficient federal funds to help states maintain their current programs and extend coverage to four million additional uninsured low-income children. Many states may experience much higher enrollment in SCHIP than projected due to job loss and lower incomes, and many would be unable to support the higher demand without this relief. By reauthorizing this program, we help states meet increased demand for SCHIP-enrollment and prevent them from cutting back on the program just when families need it the most.

The health and quality of life of our children must be a priority, and I firmly believe that this bill addresses the need to provide quality health care to our Nation's uninsured children especially in a time of economic recession. For this reason, I am proud to support this legislation, and I applaud President Obama and my colleagues in Congress for this a top priority.

Mr. ABERCROMBIE. Madam Speaker, it is my understanding that Section 214 of the Children's Health Insurance Program Reauthorization Act of 2009, H.R. 2, would apply to the citizens of the Republic of Palau, the Republic of the Marshall Islands, and the Federated States of Micronesia.

According to the Compact of Free Association negotiated and agreed to by the United States, the citizens of these countries are here legally. However, the federal government currently does not provide any financial assistance to states to pay for the care of these individuals through such programs as Medicaid or SCHIP. Since Section 214 of this bill applies to those legally residing in the United States, I believe this clearly includes the citizens of the Republic of Palau, the Republic of the Marshall Islands, and the Federated States of Micronesia. Therefore, Madam Speaker, as this bill moves forward, it is my hope that compact migrants will be treated fairly under this new law.

The SPEAKER pro tempore. All time for debate has expired.

Pursuant to House Resolution 107, the previous question is ordered.

The question is on the motion by the gentleman from California (Mr. WAXMAN).

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. LINDER. Madam Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

The SPEAKER pro tempore. Evidently a quorum is not present.

The Sergeant at Arms will notify absent Members.

The vote was taken by electronic device, and there were—yeas 290, nays 135, not voting 8, as follows:

[Roll No. 50]

YEAS—290

Abercrombie
Ackerman
Adler (NJ)
Altmire
Andrews
Arcuri
Austria
Baca
Baird
Baldwin
Barrow
Becerra
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boccieri
Bono Mack
Boren
Boswell
Boucher
Boyd
Brady (PA)
Braley (IA)
Brown, Corrine
Buchanan
Butterfield
Cao
Capito
Capps
Capuano
Cardoza
Carnahan
Carney
Carson (IN)
Castle
Castor (FL)
Chandler
Childers
Clarke
Clay
Cleaver
Clyburn
Cohen
Connolly (VA)
Conyers
Cooper
Costa
Costello
Courtney
Crowley
Cuellar
Cummings
Dahlkemper
Davis (AL)
Davis (CA)
Davis (IL)
Davis (TN)
DeFazio
DeGette
Delahunt
DeLauro
Dent
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Donnelly (IN)
Doyle
Driehaus
Edwards (MD)
Edwards (TX)
Ehlers
Ellison
Ellsworth
Emerson
Engel
Eshoo
Etheridge
Farr
Fattah
Filner
Foster
Frank (MA)
Frelinghuysen
Fudge
Gerlach
Giffords
Gonzalez
Gordon (TN)
Grayson
Green, Al
Green, Gene
Griffith
Grijalva
Gutierrez
Hall (NY)
Halvorson
Hare
Harman
Hastings (FL)
Heinrich
Herseth Sandlin
Higgins
Hill
Himes
Hinchey
Hinojosa
Hirono
Hodes
Holden
Holt
Honda
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Johnson (GA)
Johnson, E. B.
Kagen
Kanjorski
Kaptur
Kennedy
Kildee
Kilpatrick (MI)
Kilroy
Kind
King (NY)
Kirk
Kirkpatrick (AZ)
Klein (FL)
Kosmas
Kratovil
Kucinich
Lance
Langevin
Larsen (WA)
Larson (CT)
LaTourette
Lee (CA)
Lee (NY)
Levin
Lewis (GA)
Lipinski
LoBiondo
Loebsack
Lofgren, Zoe
Lowey
Luján
Lynch
Maffei
Maloney
Markey (CO)
Markey (MA)
Massa
Matheson
Matsui
McCarthy (NY)
McCollum
McCotter
McDermott
McGovern
McHugh
McIntyre
McMahon
McNerney
Meek (FL)
Meeks (NY)
Melancon
Michaud
Miller (MI)
Miller (NC)
Miller, George
Minnick
Mitchell
Mollohan
Moore (KS)
Moore (WI)
Moran (KS)
Moran (VA)
Murphy (CT)
Murphy, Patrick
Murphy, Tim
Murtha
Nadler (NY)
Napolitano
Neal (MA)
Nye
Oberstar
Obey
Olver
Ortiz
Pallone
Pascrell
Pastor (AZ)
Paulsen
Payne
Pelosi
Perlmutter
Perriello
Peters
Peterson
Petri
Pingree (ME)
Platts
Polis (CO)
Pomeroy
Price (NC)
Rahall
Rangel
Rehberg
Reichert
Reyes
Richardson
Rodriguez
Rogers (AL)
Ros-Lehtinen
Ross
Rothman (NJ)
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Salazar
Sánchez, Linda T.
Sanchez, Loretta
Sarbanes
Schakowsky
Schauer
Schiff
Schrader
Schwartz
Scott (GA)
Scott (VA)
Serrano
Sestak
Shea-Porter
Sherman
Shuler
Simpson
Sires
Skelton
Slaughter
Smith (NJ)
Smith (WA)
Snyder
Solis (CA)
Space
Speier
Spratt
Stupak
Sutton
Tanner
Tauscher
Taylor
Teague
Thompson (CA)
Thompson (MS)
Thompson (PA)
Tiberi
Tierney
Titus
Tonko
Towns
Tsongas
Turner
Upton
Van Hollen
Velázquez
Visclosky
Walz
Wasserman Schultz
Waters
Watson
Watt
Waxman
Weiner
Welch
Wexler
Wilson (OH)
Wolf
Woolsey
Wu
Yarmuth
Young (AK)
Young (FL)

NAYS—135

Akin
Alexander
Bachmann
Bachus
Barrett (SC)
Bartlett
Barton (TX)
Biggert
Bilbray
Bilirakis
Bishop (UT)
Blackburn
Blunt
Boehner
Bonner
Boozman
Boustany
Brady (TX)
Bright
Broun (GA)
Brown (SC)
Brown-Waite, Ginny
Burgess
Burton (IN)
Buyer
Calvert
Camp
Cantor
Carter
Cassidy
Chaffetz
Coble
Coffman (CO)
Cole
Conaway
Crenshaw
Culberson
Davis (KY)
Deal (GA)
Dreier
Duncan
Fallin
Fleming
Forbes
Fortenberry
Foxx
Franks (AZ)
Gallegly
Garrett (NJ)
Gingrey (GA)
Gohmert
Goodlatte
Granger
Graves
Guthrie
Hall (TX)
Harper
Hastings (WA)
Heller
Hensarling
Herger
Hoekstra
Hunter
Inglis
Issa
Jenkins
Johnson (IL)
Johnson, Sam
Jones
Jordan (OH)
King (IA)
Kingston
Kline (MN)
Lamborn
Latham
Latta
Lewis (CA)
Linder
Lucas
Luetkemeyer
Lummis
Lungren, Daniel E.
Mack
Manzullo
Marchant
Marshall
McCarthy (CA)
McCaul
McClintock
McHenry
McKeon
McMorris Rodgers
Mica
Miller (FL)
Miller, Gary
Myrick
Neugebauer
Nunes
Olson
Paul
Pence
Pitts
Posey
Price (GA)
Putnam
Radanovich
Roe (TN)
Rogers (KY)
Rogers (MI)
Rohrabacher
Rooney
Roskam
Royce
Ryan (WI)
Scalise
Schmidt
Schock
Sensenbrenner
Sessions
Shadegg
Shimkus
Shuster
Smith (NE)
Smith (TX)
Souder
Stearns
Sullivan
Terry
Thornberry
Tiahrt
Walden
Westmoreland
Whitfield
Wilson (SC)
Wittman

NOT VOTING—8

Aderholt
Bean
Campbell
Flake
Kissell
Poe (TX)
Stark
Wamp

□ 1310

Mr. HUNTER, Mrs. LUMMIS and Mr. BACHUS changed their vote from ''yea'' to ''nay.''

So the motion was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

Stated for:

Ms. BEAN. Madam Speaker, on rollcall No. 50, had I been present, I would have voted "yea."

Stated against:

Mr. WAMP. Mr. Speaker, on rollcall No. 50, I was unavoidably detained and missed the rollcall vote. However, had I been present, I would have voted "nay."

ELECTING CERTAIN MINORITY MEMBERS TO CERTAIN STANDING COMMITTEES OF THE HOUSE OF REPRESENTATIVES

Mr. PENCE. Madam Speaker, by direction of the Republican Conference, I offer a privileged resolution and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 118

Resolved, That the following members are, and are hereby, elected to the following standing committees:

COMMITTEE ON AGRICULTURE— Ms. Lummis.

COMMITTEE ON EDUCATION AND LABOR— Mr. Thompson of Pennsylvania.

COMMITTEE ON SMALL BUSINESS— Mr. Coffman of Colorado.

Mr. PENCE (during the reading). Madam Speaker, I ask unanimous consent that the resolution be considered as read and printed in the RECORD.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Indiana?

There was no objection.

The resolution was agreed to.

A motion to reconsider was laid on the table.

REMOVAL OF NAME OF MEMBER AS COSPONSOR OF H.R. 135

Mrs. NAPOLITANO. Madam Speaker, I ask unanimous consent that my name be removed as a cosponsor of H.R. 135.

The SPEAKER pro tempore. Is there objection to the request of the gentlewoman from California?

There was no objection.

COMMUNICATION FROM CHAIRMAN OF COMMITTEE ON WAYS AND MEANS

The SPEAKER pro tempore laid before the House the following communication from the chairman of the Committee on Ways and Means:

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, DC, January 12, 2009.

Hon. NANCY PELOSI,
Speaker, House of Representatives, The Capitol, Washington, DC.

DEAR MADAM SPEAKER, I am forwarding to you the Committee's recommendations for certain positions for the 111th Congress.

First, pursuant to Section 8002 of the Internal Revenue Code of 1986, the Committee designated the following Members to serve on the Joint Committee on Taxation: Charles Rangel, Pete Stark, Sander Levin, Dave Camp and Wally Herger.

Second, pursuant to Section 161 of the Trade Act of 1974, the Committee recommended the following Members to serve as official advisors for international conference meetings and negotiating sessions on trade agreements: Charles Rangel, Sander Levin, John Tanner, Dave Camp and Kevin Brady.

Third, pursuant to House Rule X, Clause 5 (2)(A)(i), the Committee designated the following Members to serve on the Committee on the Budget: Lloyd Doggett, Earl Blumenauer, John Yarmuth, Paul Ryan and Devin Nunes.

Sincerely,

CHARLES B. RANGEL,
Chairman.

MESSAGE FROM THE SENATE

A message from the Senate by Ms. Curtis, one of its clerks, announced that the Senate has agreed to without amendment a concurrent resolution of the House of the following title: