no one in this body knows that there is a significant number of children who are uninsured and that this measure, once offered in 1997, did begin the process that today we wish to continue and that still does not complete the task that most of us feel is necessary in order to insure all of the children in this country.

Madam Speaker, this is a good rule for a critically important bill. Although this bill cannot repair all of the flaws that are intrinsic in America's health care system, it undoubtedly serves as a strong and honorable prelude to facilitating comprehensive health care reform.

Mahatma Gandhi, among many things, said that you can learn about a country's condition by looking at its most weak and vulnerable people. The alarming rate of uninsured and poverty-stricken children in this country tells us that the richest country on Earth is in poor condition.

I urge my colleagues to vote in favor of this rule so that we may support a bill that will give millions of children the basic right to health so that they can become leaders and productive citizens.

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

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

The previous question was ordered.

The SPEAKER pro tempore. The question is on the resolution.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

RECORDED VOTE

Mr. SESSIONS. Madam Speaker, I demand a recorded vote.

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 244, noes 178, not voting 11, as follows:

[Roll No. 14]

AYES—244

Abercrombie
Ackerman
Adler (NJ)
Altmire
Andrews
Arcuri
Baca
Baird
Baldwin
Barrow
Bean
Becerra
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boccieri
Boren
Boswell
Boyd
Brady (PA)
Braley (IA)
Bright
Brown, Corrine
Butterfield
Capps
Capuano
Cardoza
Carnahan
Carney
Carson (IN)
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
Dicks
Dingell
Doggett
Donnelly (IN)
Doyle
Driehaus
Edwards (MD)
Edwards (TX)
Ellison
Ellsworth
Engel
Eshoo
Etheridge
Farr
Fattah
Filner
Foster
Frank (MA)
Fudge
Giffords
Gillibrand
Gonzalez
Gordon (TN)
Grayson
Green, Al
Green, Gene
Griffith
Grijalva
Gutierrez
Hall (NY)
Halvorson
Hare
Harman
Hastings (FL)
Heinrich
Higgins
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
Kirkpatrick (AZ)
Kissell
Klein (FL)
Kosmas
Kratovil
Kucinich
Langevin
Larsen (WA)
Larson (CT)
Lee (CA)
Levin
Lewis (GA)
Lipinski
Loebsack
Lofgren, Zoe
Lowey
Luján
Lynch
Maffei
Markey (CO)
Markey (MA)
Marshall
Massa
Matheson
Matsui
McCarthy (NY)
McCollum
McDermott
McGovern
McIntyre
McMahon
McNerney
Meek (FL)
Meeks (NY)
Melancon
Michaud
Miller (NC)
Miller, George
Mitchell
Mollohan
Moore (KS)
Moore (WI)
Moran (VA)
Murphy (CT)
Murphy, Patrick
Murtha
Nadler (NY)
Napolitano
Neal (MA)
Nye
Oberstar
Obey
Olver
Ortiz
Pallone
Pascrell
Pastor (AZ)
Payne
Perlmutter
Perriello
Peters
Peterson
Pingree (ME)
Polis (CO)
Pomeroy
Price (NC)
Rahall
Rangel
Reyes
Richardson
Rodriguez
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
Sires
Skelton
Slaughter
Smith (WA)
Space
Speier
Spratt
Stark
Stupak
Sutton
Tanner
Tauscher
Taylor
Teague
Thompson (CA)
Thompson (MS)
Tierney
Titus
Tonko
Towns
Tsongas
Van Hollen
Velázquez
Walz
Wasserman Schultz
Watson
Watt
Waxman
Weiner
Welch
Wexler
Wilson (OH)
Woolsey
Wu
Yarmuth

NOES—178

Aderholt
Akin
Alexander
Austria
Bachmann
Bachus
Barrett (SC)
Bartlett
Barton (TX)
Biggert
Bilbray
Bilirakis
Bishop (UT)
Blackburn
Blunt
Bonner
Bono Mack
Boozman
Boustany
Brady (TX)
Broun (GA)
Brown (SC)
Brown-Waite, Ginny
Buchanan
Burgess
Burton (IN)
Buyer
Calvert
Camp
Campbell
Cantor
Cao
Capito
Carter
Cassidy
Castle
Chaffetz
Coble
Coffman (CO)
Cole
Conaway
Crenshaw
Culberson
Davis (KY)
Deal (GA)
Dent
Diaz-Balart, L.
Diaz-Balart, M.
Dreier
Duncan
Ehlers
Emerson
Fallin
Flake
Fleming
Forbes
Fortenberry
Foxx
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gingrey (GA)
Gohmert
Goodlatte
Granger
Graves
Guthrie
Hall (TX)
Harper
Hastings (WA)
Heller
Hensarling
Herger
Hill
Hoekstra
Hunter
Inglis
Issa
Jenkins
Johnson (IL)
Johnson, Sam
Jones
Jordan (OH)
King (IA)
King (NY)
Kingston
Kirk
Kline (MN)
Lamborn
Lance
Latham
LaTourette
Latta
Lee (NY)
Lewis (CA)
Linder
LoBiondo
Lucas
Luetkemeyer
Lummis
Lungren, Daniel E.
Mack
Manzullo
Marchant
McCarthy (CA)
McCaul
McClintock
McCotter
McHenry
McHugh
McKeon
McMorris Rodgers
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Minnick
Moran (KS)
Murphy, Tim
Myrick
Neugebauer
Nunes
Olson
Paul
Paulsen
Pence
Petri
Pitts
Platts
Poe (TX)
Posey
Price (GA)
Putnam
Radanovich
Rehberg
Reichert
Roe (TN)
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Rooney
Ros-Lehtinen
Roskam
Royce
Ryan (WI)
Scalise
Schmidt
Schock
Sensenbrenner
Sessions
Shadegg
Shimkus
Shuler
Shuster
Simpson
Smith (NE)
Smith (NJ)
Smith (TX)
Souder
Stearns
Terry
Thompson (PA)
Thornberry
Tiahrt
Tiberi
Turner
Upton
Walden
Wamp
Westmoreland
Whitfield
Wilson (SC)
Wittman
Wolf
Young (AK)

NOT VOTING—11

Boehner
Boucher
Herseth Sandlin
Maloney
Sherman
Snyder
Solis (CA)
Sullivan
Visclosky
Waters
Young (FL)

□ 1225

Messrs. GINGREY of Georgia, BURTON of Indiana and REICHERT changed their vote from ''aye'' to ''no.''

So the resolution was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

ELECTING A MINORITY MEMBER TO A STANDING COMMITTEE

Mr. SESSIONS. Madam Speaker, by the direction of the House Republican Conference, I send to the desk a privileged resolution and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 59

Resolved, That the following Member is, and is hereby, elected to the following standing committee of the House of Representatives:

COMMITTEE ON RULES—Ms. FOXX.

The resolution was agreed to.

A motion to reconsider was laid on the table.

CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009

Mr. PALLONE. Madam Speaker, pursuant to House Resolution 52, I call up 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, and ask for its immediate consideration in the House.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 2

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

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. 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) $3,000,000,000 for the period beginning on October 1, 2012, and ending on March 31, 2013, and

''(B) $3,000,000,000 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.—For purposes of this subsection, 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. Such term does not include any children for whom the State has made an election to provide medical assistance under section 1903(v)(4).

''(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 4 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 preprinted 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.''.

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, $11,406,000,000 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.

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

''(4) EXCLUSION OF CERTAIN EXPENDITURES FROM PAYMENT LIMITS.—With respect to fiscal years beginning with fiscal year 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.''.

(b) GAO STUDY AND REPORT.—Not later than September 30, 2010, 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 regarding Federal funding under Medicaid and CHIP for Puerto Rico, the United States Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands. The report shall include the following:

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

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

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

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

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

(2) Recommendations regarding methods for the collection and reporting of reliable data regarding the enrollment under Medicaid and CHIP of children in such commonwealths and territories.

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

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 FISCAL YEAR 2010.—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 paragraphs (2) and (3) shall apply for purposes of any period beginning on or after October 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 FISCAL YEAR 2010.—

''(A) IN GENERAL.—No funds shall be available under this title for child health assistance or other health benefits coverage that is provided to a nonpregnant childless adult under an applicable existing waiver after September 30, 2010.

''(B) EXTENSION UPON STATE REQUEST.—If an applicable existing waiver described in

subparagraph (A) would otherwise expire before October 1, 2010, and the State requests an extension of such waiver, the Secretary shall grant such an extension, but only 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 nonpregnant childless adult during fiscal year 2010.

''(3) OPTIONAL 1-YEAR TRANSITIONAL COVERAGE BLOCK GRANT FUNDED FROM STATE ALLOTMENT.—Subject to paragraph (4)(B), each State for which coverage under an applicable existing waiver is terminated under paragraph (2)(A) may elect to provide nonpregnant childless adults who were provided child health assistance or health benefits coverage under the applicable existing waiver at any time during fiscal year 2010 with such assistance or coverage during fiscal year 2011, as if the authority to provide such assistance or coverage under an applicable existing waiver was extended through that fiscal year, but subject to the following terms and conditions:

''(A) BLOCK GRANT SET ASIDE FROM STATE ALLOTMENT.—The Secretary shall set aside for the State an amount equal to the Federal share of the State's projected expenditures under the applicable existing waiver for providing child health assistance or health benefits coverage to all nonpregnant childless adults under such waiver for fiscal year 2010 (as certified by the State and submitted to the Secretary by not later than August 31, 2010, and without regard to whether any such individual lost coverage during fiscal year 2010 and was later provided child health assistance or other health benefits coverage under the waiver in that fiscal year), increased by the annual adjustment for fiscal year 2011 determined under section 2104(m)(5)(A). The Secretary may adjust the amount set aside under the preceding sentence, as necessary, on the basis of the expenditure data for fiscal year 2010 reported by States on CMS Form 64 or CMS Form 21 not later than November 30, 2010, but in no case shall the Secretary adjust such amount after December 31, 2010.

''(B) NO COVERAGE FOR NONPREGNANT CHILDLESS ADULTS WHO WERE NOT COVERED DURING FISCAL YEAR 2010.—

''(i) FMAP APPLIED TO EXPENDITURES.—The Secretary shall pay the State for each quarter of fiscal year 2011, from the amount set aside under subparagraph (A), an amount equal to the Federal medical assistance percentage (as determined under section 1905(b) without regard to clause (4) of such section) of expenditures in the quarter for providing child health assistance or other health benefits coverage to a nonpregnant childless adult but only if such adult was enrolled in the State program under this title during fiscal year 2010 (without regard to whether the individual lost coverage during fiscal year 2010 and was reenrolled in that fiscal year or in fiscal year 2011).

''(ii) FEDERAL PAYMENTS LIMITED TO AMOUNT OF BLOCK GRANT SET-ASIDE.—No payments shall be made to a State for expenditures described in this subparagraph after the total amount set aside under subparagraph (A) for fiscal year 2011 has been paid to the State.

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

''(A) IN GENERAL.—Each State for which coverage under an applicable existing waiver is terminated under paragraph (2)(A) may submit, not later than June 30, 2011, 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 September 30, 2011, on the application of a State for a Medicaid nonpregnant childless adults waiver that was submitted to the Secretary by June 30, 2011, 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 2012, allow expenditures for medical assistance under title XIX for all such adults to not exceed the total amount of payments made to the State under paragraph (3)(B) for fiscal year 2011, increased by the percentage increase (if any) in the projected nominal per capita amount of National Health Expenditures for calendar year 2012 over 2011, as most recently published by the Secretary; and

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

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

''(1) TWO-YEAR TRANSITION PERIOD; AUTOMATIC EXTENSION AT STATE OPTION THROUGH FISCAL YEAR 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 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 STATE MATCH REQUIRED.—In the case of a State that is awarded a grant under this section—

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

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

''(f) DEFINITIONS.—In this section:

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

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

''(B) A local government.

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

''(D) A Federal health safety net organization.

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

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

''(i) GRANTS FOR OUTREACH AND ENROLLMENT OF NATIVE AMERICAN BENEFICIARIES.—

''(1) IN GENERAL.—To overcome language and cultural barriers to program access by Native Americans, the Secretary shall establish grant programs to conduct outreach and enrollment efforts to increase the enrollment and participation of eligible individuals in programs of the Social Security Act (42 U.S.C. 1397aa et seq.) and other Federal health and social service programs.

''(2) USE OF TRIBAL BENEFITS-COUNSELORS MODEL.—The grant program under this subsection shall incorporate expansion and stabilization of the tribal benefits-counselors model developed in the State of Washington to overcome language and cultural barriers to Federal programs.

''(3) RECIPIENTS.—In order to qualify for a grant under this subsection, an applicant shall be a national, nonprofit organization with successful and verifiable experience in assisting Native Americans access Federal programs.

''(4) REPORT.—At the end of the period of funding provided under subsection (f), the Secretary shall submit to Congress a report on the grants made under this subsection, including the efficacy of outreach efforts and the cost effectiveness of projects funded by such grants in improving access to Federal programs by Native Americans.''.

(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 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, NATIONALITY STATUS, OR QUALIFIED ALIEN STATUS.—The State shall satisfy the requirements of sections 1137(d) and 1902(a)(46)(B) for verifications of citizenship, nationality status, or qualified alien 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 relieve a State of the obligation to determine components of eligibility that are not the subject of an Express Lane agency's finding, as described in subparagraph (A);

''(ii) 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

''(iii) 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 and 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) APPLICATION.—This paragraph shall not apply to 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 October 1, 2009.

(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) PURPOSE.—In order to promote the health of needy children and pregnant women residing lawfully in the United States, States should be permitted to waive certain restrictions which result in a 5-year delay for coverage of necessary health services for such children and women under the Medicaid program and CHIP.

(b) MEDICAID PROGRAM.—Section 1903(v) of the Social Security Act (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, notwithstanding sections 401(a), 402(b), 403, and 421 of Public Law 104–193, medical assistance under a State plan under this title 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 are otherwise eligible for such assistance.

''(B) Such election may be made only with respect to either or both of the following categories of individuals:

''(i) Children.

''(ii) Pregnant women.

''(C) In this paragraph:

''(i) The term 'pregnant women' means women during pregnancy (and during the 60-day period beginning on the last day of the pregnancy).

''(ii) The term 'children' means individuals under age 19 (or such higher age as the State has elected under section 1902(l)(1)(D)), including optional targeted low-income children described in section 1905(u)(2)(B).''.

(c) CHIP.—Section 2107(e)(1) of such Act (42 U.S.C. 1397gg(e)(1)), as amended by section 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), insofar as it relates to the category of children or pregnant women (as such terms are defined in such paragraph), but only if the State has elected to apply such paragraph with respect to such category of children or pregnant women under title XIX and only if, in the case of pregnant women, the State has elected the option under section 2111 to provide assistance for pregnant women under this title.''.

(d) CONFORMING AMENDMENT.—Section 423(d)(1) of Public Law 104–193 is amended by inserting before the period the following: ''and medical or child health assistance furnished under section 1903(v)(4) or 2107(e)(1)(E), respectively, of the Social Security Act''.

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

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).''.

(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, problemsolving 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 paragraph (1) shall apply to coverage of items and services furnished on or after October 1, 2009.

(b) 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.

(c) 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.

(d) 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.

(e) 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.

(f) 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,''.

(g) 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.

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.''.

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 fiscal year 2009, on the basis of such information as the Secretary determines appropriate. In establishing such sample sizes, the Secretary shall, to the greatest extent practicable—

(1) minimize the administrative cost burden on States under Medicaid and CHIP; and

(2) maintain State flexibility to manage such programs.

SEC. 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.

Nothing in this Act allows Federal payment for individuals who are not lawfully residing in the United States. 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''.

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.

SEC. 623. LIMITATION ON MEDICARE EXCEPTION TO THE PROHIBITION ON CERTAIN PHYSICIAN REFERRALS FOR HOSPITALS.

(a) IN GENERAL.—Section 1877 (42 U.S.C. 1395nn) is amended—

(1) in subsection (d)(2)—

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

(B) in subparagraph (B), by striking the period at the end and inserting ''; and''; and

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

''(C) in the case where the entity is a hospital, the hospital meets the requirements of paragraph (3)(D).'';

(2) in subsection (d)(3)—

(A) in subparagraph (B), by striking ''and'' at the end;

(B) in subparagraph (C), by striking the period at the end and inserting ''; and''; and

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

''(D) the hospital meets the requirements described in subsection (i)(1).''; and

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

''(i) REQUIREMENTS FOR HOSPITALS TO QUALIFY FOR RURAL PROVIDER AND HOSPITAL EXCEPTION TO OWNERSHIP OR INVESTMENT PROHIBITION.—

''(1) REQUIREMENTS DESCRIBED.—For purposes of subsection (d)(3)(D), the requirements described in this paragraph for a hospital are as follows:

''(A) PROVIDER AGREEMENT.—The hospital had—

''(i) physician ownership or investment on January 1, 2009; and

''(ii) a provider agreement under section 1866 in effect on such date.

''(B) PROHIBITION ON PHYSICIAN OWNERSHIP OR INVESTMENT.—The percentage of the total value of the ownership or investment interests held in the hospital, or in an entity whose assets include the hospital, by physician owners or investors in the aggregate does not exceed such percentage as of the date of enactment of this subsection.

''(C) PROHIBITION ON EXPANSION OF FACILITY CAPACITY.—Except as provided in paragraph (3), the number of operating rooms, procedure rooms, and beds of the hospital at any time on or after the date of the enactment of this subsection are no greater than the number of operating rooms, procedure rooms, and beds as of such date.

''(D) PREVENTING CONFLICTS OF INTEREST.—

''(i) The hospital submits to the Secretary an annual report containing a detailed description of—

''(I) the identity of each physician owner and physician investor and any other owners or investors of the hospital; and

''(II) the nature and extent of all ownership and investment interests in the hospital.

''(ii) The hospital has procedures in place to require that any referring physician owner or investor discloses to the patient being referred, by a time that permits the patient to make a meaningful decision regarding the receipt of care, as determined by the Secretary—

''(I) the ownership or investment interest, as applicable, of such referring physician in the hospital; and

''(II) if applicable, any such ownership or investment interest of the treating physician.

''(iii) The hospital does not condition any physician ownership or investment interests either directly or indirectly on the physician owner or investor making or influencing referrals to the hospital or otherwise generating business for the hospital.

''(iv) The hospital discloses the fact that the hospital is partially owned by physicians—

''(I) on any public website for the hospital; and

''(II) in any public advertising for the hospital.

''(E) ENSURING BONA FIDE OWNERSHIP AND INVESTMENT.—

''(i) Any ownership or investment interests that the hospital offers to a physician owner or investor are not offered on more favorable terms than the terms offered to a person who is not a physician owner or investor.

''(ii) The hospital (or any investors in the hospital) does not directly or indirectly provide loans or financing for any physician owner or investor in the hospital.

''(iii) The hospital (or any investors in the hospital) does not directly or indirectly guarantee a loan, make a payment toward a loan, or otherwise subsidize a loan, for any individual physician owner or investor or group of physician owners or investors that is related to acquiring any ownership or investment interest in the hospital.

''(iv) Ownership or investment returns are distributed to each owner or investor in the hospital in an amount that is directly proportional to the ownership or investment interest of such owner or investor in the hospital.

''(v) Physician owners and investors do not receive, directly or indirectly, any guaranteed receipt of or right to purchase other business interests related to the hospital, including the purchase or lease of any property under the control of other owners or investors in the hospital or located near the premises of the hospital.

''(vi) The hospital does not offer a physician owner or investor the opportunity to purchase or lease any property under the control of the hospital or any other owner or investor in the hospital on more favorable terms than the terms offered to an individual who is not a physician owner or investor.

''(F) PATIENT SAFETY.—The hospital has the capacity to—

''(i) provide assessment and initial treatment for patients; and

''(ii) refer and transfer patients to hospitals with the capability to treat the needs of the patient involved.

''(G) LIMITATION ON APPLICATION TO CERTAIN CONVERTED FACILITIES.—The hospital was not converted from an ambulatory surgical center to a hospital on or after the date of enactment of this subsection.

''(2) PUBLICATION OF INFORMATION REPORTED.—The Secretary shall publish, and update on an annual basis, the information submitted by hospitals under paragraph (1)(D)(i) on the public Internet website of the Centers for Medicare & Medicaid Services.

''(3) EXCEPTION TO PROHIBITION ON EXPANSION OF FACILITY CAPACITY.—

''(A) PROCESS.—

''(i) ESTABLISHMENT.—The Secretary shall establish and implement a process under which an applicable hospital (as defined in subparagraph (E)) may apply for an exception from the requirement under paragraph (1)(C).

''(ii) OPPORTUNITY FOR COMMUNITY INPUT.—The process under clause (i) shall provide individuals and entities in the community in which the applicable hospital applying for an exception is located with the opportunity to provide input with respect to the application.

''(iii) TIMING FOR IMPLEMENTATION.—The Secretary shall implement the process under clause (i) on July 1, 2010.

''(iv) REGULATIONS.—Not later than June 1, 2010, the Secretary shall promulgate regulations to carry out the process under clause (i).

''(B) FREQUENCY.—The process described in subparagraph (A) shall permit an applicable hospital to apply for an exception up to once every 2 years.

''(C) PERMITTED INCREASE.—

''(i) IN GENERAL.—Subject to clause (ii) and subparagraph (D), an applicable hospital granted an exception under the process described in subparagraph (A) may increase the number of operating rooms, procedure rooms, and beds of the applicable hospital above the baseline number of operating rooms, procedure rooms, and beds of the applicable hospital (or, if the applicable hospital has been granted a previous exception under this paragraph, above the number of operating rooms, procedure rooms, and beds of the hospital after the application of the most recent increase under such an exception).

''(ii) 100 PERCENT INCREASE LIMITATION.—The Secretary shall not permit an increase in the number of operating rooms, procedure rooms, and beds of an applicable hospital under clause (i) to the extent such increase would result in the number of operating rooms, procedure rooms, and beds of the applicable hospital exceeding 200 percent of the baseline number of operating rooms, procedure rooms, and beds of the applicable hospital.

''(iii) BASELINE NUMBER OF OPERATING ROOMS, PROCEDURE ROOMS, AND BEDS.—In this paragraph, the term 'baseline number of operating rooms, procedure rooms, and beds' means the number of operating rooms, procedure rooms, and beds of the applicable hospital as of the date of enactment of this subsection.

''(D) INCREASE LIMITED TO FACILITIES ON THE MAIN CAMPUS OF THE HOSPITAL.—Any increase in the number of operating rooms, procedure rooms, and beds of an applicable hospital pursuant to this paragraph may only occur in facilities on the main campus of the applicable hospital.

''(E) APPLICABLE HOSPITAL.—In this paragraph, the term 'applicable hospital' means a hospital—

''(i) that is located in a county in which the percentage increase in the population during the most recent 5-year period (as of the date of the application under subparagraph (A)) is at least 150 percent of the percentage increase in the population growth of the State in which the hospital is located during that period, as estimated by Bureau of the Census and available to the Secretary;

''(ii) whose annual percent of total inpatient admissions that represent inpatient admissions under the program under title XIX is equal to or greater than the average percent with respect to such admissions for all hospitals located in the county in which the hospital is located;

''(iii) that does not discriminate against beneficiaries of Federal health care programs and does not permit physicians practicing at the hospital to discriminate against such beneficiaries;

''(iv) that is located in a State in which the average bed capacity in the State is less than the national average bed capacity; and

''(v) that has an average bed occupancy rate that is greater than the average bed occupancy rate in the State in which the hospital is located.

''(F) PROCEDURE ROOMS.—In this subsection, the term 'procedure rooms' includes rooms in which catheterizations, angiographies, angiograms, and endoscopies are performed, except such term shall not include emergency rooms or departments (exclusive of rooms in which catheterizations, angiographies, angiograms, and endoscopies are performed).

''(G) PUBLICATION OF FINAL DECISIONS.—Not later than 60 days after receiving a complete application under this paragraph, the Secretary shall publish in the Federal Register the final decision with respect to such application.

''(H) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the process under this paragraph (including the establishment of such process).

''(4) COLLECTION OF OWNERSHIP AND INVESTMENT INFORMATION.—For purposes of subparagraphs (A)(i) and (B) of paragraph (1), the Secretary shall collect physician ownership and investment information for each hospital.

''(5) PHYSICIAN OWNER OR INVESTOR DEFINED.—For purposes of this subsection, the term 'physician owner or investor' means a physician (or an immediate family member of such physician) with a direct or an indirect ownership or investment interest in the hospital.

''(6) PATIENT SAFETY REQUIREMENT.—In the case of a hospital to which the requirements of paragraph (1) apply, insofar as the hospital described in this subsection admits a patient and does not have any physician available on the premises to provide services during all hours in which the hospital is providing services to such patient, before admitting the patient—

''(A) the hospital shall disclose such fact to a patient; and

''(B) following such disclosure, the hospital shall receive from the patient a signed acknowledgment that the patient understands such fact.

''(7) CLARIFICATION.—Nothing in this subsection shall be construed as preventing the Secretary from revoking a hospital's provider agreement if not in compliance with regulations implementing section 1866.''.

(b) ENFORCEMENT.—

(1) ENSURING COMPLIANCE.—The Secretary of Health and Human Services shall establish policies and procedures to ensure compliance with the requirements described in subsections (i)(1) and (i)(7) of section 1877 of the Social Security Act, as added by subsection (a)(3), beginning on the date such requirements first apply. Such policies and procedures may include unannounced site reviews of hospitals.

(2) AUDITS.—Beginning not later than July 1, 2011, the Secretary of Health and Human Services shall conduct audits to determine if hospitals violate the requirements referred to in paragraph (1).

TITLE VII—REVENUE PROVISIONS

SEC. 701. INCREASE IN EXCISE TAX RATE ON TOBACCO PRODUCTS.

(a) CIGARS.—

(1) SMALL CIGARS.—Paragraph (1) of section 5701(a) of the Internal Revenue Code of 1986 is amended to read as follows:

''(1) SMALL CIGARS.—On cigars, weighing not more than 3 pounds per thousand, the amount determined in accordance with the following table:

''Cigars Removed During Calendar Year—	Tax Rate Per Thousand—
2009 or 2010	$12.50
2011 or 2012	$25.00
2013 or 2014	$37.50
2015 or thereafter	$50.00.''.

(2) LARGE CIGARS.—Paragraph (2) of section 5701(a) of such Code is amended—

(A) by striking ''20.719 percent (18.063 percent on cigars removed during 2000 or 2001)'' and inserting ''52.4 percent'', and

(B) by striking ''$48.75 per thousand ($42.50 per thousand on cigars removed during 2000 or 2001)'' and inserting ''40 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 ''$50.00 per thousand'', and

(2) by striking ''$40.95 per thousand ($35.70 per thousand on cigarettes removed during 2000 or 2001)'' in paragraph (2) and inserting ''$105.00 per thousand''.

(c) CIGARETTE PAPERS.—Section 5701(c) of such Code is amended by striking ''1.22 cents (1.06 cents on cigarette papers removed during 2000 or 2001)'' and inserting ''3.13 cents''.

(d) CIGARETTE TUBES.—Section 5701(d) of such Code is amended by striking ''2.44 cents (2.13 cents on cigarette tubes removed during 2000 or 2001)'' and inserting ''6.26 cents''.

(e) SMOKELESS TOBACCO.—Section 5701(e) of such Code is amended—

(1) by striking ''58.5 cents (51 cents on snuff removed during 2000 or 2001)'' in paragraph (1) and inserting ''$1.50'', and

(2) by striking ''19.5 cents (17 cents on chewing tobacco removed during 2000 or 2001)'' in paragraph (2) and inserting ''50 cents''.

(f) PIPE TOBACCO.—Section 5701(f) of such Code is amended by striking ''$1.0969 cents (95.67 cents on pipe tobacco removed during 2000 or 2001)'' and inserting ''$2.8126''.

(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 ''$24.62''.

(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 any tax increase date 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 such date, 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 any tax increase date, 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.—

(i) IN GENERAL.—The tax imposed by paragraph (1) shall be paid on or before August 1, 2009.

(ii) SPECIAL RULE FOR SMALL CIGARS.—In the case of small cigars, the tax imposed by paragraph (1) on or after January 1, 2011, shall be paid on or before April 1 following any tax increase date.

(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 any tax increase date 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) TAX INCREASE DATE.—The term ''tax increase date'' means April 1, 2009, January 1, 2011, January 1, 2013, and January 1, 2015.

(C) 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 AMENDMENT.—Sections 5702(j), 5702(k), and 5704(h) of such Code is amended by inserting '', or any processed tobacco,'' after ''nontaxpaid 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 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 1 percentage point.

The SPEAKER pro tempore. Pursuant to House Resolution 52, the gentleman from New Jersey (Mr. PALLONE), the gentleman from Missouri (Mr. BLUNT), the gentleman from New York (Mr. RANGEL), and the gentleman from California (Mr. HERGER) each will control 15 minutes.

The Chair recognizes the gentleman from New Jersey.

GENERAL LEAVE

Mr. PALLONE. Madam Speaker, I ask unanimous consent that every Member have 5 legislative days in which to revise and extend their remarks and include extraneous material on the legislation now before us.

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

There was no objection.

Mr. PALLONE. Madam Speaker, I yield myself 1 minute.

Madam Speaker, we have been working to reauthorize the Children's Health Insurance Program for the past 2 years. In the last Congress, we passed legislation that enjoyed bipartisan support in both the House and Senate as well as the support of the American people. Unfortunately, it did not enjoy the support of the President, who vetoed our bill not once, but twice, and went on to proclaim that uninsured children can simply go to the emergency room to have their medical needs met.

But this is a new day in Washington. Soon we will have a new President who has committed himself to reforming our Nation's health care system so every American can access affordable and quality health care. The bill we are considering today makes a down payment on that promise by putting the health and well-being of our children first.

Madam Speaker, this bill will make critical improvements to CHIP. There will be more resources for States to enroll eligible children. There will be better benefits. As a result, there will be 11 million children who will have access to the quality health coverage they need and deserve.

□ 1230

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

Mr. PALLONE. Madam Speaker, I yield myself another 15 seconds.

After 2 years of trying to get this bill enacted, we are now nearing the finish line and with not a moment to spare. As the Nation moves deeper into a recession and unemployment rates continue to rise, millions of Americans are joining the ranks of the uninsured, many of whom are children. We can't delay. We must enact this legislation now.

Madam Speaker, I reserve the balance of my time.

Mr. BLUNT. Madam Speaker, I yield myself 2 minutes.

As I have returned to a more active role in the Energy and Commerce Committee, Madam Speaker, in this Congress, I will say I was surprised not to have a markup of this bill.

We don't have to reauthorize this program until April. Certainly I'm for, as almost all the Members are for, a reauthorization of the current program and even for discussing how we can make that program better. But we didn't have a markup. We didn't see the bill, at least I haven't seen it, until today. And I have concerns about this bill. Certainly there are several reasons to look at this bill and think we could have improved it, bring it to the floor.

Poor kids first, poor children first being served was the reason to have SCHIP, for children whose families couldn't afford insurance. This bill doesn't require the States to meet any kind of threshold standard that would ensure that States were doing everything they could to find kids who needed insurance before they begin to spend money to find kids who may not have the same need.

Under the bill several thousands of American families would be poor enough to qualify for SCHIP and have the government pay for their health care, but they'd be rich enough to still be required to pay the alternative minimum tax. The bill changes welfare participation laws by eliminating the 5-year waiting period for legal immigrants to lawfully reside in the country before they can participate in this program. The bill significantly weakens provisions in current law requiring citizenship verification standards before an individual can be enrolled in this particular program. The bill will ship 2.4 million privately insured children to a government-run program.

We think we have a better response. While there will be debate about how this bill is paid for, the biggest problem in the paid-for is in the 10th year, the final year, we assume that 65 percent of the people who are receiving the benefit——

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

Mr. BLUNT. Madam Speaker, I yield myself 30 more seconds.

In the final bill, we assume that 65 percent of the children receiving the benefit wouldn't get the benefit anymore.

It seems to me this bill needs more work, would have benefited from a committee hearing. It doesn't prioritize poor kids to ensure that they get health care first.

I look forward to the debate today.

Madam Speaker, I reserve the balance of my time.

Mr. RANGEL. Madam Speaker, I yield myself such time as I may consume, and that won't be long.

This is a great opportunity for Members who have returned to this Congress, but it's a better opportunity for the new Members.

I won't be speaking on this bill because so many people want to be associated with this on our side. And I'm convinced it's not a Republican/Democratic issue. It's an issue of whether the families of 11 million kids are going to get health care. You cannot say in dollars and cents what it's worth. We had overwhelming support in the other Congress. Now we don't have the threat of a veto.

So I hope that you consider the children and not technical things that you're seeking in perfection.

Madam Speaker, I yield the balance of my time over to PETE STARK, who for over a year has attempted to perfect this bill to reach the popularity and support it's gained on both sides of the aisle. I thank Chairman WAXMAN for the work that his committee and Mr. DINGELL have made to make certain that we all read from the same page. And I look forward to this being the beginning where one day this Congress can say that no child will be able to say they're not covered by a decent health care program. So by unanimous consent I do hope that you will allow me to turn the balance of my time and

my thanks to Chairman STARK, who brought us to this point once again.

The SPEAKER pro tempore. Without objection, the gentleman from California will control the time.

There was no objection.

Mr. BLUNT. Madam Speaker, I yield 1 minute to a member of the Health Subcommittee of the full committee, Mr. SHADEGG from Arizona.

Mr. SHADEGG. Madam Speaker, this is a sad day. It's a sad day because we are about to adopt a radically different bill than the bills that were before with no hearings and no amendments. I would suggest democracy deserves better.

About an hour ago, the Democratic majority leader told the tragic story of Deamonte Driver, a 12-year-old Maryland boy who died in 2007 from complications resulting from what started as a simple toothache. The majority leader used Deamonte's story to argue that we need to expand SCHIP.

Stunningly, however, Deamonte Driver's story is a story of a government health care program that failed. This was a child that went into a government health care program. It failed him so miserably, he died.

Several colleagues on the opposite side of the aisle argue that Republicans don't care about health care. That's dead wrong. We care about health care for America's poor and America's children. What we are against and adamantly against is promising Americans health care but failing to live up to that promise. That is what this bill will do.

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

Mr. BLUNT. Madam Speaker, I yield the gentleman an additional 30 seconds.

Mr. SHADEGG. The Republican alternative is to give every single American family, every single one, the ability to buy a health care plan of their choice, not just the rich, not just the poor, but even those who don't respond to a government request that they enroll. We want to put them in a position to buy the health care they need by their choice from the doctor they choose.

That's not good enough for the other side. They want to expand government programs that in the tragic story of Deamonte Driver resulted in the death of a 12-year-old boy from a problem that started as a toothache.

Mr. PALLONE. Madam Speaker, I yield 1 minute to the gentleman from California, the chairman of the Energy and Commerce Committee (Mr. WAXMAN).

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

Mr. WAXMAN. Madam Speaker, I want to thank the gentleman from New Jersey, a very able chairman of the subcommittee of the Energy and Commerce Committee, for his authorship and managing this bill today.

This is an important bill, and I want to commend Chairman Emeritus JOHN DINGELL for all the work he has done on this legislation.

This bill and everything that's in it has already passed the House in the last 2 years; so we're not talking about anything new. What we are talking about is legislation that President Bush vetoed twice even though there was a strong bipartisan majority in the House and the Senate to try to get this legislation into law. The original program was a bipartisan program adopted in 1998, and it's going to be expiring; so we need to reauthorize it.

This bill is a down payment, a down payment on health care for all Americans. But at least we will start covering millions of low-income children, children who are right above the poverty line.

I urge support for the legislation.

Ten years ago, a Democratic President and Republican Congress worked together to pass a landmark program to provide health care to children who had fallen through the cracks of our health care system.

That program—CHIP—expires in less than 3 months. This bill extends and improves that program and makes the largest investment in children's health since the original CHIP law was enacted.

It provides new outreach tools and bonus payments to states that find and enroll these children.

The bill provides a new option to cover pregnant women in CHIP. It provides states the ability to ensure that children don't have to wait 5 years for health care just because they are legal immigrants residing in this country.

This bill is not the end but the beginning of a health reform effort that will ensure all children and all Americans will have health care coverage.

I urge my colleagues to support this bill. Let's send to incoming President Obama legislation that will make all the difference in the lives of millions of children across this Nation.

Mr. BLUNT. Madam Speaker, I yield 1 minute to the gentleman from Texas, Dr. Burgess, who is on our committee and on the subcommittee.

Mr. BURGESS. I thank the gentleman for yielding.

Madam Speaker, the bill before us today is going to harm access to high-quality hospital care by prohibiting physician ownership of hospitals.

In past Congresses there have been attempts to prohibit physician ownership, and they have been struck down due in large part by the recognition of many Members of Congress across the aisle and on this side that these few physician-owned hospitals are doing a great job. Patients like going there. Physicians and nurses like working there. And I will just tell you as someone who has worked in a physician-owned facility, there's nothing like the pride of ownership in helping you deliver first class care.

The bill before us today will put rural Americans at risk. Physician-owned hospitals also provide care in many rural areas of this country where patients have few health care options.

The attack on physician-owned hospitals will hurt the economy in a number of States. It's estimated up to $4 billion is generated in activity in these facilities in eight States in the country including my own home State of Texas.

During this time of economic downturn, it is simply irresponsible to shut down a strong stream of economic activity in these States while shutting down patient access to care.

Mr. STARK. Madam Speaker, I am delighted to yield 1 minute to the distinguished gentleman from Washington, Dr. MCDERMOTT.

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

Mr. MCDERMOTT. Madam Speaker, I rise in strong support for SCHIP reauthorization legislation, and I want to thank Speaker PELOSI for her leadership in bringing this bill to the floor as the first bill.

H.R. 2 clearly says that change has arrived for our country and our children. Instead of a 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 to begin a new chapter in America's commitment to its children and our future.

H.R. 2 is a real down payment on our efforts to get universal access to affordable health care for all Americans. It builds on a successful model that has 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 the new Congress to serve all the people, not merely those with means who can pay any price for health care while the Nation pays a steep price for not covering its children. H.R. 2 represents an additional 4 million children who will get health care.

It's time to act, now.

H.R. 2 means an additional 4 million children will have access to health care. It will provide access to preventive health care and this alone means America will raise healthier children who will 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 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 to represent a State that took the lead on expanded access for children. In 1994, 3 years before the enactment of the original SCHIP, Washington State expanded access to children up to 200 percent of the Federal poverty level.

This 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 all of us in the State.

H.R. 2 recognizes Washington State's efforts and includes language that will allow the State to access a more than $30 million to maintain this commitment. H.R. 2 rewards States like Washington who knew early on

that providing quality affordable health care to children was a sound and humane investment.

H.R. 2 will also allow Washington State to expand our successful program to cover more uninsured children in working families. The bill provides greater flexibility and will allow the State to meet the needs of our low income working families.

I am also grateful that this legislation includes important access for legal immigrant children who are currently denied coverage—children who are born in the U.S. and are legal U.S. 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.

Mr. BLUNT. Madam Speaker, I yield 1 minute to the gentleman from Texas, a member of the Ways and Means Committee (Mr. CULBERSON).

Mr. CULBERSON. Madam Speaker, the most open, allegedly transparent Congress in the history of America has begun this session by throwing out a bill that may cost upwards of $100 billion over 10 years that was written in secret. This bill has never had a committee hearing, not allowed amendments. There are no amendments allowed on the floor of the House.

No one would consider buying a house, buying a car without reading the contract; yet you're asking the American people to spend borrowed money, up to $100 billion of borrowed money—every dollar we spend from this day forward is borrowed money—asking us to spend up to $100 billion over 10 years and not knowing what's in the bill. This is a blind ''yes'' vote for all of you.

We all support health insurance for children, but we must remember the $62 trillion of unfunded liability that our children and grandchildren are facing today. The money we spend today is going to be passed on to future generations, and it's essential that the public be given the right to read these bills. This bill was not even posted up on the Web site publicly until about 24 hours ago. What are you afraid of?

Let the sunshine in and let the public read your legislation.

Mr. PALLONE. Madam Speaker, I yield 1 minute to the gentleman from Michigan, the chairman emeritus of the Energy and Commerce Committee (Mr. DINGELL).

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

Mr. DINGELL. I thank the gentleman for yielding.

Madam Speaker, I stand in strong support of H.R. 2, the Children's Health Insurance Program Reauthorization Act of 2009. This bill was passed twice last year by overwhelming votes, with the support of large numbers of my Republican colleagues.

Since its inception CHIP has covered more than 7 million children who otherwise would not have had health care. H.R. 2 would extend coverage to 4 million more children identically situated.

Since last year when this bill passed, more than 1 million children have lost their health coverage because parents were laid off and lost employer-based coverage. My own State is particularly hard hit with over 150,000 uninsured children. These children are our treasure and we must see to it that they are protected, educated, nurtured, and properly fed.

The bill is only a beginning. I look forward to working with the new administration towards reforming our health care system. We must not stop until all Americans qualify for quality, affordable health care.

I urge my colleagues to vote again for the CHIP Reauthorization Act of 2009. This bill will be signed into law, and it will help 4 million kids that without this bill would have no health care.

Mr. BLUNT. Madam Speaker, I yield 1 minute to the gentleman from Michigan, a member of the Health Subcommittee, Mr. ROGERS.

□ 1245

Mr. ROGERS of Michigan. Madam Speaker, we have seen pictures of children on the floor, certainly touched our hearts. We have heard stories, I think from the new gentleman, the new Member from Colorado, who talked about the 100,000 kids who are eligible and not enrolled.

But what we haven't heard today, or we haven't seen, are the faces of hundreds of thousands of senior citizens who will be told, when this is signed into law, you cannot go get your cancer care. You cannot go get your pain care at the hospital of your choice that your doctor has referred you to.

We found one hospital in Washington where 90,000 Medicare seniors will not be able to get the care that they have and the relationship that they have with their doctors. We can do better.

We should not pit kids against seniors. We don't have to do that. And what you say to that family in Colorado is, you may be a family of four making $21,000, and we haven't found you yet to get connected to the services you deserve, but we think we are going to go out and find that family in New Jersey making $80,000. Apparently that $80,000 family is more important than that Colorado $21,000 family.

Let's get our priorities right. Let's not pit kids against seniors.

I would urge a strong ''no'' vote against the bill.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Members are reminded to heed the gavel and conclude their remarks within the time yielded.

Mr. STARK. Madam Speaker, I am pleased to recognize the distinguished gentleman from Georgia (Mr. LEWIS) for 1 minute, and Mr. LEWIS understands that the AARP has endorsed this bill.

Mr. LEWIS of Georgia. Madam Speaker, I want to thank the chairman for yielding.

Madam Speaker, at long last we will do what is right for our Nation's poorest children. Today we will expand SCHIP to 4 million more children. We have a mission, an obligation and a mandate to provide health insurance for all Americans and now we have a Congress and a President who will meet that obligation for our children.

It has taken too long. This Nation has been wrong to choose war and greed over children and health. Children need our help. They have a right to health care.

Today we will do what is right and pass this expansion of SCHIP.

Mr. BLUNT. Madam Speaker, I yield 1 minute to the newest member of our committee, who is going to add a lot on health care issues, Dr. GINGREY from Georgia.

Mr. GINGREY of Georgia. Madam Speaker, I rise in opposition to H.R. 2, not because of the 4 million children expansion, as my colleague from Georgia on the other side of the aisle, the distinguished Representative JOHN LEWIS just said. It's not that; it's that we are expanding beyond the original intent of the bill. And the chairman, Mr. WAXMAN, said in his remarks, right above the poverty line.

Indeed, 200 percent of the Federal poverty level is the intent of the bill, and yet there are States, 13 of them, who are using a gimmick called ''income disregard'' to lower the income of a family so that they become eligible, not only for this program but for Medicaid. That's wrong. That's gaming the system.

If you had allowed a modified open rule so that we could have brought amendments to correct that and other things, then I would certainly be very comfortable and enthusiastic in supporting this bill and supporting the expansion. But, no, you wouldn't allow that, so I am going to have to regretfully oppose the bill.

Mr. PALLONE. Madam Speaker, I yield 1 minute to the gentlewoman from Colorado, the vice chair of our committee, Ms. DEGETTE.

(Ms. DEGETTE asked and was given permission to revise and extend her remarks.)

Ms. DEGETTE. Madam Speaker, 6 million children in this country who are currently eligible for SCHIP and Medicaid do not have health insurance. These children's parents work, but they cannot afford to ensure that their children have well-child care, and they have to resort to the emergency room for even the most basic services, like treatment for an ear infection. This is wrong.

Today's bill will help these families, but with a number of changes that vastly improve the legislation. It allows States to give coverage to pregnant women and people who are here

legally. It preserves simplified outreach and enrollment procedures.

Madam Speaker, in the face of the current economic downturn, it is even more vital that we enact this bill. Sharp increases in unemployment are adding to the ranks of the uninsured, while at the same time State budgets are shrinking, and the safety net is struggling to meet this increased demand.

Because, Madam Speaker, we need to provide this care for our kids because in the most civilized country in the world, no child should go without health care.

Mr. BLUNT. Madam Speaker, I yield 1 minute to the gentlelady from Tennessee (Mrs. BLACKBURN).

Mrs. BLACKBURN. Madam Speaker, you know, it is so interesting as we have this debate, SCHIP, as it was originally put in place, is something that we are all for. That program as a block grant program worked well.

But, Madam Speaker, here is a 285-page bill that the Democrat majority laid on the table yesterday about 1:00.

In that bill, it allows for expansion of coverage to adults. We know that there were over 700,000 adults on this program at some point in 2006. We also know I had an amendment that would have removed, phased out all non-pregnant adults from this program and that amendment was not allowed.

This bill, this bill, will actually crowd out a lot of the low-income children who have benefited from being on the SCHIP program, and I find that very unfortunate that we will reduce the amount of health care available to the children of the working poor and allow the expansion of adults and middle-income children.

Mr. STARK. Madam Speaker, I am pleased to yield 1 minute to the distinguished gentleman from New Jersey (Mr. PASCRELL) who understands that many of the adults on the program last year were pregnant women.

Mr. PASCRELL. Madam Speaker, you can't have it both ways. You can't be for it and then you are going to vote against it.

I am listening to the many people on the other side. Substance is more important than process. You don't get it. You don't understand it.

So I am in strong support as a proud cosponsor of the Children's Health Insurance Program which does reauthorize and is fiscally responsible, reasonable. This is long overdue.

Ensuring health coverage for our Nation's children is a critical first step in any health reform effort. In fact, it's the least we can do. If we can't have universal care automatically right now, then we need to at least take care of the children of our country. You say you agree with it, then you ought to vote for it.

Taking swift and decisive action on this legislation has become critically important. As unemployment climbs, the ranks of the uninsured swell, and the roles of our safety-net programs grow. I am particularly proud that this bill provides flexibility in determining eligibility criteria that makes sense for individual States.

Higher income eligibilities, for example, are common sense in States like New Jersey where a dollar simply doesn't go as far.

In New Jersey, we have set out on an ambitious endeavor to cover every child by July of this year, including the 267,000 currently uninsured children in our State.

It is estimated that as many as 130,000 of these children are eligible for FamilyCare, New Jersey's CHIP plan, but are not currently enrolled.

Passing the important legislation that is before us will help States like mine to take the steps necessary to ensure that every child has access to affordable, quality health care.

The stakes are bigger now than ever, so it is time to cast aside political games and pass this bill.

Mr. BLUNT. Madam Speaker, I yield 1 minute to the gentleman from Nebraska, a member of our committee, Mr. TERRY.

Mr. TERRY. Madam Speaker, under this legislation, physician-owned hospitals would be banned in the future. This includes the Bellevue Medical Center currently under construction in my congressional district.

This first photo is a view of the finished—this is 48 hours old, this photo here, showing a nice steel structure and a half-completed building. If this bill would pass today, construction on this facility has to stop because it's 40 percent owned by physicians. The other partner in here is a hospital. We have two facilities like this in my district.

Now, not only is it appalling that we are going to have to shut down construction on it or else not accept Medicare patients, but the fact is the community that this is being built in is a town, it's incorporated within the Omaha area, about 50, 60,000 people and also has a base, an Air Force base on it. There are no other medical facilities in this general area. This will be it, and we will be shutting this down.

Madam Speaker, I rise today in opposition to this SCHIP bill.

Under this legislation, physician-owned hospitals would be banned in the future. This includes the Bellevue Medical Center currently under construction in my congressional district. Also, the Midwest Neuroscience Center and Nebraska Orthopedic Hospital, which are both specialty hospitals that would not be allowed to expand under this legislation. The Bellevue Medical Center, to be located at Highway 370 and 25th Street in Bellevue, will have 60 inpatient and observation beds which will all be private rooms. Potential future expansion can allow for additional 60 beds. In addition to general medical services, the hospital will provide labor and delivery care, emergency care, inpatient and outpatient surgery and intensive care. Facilities will feature state-of-the-art diagnostic services and equipment, including a cardiac catheterization lab, radiology, lab testing and pharmacy on premises. There will be a medical office building adjacent to hospital which will house patient clinics.

Construction of the Bellevue Medical Center is ongoing. It started late in 2007 and is expected to be completed later this year with a total cost of $135 million. Sixty percent of this hospital will be owned by the Nebraska Medical Center, which is a community hospital, and up to 40 percent of this hospital will be owned by community physicians and faculty of the University of Nebraska College of Medicine. Unfortunately, under Sec. 623, Bellevue Medical Center would have had to have their Medicare Agreement signed by January 1, 2009, in order to be compliant. This is very unfortunate for a number of reasons, but none larger than the community in which this hospital will serve.

The location in which the hospital is being built is an ideal location for a new hospital since there is a population of almost 100,000 people who can take advantage of it. This would include the city of Bellevue, Offutt Air Force Base and Plattsmouth. In particular, the Bellevue Medical Center would have a strong focus on serving the healthcare needs of the following military related personnel in the Bellevue area: 10,000 active duty personnel, 20,000 dependents of active duty personnel and 11,000 military retirees.

Bellevue's other medical facility, Ehrling Bergquist Clinic, located at Offutt Air Force Base, no longer has inpatient services and has limited outpatient services. Operations at this clinic include same-day surgery, and urgent care. As a result, the Bellevue Medical Center is needed to meet the hospital needs of the Offutt community. The Bellevue Medical Center will also serve as a training area for Air Force physicians, including approximately one-third of the Air Forces's complement of family practice physicians.

This hospital is also needed to serve the fast-growing population of Sarpy county, which according to the U.S. Census Bureau, is the fastest growing county by population in Nebraska and western Iowa. Nebraska Governor Dave Heineman and the Bellevue Chamber of Commerce support the Bellevue Medical Center.

Madam Speaker, this is one of the major reasons that I cannot support this legislation and will be voting against it today.

Mr. PALLONE. Madam Speaker, I yield 1 minute to the gentlewoman from California (Ms. ESHOO).

Ms. ESHOO. Madam Speaker, I thank the chairman of our subcommittee, Mr. PALLONE, also Mr. DINGELL, Mr. WAXMAN, and everyone that's been involved in shaping this legislation.

Senator Hubert Humphrey was very fond of saying that a society is measured on how it treats those in the autumn of their lives and how it treats those in the spring of their lives.

Today we rise to honor the young in our country with legislation that will provide for them what is one of the great necessities of life, and that is health care. We will not have healthy adults in our country unless we have healthy children.

Today we put down a magnificent down payment to ensure health care for 11 million children in our country. This is a smartly drafted bill. Why? Because it is responsible, because it is paid for.

Over 90 percent of the providers are private sector. So I think today is not only a profound moment in the Congress, but a sacred one. I look forward

to its passage and what it will do to strengthen our country and strengthening our country's children.

Mr. BLUNT. Madam Speaker, I yield 1 minute to the gentleman from Indiana (Mr. BUYER).

Mr. BUYER. I thank the gentleman for yielding.

Madam Speaker, a lot of my colleagues, some of whom were here in 1997, voted against the Balanced Budget Act of 1997, actually voted against the SCHIP program.

So you are coming here to the floor now accusing Republicans saying if you are going to go vote against this you are voting against children.

When we passed this on a bipartisan basis, please don't do that. I am not going to come here to the floor and say, oh, you were against children because you voted against the Balanced Budget Act. So let's be really accurate with regard to our language.

One thing that does concern me right now is when you look at the number of adults that are on the SCHIP program, every time an adult is in that program, over 700,000 of them, it costs more money.

So what we should be doing is saying in agreement here SCHIP is a good program. Republicans created the SCHIP program. When we worked with Bill Clinton in doing welfare reform, we said we are going to put people to work. We are going to take care of those children.

The States then got all overeager and excited in a good economy and expanded the eligibility.

Now, as the economy turns down, now we have President-elect Obama——

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

Mr. BLUNT. Madam Speaker, I yield the gentleman an additional 30 seconds.

Mr. BUYER. He is now proposing in the stimulus plan to say well, gee, let's go to the Federal Government. We don't want to change our program. Let's go to the Federal Government and ask for 200 billion-plus to bail out those judgments of the past.

So what, we are going to stimulate the past as now we are going to add to exacerbate the problem here on the House floor? Let's stop and pause and think about what we are doing here, folks. Let's look at this program to actually cover children. You are about to say of the 700,000 adults that are on the program, by 2013 we could have over 1.4 million in the program.

For every adult that is in this program, we are taking away more money that actually could cover children.

Mr. STARK. Madam Speaker, I am delighted to yield 1 minute to the distinguished Congresswoman from Florida (Ms. KOSMAS).

Ms. KOSMAS. Thank you, Mr. Chairman.

Madam Speaker, I am pleased today to rise, my first time on the floor of the House, to speak in favor of the State Children's Health Insurance Program Reauthorization Act.

This bill, for me, is an opportunity for working families in my district to provide health care to their children. Let me say it again, it's an opportunity for parents to provide health care, working families to provide health care for their children. In these tough economic times, we have more and more families which are unemployed or underemployed, and this gives them an opportunity to give their children the health care that they need and deserve.

With many of them providing health care to their children through emergency rooms, as opposed to having this access to quality care, we are losing both an efficiency factor and an economic factor.

So I rise again, as I say, to speak in favor of this bill. Providing health care to children is not just the right thing to do, but this is an economic investment that we are making in the future of those who will carry us forward into the next generation.

Mr. BLUNT. Madam Speaker, I yield 1 minute to the gentleman from Indiana (Mr. BURTON).

Mr. BURTON of Indiana. I don't want to discuss things that have already been discussed, but the things that concern me are things like this will be a magnet for more illegal aliens coming into this country because it's going to provide a mechanism for illegals to get coverage under this bill.

It's going to cost $44 billion more than the baseline. It's going to involve a tax increase.

You know, one of the things that really concerns me about what we are doing is we passed a bailout bill for $700 billion. We are going to pass another bill here, a supplemental, it's going to be $1.2 trillion. We spent $14 billion for the auto industry.

This is going to cost $44 billion over the baseline. Where do you think all this money is coming from? And I wish my colleagues would start thinking about the kids in the future as well as what we are talking about today. Because the inflation problem they are going to face is going to be huge.

You have got to print this money. It has got to come from someplace. And the kids of kids of today and tomorrow are going to have to pay through the nose for the things we are doing today. We don't have all the money to do these things, and yet we are spending. That will lead to hyperinflation down the road and severe economic problems.

□ 1300

Mr. PALLONE. Madam Speaker, I yield 1 minute to the gentleman from Texas (Mr. GENE GREEN).

(Mr. GENE GREEN of Texas asked and was given permission to revise and extend his remarks.)

Mr. GENE GREEN of Texas. Madam Speaker, I thank our Chair of our subcommittee.

I rise in strong support and as a cosponsor of H.R. 2, the Children's Health Insurance Program Reauthorization Act, or CHIPRA. During the 110th Congress, we made two attempts to reauthorize the SCHIP program. Unfortunately, both these bills were vetoed by the President.

With 6 million American children currently eligible yet unenrolled, the passage of this bill is overdue. CHIPRA reauthorizes SCHIP through 2013 and extends SCHIP coverage to 7 million children already enrolled, but the SCHIP program covers 4 million more children. Eleven million children will be covered under SCHIP when we pass this bill.

The bill includes a provision that I am proud is in there, H.R. 465, the Immigrant Children's Health Improvement Act, which gives the States the option to cover children and pregnant women of lawfully residing children in our country. These are not illegal immigrants. They are children who go to school and go to daycare with our children and our grandchildren. Those children ought to have health care to protect our own children.

CHIPRA also includes language from another bill of mine, H.R. 1238, which provides 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 do have to express my disappointment that the bill did not include the provision that was included in the first SCHIP bill we passed which would guarantee that children in families earning less than 200 percent of the poverty level will have 12 months of continuous eligibility under SCHIP.

The outreach and enrollment package includes an incentive for States to provide this eligibility guarantee.

But for a State like mine, we need to ensure that the State of Texas does right by Texas children and doesn't use the flexibility inherent in the program to kick them off the rolls on a budgetary whim.

The 175,000 Texas children who were kicked off the rolls in 2003 know all too well of the State's willingness to balance the State budget on their backs, and I hoped that this bill would take away the State's ability to do that in the future.

However, the need to reauthorize SCHIP before the program expires on March 31st is more important than political battles.

I hope my colleagues will join me in supporting this legislation and sending a strong message to the President that we must abandon partisan politics and reauthorize SCHIP for America's low-income children.

Mr. BLUNT. Madam Speaker, I yield 1 minute to the gentleman from Iowa (Mr. LATHAM).

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

Mr. LATHAM. Madam Speaker, I thank the gentleman.

Madam Speaker, there is no question the State Children's Health Insurance Program needs to be reauthorized to provide the funds necessary to maintain current coverage and enroll currently eligible low-income children.

In the past I have supported bipartisan legislation that represented the

input of both parties to reauthorize the SCHIP program, H.R. 976 and H.R. 3963, including legislation that was vetoed by President Bush. However, I cannot support this partisan legislation before us today because Democrats have radically departed from the bipartisan agreement that had been reached.

First, they have removed the provision that would have capped eligibility for SCHIP for families making over 300 percent of the Federal poverty line, or roughly $63,000 per family of four, allowing unlimited expansion of the program in the future. Furthermore, there are no requirements that a certain level of coverage for low-income children be met before expanding eligibility to higher income groups.

Second, they have rescinded a requirement in current law that noncitizens who are here must legally wait 5 years to become eligible for the SCHIP program.

The bill also reduces citizenship verification requirements for the Medicaid program, potentially allowing illegal aliens to game the system to obtain taxpayer-funded welfare benefits.

At a time when nearly 70 percent of uninsured American children are already eligible for Medicaid or SCHIP, our economy is weak and the budget deficit is soaring, it makes no sense to put non-citizens or wealthier children ahead of poor American children from hard-working, tax paying families who desperately need access to these programs.''

Mr. STARK. Madam Speaker, I yield 1 minute to the distinguished gentleman from Maryland (Mr. VAN HOLLEN).

Mr. VAN HOLLEN. I thank my colleague.

Madam Speaker, this is a moment of important substance and important symbolism. The substance and merits of this bill are clear. We are going to preserve health coverage for 7 million American children and expand it to another 4 million children from working families who earn too much to qualify for Medicaid, but do not earn enough to be able to afford the very high costs of private health insurance.

Taking this bill up right now also sends a very important signal that change has come to Washington, DC as a result of the last election. President Bush twice vetoed this legislation on children's health. We will soon have a new President, President Barack Obama, who as one of his first acts as President will sign this legislation, a President who understands the hardships American families are struggling under at a time when more than 2 million Americans have lost their jobs in just 2 months.

The difference could not be clearer. The current President used his mighty veto pen to say ''no,'' to veto and protect the status quo. The new President will use that pen to say ''yes,'' to change the status quo and provide health care to 4 million new American children as we continue to protect 7 million American children. That is change we can believe in.

Mr. BLUNT. Can I ask how much time is remaining on each side?

The SPEAKER pro tempore. The gentleman from Missouri (Mr. BLUNT) has 90 seconds remaining; the gentleman from California (Mr. HERGER) has 15 minutes remaining; the gentleman from New Jersey (Mr. PALLONE) has 8¾ minutes remaining; and the gentleman from California (Mr. STARK) has 9 minutes remaining.

Mr. BLUNT. I reserve the balance of my time.

Mr. HERGER. Madam Speaker, I yield myself such time as I may consume.

Madam Speaker, I rise in support of SCHIP and believe its reauthorization is critical to millions of children, but I am opposed to the bill before us today. This legislation does nothing to make private health coverage more affordable. By expanding a program that severely underpays doctors in my State of California, it may result in higher costs for private coverage. And assuming that the increased tobacco tax achieves the goal of discouraging smoking, it commits an irrational policy of financing a growing program through a declining revenue source.

In addition, this new version would effectively shut down physician-owned hospitals currently under construction, including a $40 million project in my district in Yuba City, California, scheduled to open in a couple of months. This will be a severe blow to a small county that has long had one of the highest unemployment rates in California.

Madam Speaker, in the middle of the worst economic downturn in decades, this provision would destroy jobs in Yuba City and in dozens of other cities across America.

I would urge all of my colleagues to ask themselves, do you believe that a corporate board halfway across the country would do a better job of holding down costs and ensuring high quality care than a team of local doctors, and, if so, are you certain enough that you are willing to deny your constituents the opportunity to make that choice?

I urge rejection of this misguided provision and a ''no'' vote.

I reserve the balance of my time.

Mr. PALLONE. Madam Speaker, I yield to the gentlewoman from New York (Mrs. MALONEY) for the purpose of a unanimous consent request.

(Mrs. MALONEY asked and was given permission to revise and extend her remarks.)

Mrs. MALONEY. Madam Speaker, I rise in strong support of this bill.

Madam Speaker, if history is any guide, the current recession will lead to a substantial increase in the demand for children's health care coverage under SCHIP and Medicaid.

Rising unemployment and staggering job losses have left many families without health insurance. The high cost of private coverage means more and more Americans are turning to state programs for assistance.

But state budgets are already strained by the recession, and many have already enacted budget cuts that would reduce funding for these programs.

My home state of New York has been forced to propose such cuts.

Unprecedented need combined with a shortage of funding is creating a perfect storm—a storm that can only be avoided if Congress votes to reauthorize the Children's Health Insurance Program.

Over the next 4½ years, our bill, H.R. 2, would preserve coverage for the more than 7 million children currently covered by SCHIP, and extend coverage to nearly 4 million children who are currently uninsured.

Passing SCHIP reauthorization would guarantee sufficient funding levels for the Children's Health Insurance Program to serve future enrollment needs. It would bring much needed stability to the program, giving states fiscal security to plan for expansions and make improvements in advance of broader health care reform.

This legislation will make covering children the top priority for SCHIP, while also giving states the option to enroll mothers during pregnancy. And under the bill all children enrolled in SCHIP will have dental coverage and access to mental health services.

We are in an economic crisis as serious as any this nation has ever faced. As families struggle to make ends meet, and states are forced to make difficult budget cuts, we cannot afford to leave millions of children without the health insurance they so critically need.

We have the opportunity now to make good on our commitment to helping America's families in these tough economic times.

I urge my colleagues to vote ''yes'' on H.R. 2.

Mr. PALLONE. Madam Speaker, I yield 1 minute to the gentleman from Georgia (Mr. BARROW).

Mr. BARROW. Madam Speaker, I thank the gentleman.

Madam Speaker, I am proud to be up here today to support H.R. 2, the Children's Health Insurance Program Reauthorization Act of 2009. It has been a long time coming. I am glad we are considering this bill on the floor so early in this Congress, when we spent most of the last 2 years trying to enact it. I think it says something very positive about the commitment of this new Congress and of our new President to improving health care for all Americans.

H.R. 2 will allow us to enroll 4 million more kids in programs like Georgia's PeachCare who are just as eligible as the 7 million kids already enrolled. It is not a free lunch. Parents will still have to pay what they can afford to pay, but the kids will be able to go to the doctor, where they get good preventive care at the lowest cost, and keep them out of the emergency room, where they get the least effective care at the greatest possible cost to the taxpayer. That is more health care, better outcomes, at less cost. It is not only the right thing to do, it is the smart thing to do, and that is why I am proud to be a cosponsor of this legislation and urge all of my colleagues to support it.

Mr. HERGER. Madam Speaker, I yield 2 minutes to the gentleman from Texas (Mr. SAM JOHNSON), a member of the Health Subcommittee.

(Mr. SAM JOHNSON of Texas asked and was given permission to revise and extend his remarks.)

Mr. SAM JOHNSON of Texas. Madam Speaker, I rise today in strong opposition to a provision in this bill that would have drastic consequences for hospitals in my district and hospitals around the Nation. Everyone in this Chamber can agree that health care in this country needs transformation. America has always been a leader when it comes to medical research, training the best, the brightest, and providing superior care. We need to make sure that tradition continues.

Physicians across the country have decided they can provide better health care to more people by engaging in the process. Some doctors have decided to play a role in the care delivered in the hospitals in their community, and studies show that this has resulted in higher quality care and higher patient satisfaction.

Physician-owned hospitals employ highly skilled workers. They are an engine in the local economy, and language in this bill will devastate most of them. I say most, because a handful of hospitals located in special congressional districts will have rights that hospitals in my district and the majority of others will not. Why do only a handful of Members of Congress receive the privilege of a carve-out for their hospitals?

Many facilities have poured millions of dollars into constructing hospitals that will be forced to shut down because of this bill. Baylor Hospital in particular in my district is in the process of adding additional operating rooms and hospital beds to serve the community needs. This local hospital won't be able to complete the project because of this bill.

I ask my colleagues on both sides of the aisle to work with me to see that all existing hospitals and those under development are treated the same in this legislation. No carve-outs, no special privileges. It has to be all fair and all the same. Physician-owned hospitals have proven over and over again they spur greater choice and offer higher quality care to patients. These hospitals all deserve the right to be able to continue to serve their community. That is the American way.

Mr. STARK. Madam Speaker, at this time I am pleased to yield 1 minute to the distinguished gentlewoman from Nevada (Ms. BERKLEY).

Ms. BERKLEY. I thank the gentleman for yielding.

I rise in support of this long-overdue legislation. Coming from a State with one of the highest percentages of uninsured children, it is essential to reauthorize SCHIP to extend the program to cover more low-income uninsured children.

In 2007, more than 40,000 youngsters benefited from the Nevada Check Up program. This bill will enable Nevada to continue coverage for these children and to reach out to a portion of the 70,000 children currently eligible who remain uninsured. This bill also includes funding to improve outreach to eligible populations. Increased funding and the focus on outreach and enrollment will help extend coverage to thousands of additional Nevada children and an additional 4 million kids nationwide.

I urge my colleagues to support this bill. I look forward to having a President in the White House that is anxious to sign it.

Mr. HERGER. Madam Speaker, I yield 2 minutes to the gentleman from Wisconsin (Mr. RYAN), a member of the Health Subcommittee.

(Mr. RYAN of Wisconsin asked and was given permission to revise and extend his remarks.)

Mr. RYAN of Wisconsin. Madam Speaker, today is the beginning of a new Congress. Our new President hasn't even taken the oath of office and we are throwing fiscal discipline out the door. This whole idea of PAYGO is gone. It doesn't exist. It is a charade.

Let's take a look at what this bill actually does. This bill proposes to add all these new kids on the SCHIP program, and then in the out-years it shoves them off a cliff, taking 7 million children off of the SCHIP program. They do this only to carve and jam this bill into compliance with PAYGO.

I received a letter from the CBO just this morning that if this bill was actually carried through, if you didn't kick all of these children off of this program, it would cost $42 billion more. This bill has a $42 billion deficit hole in it. The spending increase in SCHIP in this bill increases on average 23 percent a year. Madam Speaker, Medicare is going bankrupt according to the trustees, and that increases at 6.5 percent a year.

We are being deprived of a bipartisan opportunity to extend the current SCHIP program, which would have an enormous vote here if you brought a bipartisan bill to the table. That is not what is happening. Budget gimmicks, fiscal irresponsibility, a $42 billion deficit, and the creation of a brand new entitlement program. And what is worse, we are committing our taxpayer dollars, which are so precious in this difficult economic time, to pay for insurance that people already have. 2.4 million people who already have private health insurance are going to get kicked off of their private health insurance and the taxpayers are going to pick up the tab. That is not fiscal responsibility.

Let's solve the uninsured problem. Let's come together and fix the health care problems in America. Let's not bankrupt the country. Let's not play budget gimmicks. Let's not throw PAYGO out the window. And let's not take away the health insurance that people already have and make them have government-sponsored health insurance. We should reject this bill.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, January 14, 2009.

Hon. PAUL RYAN,
Ranking Member, Committee on the Budget, House of Representatives, Washington, DC.

DEAR CONGRESSMAN: As you requested, the Congressional Budget Office (CBO) has estimated the budgetary effects of modifying H.R. 2, the Children's Health Insurance Program Reauthorization Act of 2009, to extend the program's authorization through 2019 in a manner that would provide sufficient funding to allow states to meet demand for increasing enrollment within the program's parameters. If H.R. 2 were changed to authorize the Children's Health Insurance Program (CHIP) through 2019 and to provide sufficient funding for such increasing enrollment throughout that period, CBO estimates that enacting that alternative version of the bill would increase deficits by $41.6 billion over the 2009–2019 period. In contrast, CBO estimates that the version of H.R. 2 introduced in the House of Representatives on January 13, 2009, would result in a net reduction in deficits of $0.4 billion over that 11-year period.

The introduced version of H.R. 2 would authorize CHIP through 2013 and would provide significant funding increases over the next few years, leading up to a total funding level of $17.4 billion in 2013. The program's funding for the second half of fiscal year 2013 would be $3 billion. Under baseline rules, that amount annualized—$6 billion—would be projected for each subsequent year. The estimated cost of the bill assumes that funding level for CHIP for fiscal years 2014 through 2019. On that basis, CBO estimates that the introduced version of H.R. 2 would increase federal direct spending by $73.3 billion through 2019, including the costs of other provisions in the bill. (That spending would be offset by increases in federal tax revenues totaling $73.6 billion over the same period, primarily from increases in the excise taxes levied on tobacco products.)

As an alternative to the introduced version of H.R. 2, you requested that CBO assume the CHIP rules and structure as currently delineated in H.R. 2 would remain unchanged through 2019 and that sufficient funding would be made available after 2013 to accommodate projected enrollment growth. The projected enrollment growth is based on expected growth in the total population, as well as changes in the health insurance market and the economy as a whole. Under those assumptions, CBO estimates that average monthly enrollment in CHIP would rise from about 9 million in 2013 to about 12 million in 2019.

Based on the assumptions you specified, CBO estimates total changes in direct spending of $115.2 billion, as compared with the $73.3 billion increase we estimate for the introduced version of H.R. 2. (Revenue increases would remain unchanged.) Thus, the net budget impact of a modified version of H.R. 2, as you specified, would be an increase in deficits totaling $41.6 billion over the 2009–2019 period.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contacts are Robert Stewart and Sean Dunbar.

Sincerely,

ROBERT A. SUNSHINE,
Acting Director.

Mr. PALLONE. Madam Speaker, I yield 30 seconds to the gentlewoman from California (Mrs. CAPPS).

Mrs. CAPPS. Madam Speaker, I have 30 seconds to explain why H.R. 2, the State Children's Health Insurance Program, means everything to a school nurse.

□ 1315

And I'll just tell you, I can see the faces of the children I cared for as best as I could who would have benefited so dramatically from this program. And I'll tell you what this feels like now, as so many moms and dads are losing their jobs and need this program even more. And my State, California, is cutting even the children who presently are served so dramatically.

And give States the option of covering pregnant women. That is the greatest thing we can do for the health of a child is to cover the mom.

Mr. HERGER. Madam Speaker, I yield 3 minutes to the ranking member of the Ways and Means Committee, the gentleman from Michigan (Mr. CAMP).

Mr. CAMP. Madam Speaker, I believe every child in America should have access to quality health care. The Children's Health Insurance Program has done just that for those in families without the means to provide or buy insurance on their own.

SCHIP was created as a bipartisan program, and it was one I was proud to support. The bill before us today, however, not only threatens the core mission of the program, which is providing health care to low-income children, but creates a new entitlement that will demand higher taxes on all Americans in just a few short years.

Let me first state the obvious problem with this bill. A children's health program should not be used to cover adults, noncitizens, potentially illegal immigrants and those making $80,000 a year.

There's another problem with the bill, one the majority hopes you ignore. This bill blatantly attempts to hide the true cost of the bill to the American taxpayer. It's irresponsible and untenable to fund a children's health program with the revenue stream that's fast drying up. Increasing the cigarette tax, regardless of your support for such an idea, does not, will not, and cannot cover the cost of this program.

The Democrats are blowing a giant cloud of smoke into the face of the American taxpayers, and I believe the impending tax increases that must come to cover this program will have us all in a severe coughing fit.

The Democrats want you to ignore the fact that the percentage of Americans who smoke has been dropping for decades. But research and logic both show that raising the prices of cigarettes will lead to less smoking and fewer tax dollars coming into the Federal Treasury. Yet, the only way for this funding scheme to work is if the majority finds 22.4 million new smokers. I can't wait to see the look on Senator Daschle's face when the Speaker tells the soon to be Health and Human Services Secretary that little tidbit.

But in all seriousness, with its funding base declining, SCHIP costs will increase exponentially. CBO predicts that SCHIP spending will more than double under the Democrats proposal. The resulting gap between program spending and revenue becomes staggering, a gap the Democrats will soon ask the American taxpayers to fill.

In closing, I'd like to add one final note. This bill represents a broken promise to lower- and middle-income Americans. President-elect Obama promised that no one making less than $250,000 per year would see their taxes go up; yet, under this proposal, a working-class family with two adult smokers would face hundreds of dollars in additional Federal tobacco taxes each year.

We haven't made it to Inauguration Day, and House leaders are already breaking this campaign promise. That might be a record, even here in Washington, D.C.

Let's keep SCHIP focused on low-income children. Let's not ask 22.4 million Americans to start smoking, and let's demand a better bipartisan bill.

I ask my colleagues to vote ''no'' on this bill.

Mr. STARK. Madam Speaker, I am pleased to recognize Mr. SCHAUER from Michigan for 1 minute.

Mr. SCHAUER. Madam Speaker, I came to Washington to be a voice for those in my State who are hurting.

H.R. 2 will help children and families who are victims of our economic crisis; 100,000 children in Michigan lack health insurance. That is immoral and weakens our economy. This bill ensures comprehensive health care coverage for children, and is an investment in prevention and approved overall health status for America.

With Michigan's economy in crisis, with our Nation's economy struggling, with our families losing health insurance due to this recession and unfair trade, now is exactly the right time, colleagues, to act, to cover 11 million children with the health care coverage they deserve and need.

Mr. HERGER. Madam Speaker, I yield 1 minute to the gentleman from Louisiana (Mr. BOUSTANY), who is a physician.

Mr. BOUSTANY. Madam Speaker, as a physician, we all recognize the importance of high quality health care for all children in this country. In addition to the declining source of revenue as a means to pay for this, which I believe is an irresponsible way to legislate on health care, there's a serious other problem that needs to be discussed and that is, does this bill provide real access to quality health care?

Too often children on Medicaid and SCHIP receive fewer visits from primary care providers than those with private coverage. That's clear. And they are much more likely to seek care in the emergency room when it's late. They don't get the necessary screenings and vaccinations.

GAO criticized government-run programs like SCHIP for disregarding patients' access problems.

It's disappointing to me, as a physician, that the majority rushed this flawed bill to the floor without permitting any opportunity for improvements. I offered an amendment that went to Rules which was not allowed, which would have encouraged States to measure and report provider access problems for SCHIP programs. It would also require States to report their plans to limit ''crowd out'' of private coverage.

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

Mr. BOUSTANY. I would like to include the rest of my statement in the RECORD.

In section 402 of their bill, Majority leaders failed to address the access problems I brought to their attention last year.

Their vague language does not require states to uniformly report primary care visits.

It does not mention surveying parents on whether sick children received needed care quickly.

It also fails to require states to describe their plans to avoid displacing children's private coverage.

We need to help poor children first.

A plastic government coverage card that delays access to needed care is an insult to low-income families.

Congress has a duty to help enrolled children who—despite being covered—still can't find a doctor to treat them when they're sick.

Mr. PALLONE. Madam Speaker, I would yield 1 minute to the gentleman from New York (Mr. ENGEL).

Mr. ENGEL. Madam Speaker, I rise in strong support of the bill. I am so proud that under our new administration we'll finally enact a comprehensive, robust reauthorization of the SCHIP program which will provide health care to over 11 million low-income children. No more playing politics with our children, no more Presidential vetoes of this bill. We are finally going to do what is right for our Nation.

It simply makes economic sense to cover the uninsured. When we fail to provide our citizens with primary and preventive care, routine health problems compound into emergency conditions.

New York, my home State, operates a separate stand-alone program under SCHIP called Child Health Plus. As of December 2006, nearly 400,000 children were enrolled and receiving comprehensive health care coverage in the program. As the third largest SCHIP program in the Nation, New York reduced the number of uninsured children in the State by 40 percent. We are only one of seven States to do that. And New York's program has increased enrollment by over a quarter of a million children since the start of SCHIP. SCHIP also contributed to a nearly 30 percent increase in children enrolled in Medicaid.

This is necessary. It is good. We should all support this bill.

The SPEAKER pro tempore. The gentleman from California (Mr. HERGER) has 5 minutes remaining. The gentleman from New Jersey (Mr. PALLONE) has 6¼ minutes remaining. The gentleman from California (Mr. STARK) has 7 minutes remaining.

Mr. HERGER. Madam Speaker, I yield 1 minute to the gentleman from Georgia (Mr. LINDER).

Mr. LINDER. Madam Speaker, when SCHIP first passed about a dozen years ago, Georgia's program was called Peach Care. It was open to large numbers of people, and millions signed up, many of whom came off private health insurance to do so. A friend of mine, who made $150,000 a year, signed up too. She never used it. But you could sign up by the Internet.

Some of that's been tightened up, but this bill opens that back up again. You're eligible by just stating your Social Security Number, no need to prove who you are.

The 5-year waiting period that's always been in place for legal immigrants who come here sponsored, is erased. And we all know that sooner or later we're going to have an amnesty for those 20 million illegals, and that will dwarf this system.

I was in dental school in 1936 when Lyndon Johnson delivered the great society speech; and he said, using easily quantifiable user statistics, we know that by 1990, Medicare will cost $9 billion, and Medicaid will cost $1 billion. He was wrong. And this will be abused also.

Mr. STARK. Madam Speaker, at this time I am delighted to yield 1 minute to the distinguished gentleman from California (Mr. THOMPSON).

Mr. THOMPSON of California. Madam Speaker, I rise in strong support of this bill because investing in children's health care is one of the wisest choices we can make. Children have to be healthy to get an education and to achieve their full potential as adults. When kids see the doctor more regularly, they receive the preventive services that keep them healthier longer, and they are less likely to end up in the emergency room, which saves everyone money.

Almost a quarter of a million children in my State of California are uninsured. That's simply not acceptable. In contrast to President Bush's multiple vetoes of similar bills, today, with President-elect Obama's enthusiastic support, the House will vote to provide coverage for 4 million, 4 million additional children.

Madam Speaker, that truly is change we can believe in.

Mr. HERGER. How much time do we have, Madam Speaker?

The SPEAKER pro tempore. The gentleman from California (Mr. HERGER) has 4 minutes remaining; the gentleman from New Jersey has 6¼ minutes; the gentleman from California (Mr. STARK) has 6 minutes; and the gentleman from Missouri has 90 seconds.

Mr. PALLONE. Madam Speaker, I yield 30 seconds to the gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN).

Mrs. CHRISTENSEN. Madam Speaker, I am proud today to rise for the 11 million children who will have health coverage when we pass H.R. 2 for the first time and it's finally signed into law by the incoming President.

CHIPRA will make a significant down payment on President-elect Obama's and our promise to insure all of our children. And it rightfully refuses to leave out children and pregnant woman legally admitted into our country.

It includes dental and mental health care, and will help eliminate health disparities because many of those covered children will be children of color. Healthy children have a better chance to also become healthy adults.

It's the right thing to do. It should not have take this long, and I urge my colleagues to pass it for the good of our children and the good of our country.

Mr. HERGER. Madam Speaker, I continue to reserve my time.

Mr. STARK. Madam Speaker, I am delighted to yield 1 minute to the distinguished gentlewoman from Colorado (Ms. MARKEY).

Ms. MARKEY of Colorado. Madam Speaker, I rise today in support of H.R. 2, the reauthorization of SCHIP.

When our Nation faces tough economic times, we must look beyond the grim statistics to see the true cost of our struggles. Seven percent of this Nation is unemployed, which leaves too many families without health insurance. 170,000 children in Colorado alone have no health coverage. That's more than one in eight.

How we as a Nation approach health care for our children speaks not just to our economic priorities but to our moral priorities.

Colorado ranks seventh worst nationally in the rate of uninsured children. As the mother of three kids who knows the worry and heartache that comes with caring late into the night for a sick child, that is one statistic I hope I have a hand in changing.

I as all of my colleagues on both sides of the aisle to pledge their support for our children and vote for this bill.

Mr. STARK. Madam Speaker, at this time I am delighted to yield 1 minute to the distinguished gentleman from Georgia (Mr. SCOTT).

Mr. SCOTT of Georgia. Madam Speaker, I represent Georgia, which has 300,000 children who badly need coverage in this legislation. Let me take a part of my moment here, if I may, to respond to what I think are some misstatements from the other side because this is, indeed, a children's health program, and they've mentioned about adults being on this program.

One category of adults, Madam Speaker, is pregnant women. Of all adults, a pregnant woman with child in her womb, they need care. They should be and are covered in this.

As far as the other category, here's what the bill says as far as parents. No new waivers to cover parents in the CHIP program will be allowed. That's in this bill.

What about childless adults who don't have? The bill says the current law, that prohibition on waivers to cover coverage of childless adults is retained. Childless adults are prohibited in this law.

Issue of illegal immigration; only legal immigrant children and their pregnant immigrant legal immigrant women are covered under this bill.

□ 1330

Mr. PALLONE. Madam Speaker, I yield 1 minute to the gentleman from Illinois (Mr. FOSTER).

Mr. FOSTER. Madam Speaker, I rise in strong support of H.R. 2, the Children's Health Insurance Program Reauthorization Act of 2009.

This historic legislation renews and improves SCHIP. It extends coverage to 4 million uninsured children who are currently eligible for but who are not enrolled in SCHIP and in Medicaid.

As a fiscal conservative, I am also proud that even in today's financial storm and even under scoring rules that do not fully reflect the long-term fiscal benefits of providing adequate health care to children that the bill is fully paid for. With a modest increase in tobacco sales tax providing a bulk of the funding, we are able to provide coverage to millions of children and not add to the deficit.

This bill honors our moral commitment to help our youngest children in their health while ensuring that this legislation does not hinder their future by saddling them with huge debts.

The bill could not come at a better time. Our economy continues to worsen, and more and more people are at risk of losing their health care. This program will help give millions of parents the peace of mind that their children at least will have access to health care.

Mr. HERGER. Madam Speaker, I yield 1 minute to the gentlewoman from Florida (Ms. GINNY BROWN-WAITE).

Ms. GINNY BROWN-WAITE of Florida. Madam Speaker, first of all, let me state that I support health insurance for children. As a matter of fact, it was my bill on the floor of the Senate where we created KidCare.

Where did the money come from? It was from a historic vote that I cast to be able to go after the tobacco companies for settlement. That's where the money came from originally for the SCHIP program, but the bill we have before us today is not a bill that taxpayers can support.

First of all, there is no prohibition against crowd-out. In other words, it pushes children off of private insurance onto the government program, and it does allow States to continue for at least 2 years the enrollment of adults. It actually does nothing to prohibit illegal aliens from being on the program, and that's something that taxpayers are very concerned about. Additionally, Madam Speaker, there is no incentive here, really, to go after and to have low-income children covered by this bill.

For those reasons, I oppose it.

Mr. STARK. Madam Speaker, I reserve the balance of my time.

Mr. PALLONE. Madam Speaker, I would yield 30 seconds to the gentlewoman from New Hampshire (Ms. SHEA-PORTER).

Ms. SHEA-PORTER. Madam Speaker, I support H.R. 2, the Children's Health Insurance Program Reauthorization Act of 2009.

We have children in New Hampshire and in America who need us to fight for them. Unemployment is rising. Even working families are losing their health insurance. Providing more money now will give 4 million more children health insurance. This is a moral issue. We are the only nation in the world that does not provide health care to all of its children. This is simply unconscionable.

I am proud to support this legislation to help New Hampshire's children and America's children.

Mr. HERGER. Madam Speaker, I yield 2 minutes to the Republican whip, the gentleman from Virginia (Mr. CANTOR).

Mr. CANTOR. Madam Speaker, I rise today to underscore that all of us, Republicans and Democrats alike, desire to ensure that all children of low-income working families have access to high-quality, affordable health care. But at this time in our economy when deficits threaten to climb to $1.6 trillion, without Republican input or without any debate, the majority has rushed a bill to the floor that substantially expands the reach of this program beyond its original intended purpose. All the while, a substantial portion of the existing target population has never been reached.

It is with much disappointment that I stand in opposition to this bill today, because it could have had significant bipartisan support had the majority opened the process to our substantive ideas.

Before our ideas and solutions were shut out at the Rules Committee, we sent President-elect Obama and Speaker PELOSI a letter which outlined four central issues that we had hoped would be addressed.

First: We believe that the SCHIP bill should follow the original intent of the law. That is to cover children in low-income working families.

Second: We Republicans believe that expanding SCHIP should not shift children away from private health insurance options into government-run programs that are funded exclusively by the taxpayers. Instead, we should be providing families who are currently uninsured with more affordable options to better meet their needs, not a one-size-fits-all government solution.

Third: We Republicans believe that the legislation should include meaningful provisions to prevent fraudulent activity by those who seek to illegally gain access to this program.

Finally, Madam Speaker, when Congress reauthorizes the program, we must do so responsibly. The budget gimmicks included in this bill suggest that the majority is not seriously trying to comply with PAYGO. This bill will only put the States and the Federal Government into further debt. I don't think there is any question that many in this House want to do the right thing. Unfortunately, Madam Speaker, I feel this bill doesn't quite reach this mark.

Mr. PALLONE. Madam Speaker, we inquire of the time that is remaining.

The SPEAKER pro tempore. The gentleman from New Jersey has 4¼ minutes remaining. The gentleman from California (Mr. STARK) has 4 minutes remaining. The gentleman from California (Mr. HERGER) has 1 minute remaining. The gentleman from Missouri has 90 seconds remaining.

Mr. PALLONE. Madam Speaker, at this time, I would yield 30 seconds to the gentleman from New York (Mr. MASSA).

Mr. MASSA. Madam Speaker, I am compelled to observe that, while Rome burns, my friends and colleagues across the aisle argue process.

We were elected to come here and make a difference in the lives of the people who we represent. Today, I will proudly cast a vote in the affirmative for the expanded State Children's Health Insurance Program Reauthorization Act of 2009 to do exactly that.

We are in a time of financial and economic crisis, and we cannot ignore the individuals who have sent us here to help them. It is a plain and clear call to action. It is wrong to say that you support children's health care and, at the same time, vote against it. This is not about process. It is about standing with America's children, and I am proud to do so today.

The SPEAKER pro tempore. The Chair will recognize in reverse order the managers for closing comments. That would be Mr. HERGER, followed by Mr. STARK, followed by Mr. BLUNT, followed by Mr. PALLONE.

Mr. PALLONE. Madam Speaker, I have some additional speakers, though.

I yield 30 seconds to the gentleman from Virginia (Mr. CONNOLLY).

Mr. CONNOLLY of Virginia. Madam Speaker, this vote is about values. If you are an uninsured kid in America and you have appendicitis, the chance of death is five times that of a kid who is insured. This is about values. We are the only developed country in the world that does not extend full health insurance to its children. History has shown no nation can truly consider itself great without providing for the well-being of its most vulnerable.

I urge my colleagues to support this legislation.

Madam Speaker, I rise in support of the bill. It is clear that the Congress sees value in this critical investment in our Nation's children, having passed a similar measure not once but twice in its last session. Thankfully, we will now have a President who shares that same compassion and commitment to our low- and middle-income working families.

Given the ongoing economic crisis, the number of at-risk children will only continue to increase. The number of Americans who are now unemployed, and ostensibly now without health care, has increased by more than half in the past year, from 4.7 percent to 7.2 percent nationally. When you factor in the skyrocketing costs of health care, coupled with the economic pinch being placed on people's pocketbooks, today's American families are being bled dry and countless children are being left without health care. In that context, we are making a critical investment in the health of our Nation by adding these 4 million children to the 7 million already covered by SCHIP.

The long-term risk of not making this investment now will surely cost us more. Let me cite just one example: It is my understanding that an uninsured child diagnosed with appendicitis is 5 times more likely to die as a result of lack of access to medical attention than a child who is has been insured. By expanding access to more working families, we begin to lay the foundation for the principles by which we hope to overhaul our Nation's health care system.

As my colleagues may be aware, the United States is the only developed nation in the world that does not provide health care for all of its children. That is unconscionable. As history has proven, no nation can truly consider itself great without providing for the well-being of its most vulnerable.

Mr. PALLONE. Madam Speaker, I would yield 30 seconds to the gentleman from Iowa (Mr. LOEBSACK).

Mr. LOEBSACK. Madam Speaker, we have voted for similar SCHIP measures in the past, but those efforts were thwarted time and time again. I believe today is a new day.

Today, we will send a clear message to those who need our help the most—our children. This Congress and the new administration will tell the 38,000 uninsured children in Iowa and the millions more across the country that we care and that we will no longer leave them without the health care they need.

I look forward to casting my vote in strong support of this legislation. I urge my colleagues to do the same.

Mr. STARK. Madam Speaker, at this time, I am delighted to recognize for 1 minute the distinguished gentleman from Illinois (Mr. DAVIS).

(Mr. DAVIS of Illinois asked and was given permission to revise and extend his remarks.)

Mr. DAVIS of Illinois. Madam Speaker, I am pleased to rise in strong support of the Children's Health Insurance Program Reauthorization Act of 2009.

I am pleased to note that my State, the State of Illinois, has made it possible for every child to receive access to health care and to see that this action takes place across the country so that every child, no matter who he or she might be, has an opportunity to grow and develop to become the kind of person that his or her potential provides.

It is a great day for the United States of America. It is a great day for this Congress. It is a great day for all of the children in America.

Mr. STARK. Madam Speaker, if I may, I will yield myself 2 minutes.

I just want to rise and ask my colleagues to support H.R. 2. It has done a lot of things. It expands insurance coverage to another 4 million children. You can argue one way or the other that they may have insurance someplace else, but this will guarantee that those 4 million additional children will get the medical care or the insurance and, without which, they will not get first-class medical care in this country.

We've passed this bill in several different forms in the past, and I want to thank the 40 or 50 Members from across the aisle who have supported it in the past. We've made some changes, and we've acknowledged the legitimacy of all legal residents in our Nation by giving States the option to cover them if they choose.

I am glad to report that the bill is fully financed. We can argue about what happens 4 or 5 years out, but I am sure we'll have more of an argument on whether the very rich should enjoy escaping the capital gains tax or whether we should do away with the inheritance tax, which will bother many of the opponents much more than the idea of the tobacco tax or, indeed, the prohibition on the unethical kickbacks that physicians receive from ownership hospitals, most of which are of questionable safety and quality. This legislation expands health coverage to our Nation's children, and it is worthy of our support.

I would like to take just a moment to thank the staff members who have worked so hard over the past almost 2 years. From the staff on the Committee on Energy and Commerce: Bridgett Taylor, Karen Nelson, Andy Schneider, Amy Hall, Purvee Kempf, Tim Gronninger, Hasan Sansour, and Bobby Clark.

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

Mr. STARK. Madam Speaker, I yield myself an additional 10 seconds.

From our own staff on the Committee on Ways and Means Health Subcommittee: our staff director—Cybele Bjorklund—Jennifer Friedman, Debbie Curtis, Karen McAfee, Chiquita Brooks-LaSure, and Drew Dawson.

I urge the passage of H.R. 2.

I reserve the balance of my time.

Mr. BLUNT. Inquiring, does the gentleman have any additional speakers besides his closing comments?

Mr. PALLONE. I do not, but I was going to ask how much time remains.

The SPEAKER pro tempore. The gentleman from Missouri has 90 seconds remaining. The gentleman from California (Mr. HERGER) has 1 minute remaining. The gentleman from California (Mr. STARK) has 1 minute remaining. The gentleman from New Jersey has 2¾ minutes remaining.

Mr. PALLONE. Madam Speaker, I would yield myself a minute and a half.

I just want to stress how important this bill is and also that it is, essentially, the same bill that we passed in the last Congress. It was bipartisan. It was passed in both houses with a fairly large margin. The only thing that stood in the way was President Bush's veto.

Now we do have a new President. We know that he has supported the legislation. It is so crucial for the children of this country, for the 4 million or so now who are eligible but for whom there is no funding, who will be covered by this legislation. It is fully paid for.

Particularly now, when we have a recession and when we know that so many people are losing their jobs and, as a consequence, their health insurance for themselves and for their families, what could be more important than making sure that those families' children are covered by this legislation?

□ 1345

I must say I'm very proud of the fact that we are here in the first week, essentially, of this new Congress passing this bill. I know the other body is about to pass it as well and that we will be able to send it to the President and have it be one of the first accomplishments of his Presidency and of this Congress.

I know Mr. STARK already thanked the various staff members, so I won't thank them again. But I do want to pay particular attention to Bridgett Taylor because I know that she worked on this legislation for 2 years or more and was even there when we first passed the SCHIP bill 10 years before that. And it has always been one of the things that she cares so much about. But I want to thank all of the staff people and all of my colleagues for all of the work that they've done on this legislation.

Mr. HERGER. Madam Speaker, I reserve the 1 minute I have to close, but I would yield to the gentleman from Missouri (Mr. BLUNT) for the time that he has that he controls.

Mr. BLUNT. Madam Speaker, I yield my minute-and-a-half to the ranking member of the Health Subcommittee on Energy and Commerce, the gentleman from Georgia (Mr. DEAL).

Mr. DEAL of Georgia. I appreciate the gentleman yielding.

Madam Speaker, very few bills come to the floor of this House with so much rhetoric disassociated from facts as we have heard in this bill.

Now, let's talk about a few of the real facts.

First of all, the program was designed, at its outset, to insure children that were above the Medicaid level of poverty but below 200 percent of poverty. All of the stories that we have heard today—from both sides of the aisle, quite frankly—as to examples of children who are uninsured, in almost every one of those instances are children that should have been insured under the current law under either SCHIP or Medicaid but are unenrolled.

One of the amendments that I offered that was not allowed was an amendment that said before you can go up the poverty scale, you should have a 90-percent saturation of those children that are below 200 percent of poverty. Many States that are well above the 300 percent of poverty still have not covered a quarter of their children that are below the 200 percent of poverty level.

So ''poor children first'' is not in this bill.

Secondly, with regard to the issue of illegal immigration. Now, you can say that illegal immigrants will not be allowed, but you are removing the requirements of certification of eligibility. And by the way, pregnant women, regardless of their immigration status, are considered ''children'' under the SCHIP bill in everybody's version of the law.

Now, if you're not acknowledging that illegals are going to be enrolled in this program by virtue of the change you're making in this bill, then you ought to talk to CBO because CBO says in the next 10 years that the Federal Government will spend $5.1 billion and States will spend $3.85 billion on people who are illegally in this country.

Mr. STARK. Madam Speaker, I'm delighted to recognize the Speaker of the House, the distinguished gentlelady from California (Ms. PELOSI).

The SPEAKER pro tempore. The gentlewoman from California is recognized for 1 minute.

Ms. PELOSI. Madam Speaker, I thank the gentleman from California for yielding.

My colleagues, this is a day of triumph for America's children. With what I expect to be a strong bipartisan vote, the House will bring us one step closer to providing health care for 11 million children in America.

With this action and with the legislation last week to ensure equal pay for equal work for women, Congress makes clear that we put women and children first. It is important that we have this legislation up so soon in this new Congress because children are our top priority. We like to be considered a Congress for the children, a Congress for the future.

At a time of economic crisis, nothing could be more essential than ensuring that children of hardworking families receive the quality health care they deserve. Many of these children are from families of hardworking Americans who have lost their jobs through no fault of their own. It's sad to say that America lost 2.6 million jobs last year. Over half a million jobs were lost in the month of December—500,000 jobs in the month of December alone. It was actually 526,000 jobs. Each month, until we have an economic recovery initiative, we will continue to lose at least 500,000 jobs per month.

With such job loss, America sees the health care coverage that we all need for our children disappear. For every 1 percent increase in the unemployment rate, it is estimated that as many as 1.5 million Americans will lose their

health care coverage. A record 47 million Americans, including nearly 9 million children, are without health insurance now.

Ensuring that children have access to affordable health care just makes sense. It's not just about addressing their health needs when they are sick. It's about keeping them healthy in advance. It's about prevention. It's about diet, not diabetes; it's about prevention, not amputation. It's about a healthier America.

Contrary to the views of some, an emergency room is not good health care on a regular basis. An emergency room is, as it describes, for emergencies—not for ongoing health care. So for those who say that all people in our country have access to health care, that they can go to an emergency room, I don't know what they could be thinking.

By ensuring health care coverage for 11 million children, families will have regular doctor visits and preventative care. We will ensure that children get the care they need and the health care costs are not inflated due to expensive emergency room care.

That is why more than 80 percent of the American people support this legislation. It's bipartisan. It is fully paid for by a 61-cent tax on a pack of cigarettes as the major part of its funding, and it represents a new direction because, again, it is good health care for America's children. It is paid for.

We have fought in the last Congress together, Democrats and Republicans, in the House and in the Senate to pass this legislation—which we did—but it was vetoed. At the time, President Bush said that we could not afford this legislation, that we could not afford to insure America's children. Forty days in Iraq equals over 10 million children in America insured for 1 year. Forty days in Iraq, 1 year insuring over 10 million children. We certainly can afford to do that.

We look forward to bringing this legislation to President Obama's desk as one of the first bills that he will sign. And when we do, we owe a great deal of gratitude to Chairman HENRY WAXMAN of the Energy and Commerce Committee, Chairman RANGEL of the Ways and Means Committee, Chairman Emeritus JOHN DINGELL, who's worked on this issue for a very long time and engineered it through the last Congress. Thank you, Mr. DINGELL. Congressman PALLONE, the Chair of the subcommittee; Congressman STARK, the Chair of the appropriate Committee on Ways and Means; the Congressional Hispanic Caucus, which led the fight to make sure that legal immigrant children are covered under this legislation, and our Congressional Black Caucus. All elements of our Congress, a coalition, and on the outside, because we could not succeed with just our inside maneuvering on legislation so important and so pervasive in its impact.

Without the support of more than 300 organizations, from AARP to the YMCA and everything in between, the March of Dimes, Easter Seals, almost every organization you can name supports this SCHIP; and they support providing quality, affordable health care to America's children, and they support doing it by the passage of the State Children's Health Insurance Program legislation that we have before us today.

So I thank all of those in the Congress for their leadership in making this important day possible for America's children. It's important to children because of their health. It's important because it's paid for. We do something great for children without adding to our deficit and delivering mountains of debt to future generations.

So this, all in all, is great for kids. Let's keep our reputation going as a Congress for children and give a strong bipartisan vote to this important legislation.

Mr. HERGER. Madam Speaker, I yield the remainder of our time to the minority leader, the gentleman from Ohio (Mr. BOEHNER).

The SPEAKER pro tempore. The gentleman from Ohio is recognized for 1 minute.

Mr. BOEHNER. Madam Speaker, let me thank my colleague from California for yielding.

I rise today in opposition to this bill, frankly because of my strong support for the SCHIP program.

In 1997, Republicans here in Congress worked with our Democrat colleagues to create the State Children's Health Insurance Program. I was there, and many of you were here as well. And throughout that process it was bipartisan, it was fair, and open discussion and open debate. And unfortunately today, the voices of millions of Americans who want to provide input into this proposal have been silenced in the process.

Earlier this week, I wrote to Speaker PELOSI and President-elect Obama expressing our willingness to work together on this critical issue. We outlined our principles for this program's reauthorization. The principles are nothing new. In fact, they're the same principles that led to the creation of SCHIP in 1997.

And they are this: This program ought to cover poor children first. Unfortunately in many States, more than two-thirds of those enrolled in the SCHIP program are adults. And there is nothing in this bill that really does ensure that poor children will be brought into the program first.

Secondly, taxpayer funds for this program should not be used to fund benefits for illegal immigrants. And there's been this big debate about whether it does or it doesn't, but the fact is that while the bill says we will not cover illegal immigrants in this bill, the whole verification process that should be in here to ensure that only American citizens and legal residents are entitled to these benefits, no verification to speak of is contained in the bill.

And we also believe that SCHIP should not force children with private insurance into a State-run health insurance program. Last year in this proposal, there was language that made it clear that children with a private health insurance program, that they should stay in that private program and not be pushed into the State-run program. Unfortunately, the bill before us does not reflect these principles, the same ones that have guided this program since its creation.

I believe that the bill before us would undermine the original intent of the SCHIP program by expanding the program to adults, illegal immigrants, and upper-income families who already have access to private health insurance.

□ 1400

I think taxpayers deserve better, and, more importantly, our Nation's children deserve better. That's why today Republicans will offer a better way.

I said on the opening day, when I gave the gavel to Ms. PELOSI, that Republicans would not just be the party of ''no,'' that we would come to this floor with better solutions. And the better solution that we will offer here soon is a program that would reauthorize SCHIP for 7 years, not the 4½ years that we see in the majority's bill; it will reflect our principles, and make it clear that poor children should be covered first; and it will fully fund the SCHIP program without raising taxes on American families across our country.

Madam Speaker, Federal funds targeted for low-income children should benefit low-income children, period. Only one measure on the floor today will serve those children's interests, and that's what the motion to recommit will contain. So I would urge my colleagues to vote ''yes'' on the motion to recommit and ''no'' on the underlying bill.

Mr. MARKEY of Massachusetts. Madam Speaker, I rise today in strong support of the Children's Health Insurance Program Reauthorization Act 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 allow the program to provide health insurance to an additional 4 million low-income children on top of the nearly 7 million who already benefit from the program.

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 even more 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 incoming Obama administration recognizes the value of ensuring that all low-income children get the health care they need.

I urge my colleagues to stand with the hard working families who want to provide their children with the health care they need. Vote yes on this critical legislation.

Mrs. BACHMANN. Madam Speaker, today I rise in opposition to H.R. 2, the Children's Health Insurance Reauthorization Act of 2009. While I support the State Children's Health Insurance Program, SCHIP, and its continued reauthorization, the proposal before the House today reauthorizes this program in an irresponsible manner, at a time when the American people need responsible government more than ever.

As you know, I recently joined many of my Republican colleagues in a letter to you, Madam Speaker, and to President-elect Obama asking that any reauthorization of SCHIP contain commonsense provisions to ensure that the program's mission is fulfilled. For instance, SCHIP is meant to ensure that children without means can gain access to health care. The program is designed to cover them first, before extending coverage to children whose families may be able to afford coverage. Unfortunately, the bill with which we have been presented includes no requirement that states focus the funds in this bill on low-income children. There is a likelihood that the failure to include such a provision will lead to funds being diverted from the children who need them most, particularly in the states that have expanded their SCHIP programs most dramatically.

Another concern that I have is the impact of this legislation on the private insurance market and the families who depend upon it. In scoring this legislation, the Congressional Budget Office (CBO) estimated that 2.4 million people will drop their existing private insurance, opting instead for the public program. This ''crowding out'' will constrict the health insurance pool and further increase the cost of private insurance for millions more. Given the ranks of Americans who already cannot afford health insurance, this is the last thing the American people need.

There are other concerns that I have with this bill and with the way it is being pushed through with so little debate and no opportunity for amendment. While the House leadership has again promised that it will work in a bipartisan fashion, bringing both sides of the aisle together to build consensus legislation, this promise has turned out to be nothing more than empty to the American public. I urge my colleagues to join me in opposing this legislation.

Mr. POMEROY. Madam Speaker, I rise today in strong support of H.R. 2, the Children's Health Insurance Program Reauthorization Act of 2009.

We were all deeply disappointed that President Bush vetoed bipartisan legislation that would have reauthorized the popular State Children's Health Insurance Program, SCHIP, not once, but twice during the 110th Congress. However, under a new Congress and a new incoming President, I am pleased that we can finally move forward with bringing health care to 11 million needy low-income children.

In my own State of North Dakota, there are roughly 14,000 children who lack health care coverage. Under this legislation, the nearly 3,600 children who are already covered under the Healthy Steps program will continue to obtain the care they need and there is the potential to cover many more given the $100 million in outreach and enrollment grants as well as the $3.2 billion in performance grants to states to help enroll needy children who are eligible but currently enrolled in SCHIP.

Our Nation's current economic crisis illustrates just how urgent the need is to reauthorize SCHIP. With 2 million jobs lost in 2008, more and more needy children are finding themselves without health care coverage this year. That is why I urge my colleagues to join me in standing up for 11 million children and pass this important bipartisan piece of legislation.

Ms. EDDIE-BERNICE JOHNSON of Texas. Madam Speaker, I rise in support of H.R. 2, the Children's Health Insurance Program Reauthorization Act of 2009.

Texas ranks last in the Nation in terms of taking care of its children. A report released in 2009 by the organization called, ''Texans Care for Children'' contains dismal statistics.

For example:

Texas continues to rank 50th out of 50 among the States in health coverage for children.

Infant mortality rates have steadily climbed in Texas this decade, while remaining unchanged in the Nation as a whole.

Texas still ranks near the bottom in child hunger, child poverty, and child deaths from abuse or neglect.

The State of Texas continues to be ineffective at resolving the problem of uninsured children in our State.

I am sympathetic to States' needs to avoid revenue shortfalls regarding SCHIP, and so I support Congress allocating the funds needed to cover children in need.

Today's legislation is similar to a bill passed by Congress in 2007 and vetoed by the President.

It would provide health care coverage to 11 million children in this country who currently have none.

I support a generous expansion of this program.

Children with health insurance are more likely to be up to date on immunizations and to receive treatment for sore throats, ear aches and other illnesses.

Good health means fewer sick days and better school performance—and less burden on our emergency rooms.

As a nurse, I can not over-emphasize how important it is for young people to have a medical home.

Having a family physician can prevent so many minor illnesses from developing into serious, expensive illnesses.

Health care coverage of children just makes good sense.

I urge my colleagues to avoid delay in passing this bill, as it is critical for the health of so many children.

Mr. MORAN of Virginia. Madam Speaker, I rise today in strong support of H.R. 2, the Children's Health Insurance Program Reauthorization Act of 2009. Truly, we face a health care crisis in this country—in the richest country on Earth; 47 million Americans do not have health insurance, including 9 million children. The need is even greater in these sad economic times. With rising unemployment, more families are losing their health insurance. This bill will go a long way to provide health care for uninsured children and fulfilling our moral obligation to them.

In my home State of Virginia, the CHIP program currently provides coverage to 144,163 low-income children each year. The CHIP Reauthorization Act will help us cover an additional 75,000 children. It will ensure that these children have access to high quality health care, including the preventative services that children need to be healthy and successful in school and later in life. This bill will provide dental and mental health benefits on par with medical and surgical services—truly ensuring that the whole child's health is provided for.

The CHIP Reauthorization Act does this without increasing the deficit, primarily by increasing the Federal excise tax on cigarettes. In my view as Chairman of the Congressional Prevention Caucus, an increase in the Federal tobacco tax is sound public health policy. It provides a reliable revenue source to offset the costs of expanding coverage to low-income children and it will reduce health care costs in this country by reducing the prevalence of chronic disease.

In the past, there has been misleading and false information regarding the bill's treatment of illegal aliens. Critics of the legislation seem to ignore existing Federal law and provisions in the CHIP Reauthorization Act that prevent federal funds from being spent to provide benefits for illegal immigrants. What H.R. 2 does do is offer an opportunity for States to waive a five year waiting period on legal non citizens. Current law requires a five-year waiting period before legal immigrants are eligible for CHIP. Allowing State flexibility in this regard is sound public health policy that would enable thousands of American children access to vital health services to help them live better, healthier, and more productive lives. The bill does not mandate the change, but leaves it to the states to make their own decisions.

Reauthorizing SCHIP is sound public health policy—research shows that children who have access to health insurance are substantially more likely to access key preventative services, miss fewer days of school due to illness, get better grades, and grow to become healthy and productive adults. Moreover, the financial benefits of covering children vastly outweigh the costs—one need only compare the cost of a visit to a primary care provider to the cost of a night spent in the emergency room. Ultimately, covering all our children is a moral imperative—it is the only possible humane, responsible course of action. I urge a yes vote on H.R. 2.

Mr. CARSON of Indiana. Madam Speaker, I rise today on behalf of the thousands of uninsured children in Indianapolis, Indiana.

In this recession, many of my constituents can no longer afford the skyrocketing cost of health care. Without checkups or medication for their children, they sit powerless.

So, I implore those who oppose this bill to think of the uninsured children in their congressional districts. Should they be made to suffer from rising health care costs and an unstable job market? And should your constituents suffer because their children hang between Medicaid and private insurance? The

answer to both of these questions should be an unwavering no.

There are few opportunities in this body where the right decision is so obvious. Support our children by voting yes on SCHIP.

Mr. SMITH of Texas. Madam Speaker, I oppose this bill for many reasons. In my role as the ranking member of the Judiciary Committee I want to point out a few immigration provisions that undermine personal responsibility and burden American taxpayers.

In the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Congress, with the overwhelming support of the American people, required that legal immigrants wait 5 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 become a ''public charge.''

H.R. 2, changes current law and allows immigrants to get medical benefits at the expense of U.S. taxpayers.

Immigrants, both legal and illegal, already have a federally mandated right to emergency medical care. That mandate has helped bankrupt hospitals all over the United States.

Federal law requires that the American sponsor of new immigrants sign an affidavit of support stating that they will be responsible for any public costs incurred by the immigrant. Unfortunately, those affidavits have never been enforced and immigrant sponsors know they will not be held accountable if the immigrants receive welfare and become public charges.

The 5-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 in any way

Prior to laws enacted in 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.

Mr. KLEIN of Florida. Madam Speaker, I rise in strong support of the Children's Health Insurance Program Reauthorization Act of 2009. This critical legislation will take care of unfinished business from the 110th Congress by providing health insurance coverage to 11 million children along with enacting needed reforms to the CHIP program.

I applaud Speaker PELOSI for bringing this bill to the floor so quickly and President-Elect Obama for calling on Congres to have this legislation ready when he takes office. To be frank, this bill can't come fast enough for the millions of children without basic healthcare coverage and for the low-income families struggling to make ends meet.

Never in my life has our country been in such a precarious state. Our once soaring economy is teetering, with unemployment at 7.2 percent, and the traditional pillars of our economy are struggling to stay in business. Now more than ever, the government must fill its role by helping the most vulnerable in our society meet their basic needs like healthcare.

Madam Speaker, we're not asking my colleagues to take a leap of faith on some untested program. Created a decade ago, the State Children's Health Insurance Program is a product of true bipartisanship. A Republican Congress passed it, and a Democratic President signed it into law. And it is not an entitlement program; it is an empowerment program that encourages enrollment into private health insurance programs and a sliding scale for premiums based on a working family's ability to pay.

In my home State of Florida, CHIP is administered through the Healthy Kids Program. During my tenure in the Florida State Senate, I helped oversee its implementation while serving on various committees. While we ran into some roadblocks with enrollment, I can say that people from both parties as well as the business community felt it was an innovative way to provide health care coverage to hundreds of thousands of low income children in Florida.

Madam Speaker, passing CHIP legislation today is our first test of leadership in the 111th Congress. If we fail—if we fail our children—then we must ask ourselves what leadership means in a time of crisis and whether we deserve the trust of the American people.

Mrs. CHRISTENSEN. Madam Speaker, I rise today for 11 million reasons—the 7 million children whose insurance will continue and the more than 4 million other children who will be insured for the first time—many of whom are children of color—with the passage of H.R. 2.

I must commend Chairmen PALLONE, WAXMAN and DINGELL—whose steadfast efforts to expand health coverage to millions of American Children and whose unwillingness to accept mediocrity is why we are here today.

If we are all having dējāvu, it is because we have done this twice before. And we are here today not just because of the charm on the third try, but because this year we will have a new president who will finally sign it into law.

H.R. 2 will not only make a significant down payment on President elect Obama's and our promise to insure all of our country's children, it rightfully refuses to leave out children and pregnant women who have been legally admitted into our country. Doing this is not only the right thing to do it is the least we can do to insure the health of all of our children.

This bill also includes important expansions to the program for screening and prevention as well as dental and mental health care, addressing child health in a more holistic way

Because more than half of all uninsured children are racial and ethnic minorities, this bill will help to eliminate health disparities in this most vulnerable group and improve the outlook for their health later in adulthood.

Today we have the opportunity to reach across the political aisle to do the right thing—to make the health and health care needs of our nation's children the priority they must be—to make sure that every child has the opportunity to reach their fullest potential, so that our Nation can too.

I urge all of my colleagues to vote for H.R. 2—to vote for America's children. It is nothing less than a vote for the future of our country.

Mr. CUELLAR. Madam Speaker, I rise today in strong support of the Children's Health Insurance Program.

Growing up as the son of migrant parents, I was among the millions of American children who had no health insurance. When someone in our family got sick, seeing a doctor simply wasn't an option.

I got lucky. Even without health insurance, I grew up into a healthy adult. But I could just as easily have ended up going untreated for a chronic disease or serious injury, and a lifetime of opportunities would have evaporated. It is unacceptable that 1.4 million Texas kids continue to bear that risk today.

When I served in the Texas State House, I had the honor of launching the first CHIP program in Texas at Farias Elementary School in Laredo. The program later expanded statewide, and today, it has helped millions of Texas families—families like the one I grew up with—afford to see a doctor.

In these difficult economic times, as millions of Texas families struggle with job losses and pay cuts, CHIP is more important than ever. For families living on the financial edge, CHIP is a critical source of care, support, and peace of mind.

Mr. HONDA. Madam Speaker, I rise today in support of H.R. 2, the State Children's Health Insurance Program Reauthorization Act of 2009. Over the last 2 years, it has become necessary to fund the Children's Health Insurance Program in some States through supplemental appropriations as program wait-lists grew and children waited for care. Now, with the country in the midst of the severest financial crisis in decades, parents are more concerned than ever about the health and well-being of their children. The bill before us today represents an investment in our Nation's safety net; by preserving and expanding the program to provide coverage for 11 million children over the next 4½ years, the bill alleviates some of the stress placed on men and women faced with unemployment.

My home county of Santa Clara was the first in the Nation to ensure that every child with parents at or below 300 percent of the federal poverty level has real access to regular health care as a result of being insured. The county's Children's Health Initiative raises its own money to add to State and Federal funding in order to keep all the children of my district healthy—last year, the program enrolled over 144,000 children and serves as a model for 17 other California counties.

This innovation is threatened by the county's $220 million projected budget deficit for fiscal year 2009; and we in Santa Clara County face the possibility of deep cuts in our healthcare system totaling nearly $100 million. The budget woes of the State of California limit the assistance it can provide, and so without this reauthorization of SCHIP, the financial burden on the county would be significantly heavier. I'm proud to vote today for legislation that will provide our program and our county's children with much needed stability for the next 4½ years.

As the chairman of the Congressional Asian Pacific American Caucus, it is particularly gratifying to see the inclusion of a provision in this bill that will allow States to waive the 5-year waiting period for Medicaid and SCHIP imposed on pregnant women and children who are legally present in the United States. It is morally unconscionable that pregnant women and innocent children have been made victims of a raucous and frequently misleading immigration debate. Hundreds of thousands of people from Asian countries immigrated legally to the United States in 2007 and 2008; at the very least the children in those

families deserve to have health insurance and access to care. CAPAC has consistently joined with the Congressional Black Caucus and Congressional Hispanic Caucus in advocating for protection of this vulnerable population and I thank Speaker PELOSI and our other House leadership for redressing this injustice.

The passage of this bill protects the health of millions of American children. It is the first step in a long journey toward repairing our healthcare system and providing universal coverage, care, and access to the people of our Nation, and I look forward to working with my colleagues to complete that journey. I urge the Senate to act in as swift and responsible manner as we do today and pass this bill.

Mr. BARTON of Texas. Madam Speaker, as we debate this new SCHIP bill, I think it is important to figure out what we know about the bill and the undemocratic methods that produced it.

First, we know that few, if any, Members of Congress actually have read the bill. Despite the promises made by Majority Leader HOYER on Friday that we would get at least 48 hours to review the bill, the new, 285 page SCHIP bill only turned up yesterday at 11:20. The 48 hours that Majority Leader HOYER promised somehow shrank to less than 24 hours. The Rules Committee met without an official score from the Congressional Budget Office. I will stipulate that Members may not always read the legislation they vote on, but most of us at least read the summaries and analyses that our staff members prepare. And every one of us has a right to the time required to know what these bills contain.

That's what the regular legislative process is all about—listening, thinking, proposing, thinking some more, amending and debating. Implicit in normal process is the notion that all useful ideas may not reside exclusively in the minds of the Speaker's assistants.

And all this careful listening and critical thinking by House Members is supposed to happen before we vote. Democrats seem to think that's got it backwards. They want to vote first and think later. It's all about bills written in private, delivered at night, and ramrodded through here with the blink of an eye. Now, I recognize that a strong majority can do things that way, and Republicans aren't without sin. But when secrecy and arrogance are combined with perfect efficiency, the country always seems to pay a heavy price.

On this bill especially, I've been treated better by used car salesmen. They didn't want me looking too closely at their products, but they didn't dump a wreck on my front lawn after sundown and tell me I had to buy it or else. The Democrats don't want anyone to inspect their product, either, and maybe that's because it has the qualities of a used Edsel.

There has been no process, much less any fair process. Evidently changes have been made to the bill from 2 years ago, but what are they? There have still been no committee markups on any SCHIP legislation and no legislative hearings. And I can't find evidence that a single one of the numerous suggested improvements to past SCHIP bills has been incorporated into this one. The majority is interested in what it wants and nothing else.

We also know, Madam Speaker, that today is largely a political exercise. The Senate is actually going to have a real markup in the Senate Finance Committee. I'll say that again to make sure my friends on the other side of the aisle heard what I said: The Senate is actually going to put their SCHIP bill through the full committee process, including considering ideas from people not on the Democrat leadership staff.

It's possible to legislate the right way, and it's pitiful that the people's House is reduced to taking lessons in democracy from our friends in the Senate.

Over here, the tricks don't stop with tactics. Every Member of this body understands that they will be vilified if they don't fall in line and support this bill. If you don't vote for the Democrats' SCHIP bill, your constituents will be told that you hate kids. Your people will be told that the only way to ensure that kids get health care is by supporting the bill produced by the Democrat leadership without a whisper of a complaint. They want the people to believe that there are no other ideas and no other options.

Well, Madam Speaker, I want to make clear to the American people that my Republican colleagues and I do want to reauthorize the SCHIP program. We have repeatedly reached out to the Democrats and have asked for a chance to sit down with them and work on a compromise that can become law. Last year, we heard many impassioned speeches about how important it was to override the President's veto of the Democrats' bills, but after these votes those same people were literally applauding when the veto was not overridden. That's right, Madam Speaker, there were Democrats applauding on the floor of the House when the bill they supported was rejected. That's more than partisan politics, that is cynicism and deception at their ugliest.

Madam Speaker, when the Democrats stop making this about political advantage at the expense of low-income children, and decide to actually produce a serious, passable SCHIP program, I am still ready to work with them.

As it stands now, I urge all Members to reject this cynical ploy and vote ''no'' on this deeply flawed and highly partisan bill.

Mr. KUCINICH. Madam Speaker, I rise in strong support of H.R. 2, which will provide health care for 4 million previously uninsured children. In Ohio, it will make the difference for up to 50,000 kids.

Ohio has had to suspend its efforts to expand eligibility to children because of tight State budgets. At the same time, the number of eligible children is growing rapidly as more parents lose their jobs or simply watch the premiums of private health insurance companies skyrocket beyond their means. This bill is needed more than ever.

The bill also includes mental health parity as well as dental coverage. Dental coverage is a topic I explored in the Domestic Policy Subcommittee of the Oversight and Government Reform Committee in a 7-month investigation into the death of 12-year-old Deamonte Driver. He died of a brain infection caused by tooth decay.

Finally, the bill allows states the option to cover children born outside the U.S. but now here legally. This provision will not only give these children the health care they deserve but will also save States money by allowing them to move routine care from the emergency room to the doctors office where it belongs. I fought for this provision in a previous version of this bill when it was excluded. I am glad to see that it has been retained this time and look forward to its passage.

Every child has a right to health care. This bill is a step in the right direction.

I urge my colleagues to pass the SCHIP reauthorization.

Mrs. CAPPS. Madam Speaker, I rise in strong support of this legislation to strengthen SCHIP and in strong support of America's children.

As a former school nurse, I consider it a crime that there are children in America who cannot access all of the healthcare services they need.

And today we have an opportunity to fix this injustice.

The excellent bill we have before us will ensure that millions of children in working families can get the proper preventive and primary care they need to ensure a healthy childhood.

I am also pleased to see that this bill preserves State options to cover pregnant women.

After all, the health of a mother is the greatest contributor to a child's health.

The current economic climate only adds to the urgency of this legislation.

States are experiencing budget shortfalls which threaten the status of children already enrolled in SCHIP.

And as parents lose their jobs; their health coverage is lost, too.

So I hope every one of my colleagues will join me in voting ''yes'' on this bill today and secure a better future for the health of our children and grandchildren.

Ms. HIRONO. Madam Speaker, I rise today in strong support of H.R. 2, the Children's Health Insurance Program (CHIP) Reauthorization Act of 2009.

I believe our Nation must show true compassion for the most vulnerable among us, and CHIP is a program that helps millions of low-income American children to receive health care so they can grow up in good health.

Since its creation in 1997, CHIP has been successful in providing vital health care coverage for children in families who cannot afford private insurance yet earn too much to qualify for Medicaid. There are now 6.6 million children enrolled in the program, which includes 20,000 keiki (children) from my home State of Hawaii.

Regrettably twice in 110th Congress, President George W. Bush vetoed bipartisan bills that would have reauthorized and improved CHIP in order to provide secure health coverage for millions of uninsured children in working families. These vetoes were made despite the fact that the bills had passed in both the House and Senate with strong bipartisan majorities. As a result of these vetoes, Congress was only able to provide a short-term extension of CHIP, through March of 2009, but was not able to enact program improvements to help States reach additional uninsured children.

The bill before us today is based on the two previously vetoed bipartisan bills. It also offers the 111th Congress the opportunity to right the wrongs of the out-going administration. President-elect Obama has previously expressed strong support for CHIP because it provides a much-needed down-payment on children's health. By extending health coverage to millions more children, this legislation is an important first step in stemming the rising tide of the uninsured.

I urge my colleagues to join me and vote in support of this bill and of the health and well-being of children most in need of our help.

Ms. TSONGAS. Madam Speaker, today, I rise in support of legislation we will be considering today to expand the Children's Health Insurance Program.

This bill provides coverage to children whose families cannot afford private insurance, and would expand access to health insurance for millions of children nationally—over 200,000 living in Massachusetts.

I first voted to override the President Bush's veto of similar legislation on the day I was sworn into office. It was my first vote and one of which I am enormously proud. Tens of thousands of people from my District, and millions more across the country, both Republicans and Democrats, have made their support for this program resoundingly clear.

This program is also important to my State of Massachusetts, where the program was first developed, because it is a critical component of the groundbreaking universal Massachusetts Health Care Plan.

Today, I stand with a strong bipartisan majority ready to give our Nation's children a chance at a healthy childhood and I urge my colleagues to do the same.

Mr. SIRES. Madam Speaker, I rise today to speak about the State Children's Health Insurance Program or SCHIP. This is a successful, popular, bipartisan program that currently provides private health care coverage for more than 6 million children who would otherwise go without care. I am very proud to stand here today and say I will vote for a bill that provides health care to children in need, and that President-elect Obama said he would sign into law.

Our action could not come at a better time. With rising unemployment, many families can no longer afford their health insurance. This bill brings them needed relief. Now parents can find comfort knowing their children will have access to health care while they look for a new job. This is particularly important in my home State of New Jersey. FamilyCare in New Jersey serves 122,000 children every year, a small percentage of which come from families with incomes up to 350 percent of the poverty line. It is expensive to live in my State, and even these families need help getting by. I am happy that this bill maintains the State's right to serve these families.

Today we get to make a real impact on the lives of many struggling families. I am proud to support H.R. 2, the SCHIP Reauthorization Act of 2009.

Mr. BARTON of Texas. Madam Speaker, I rise today to discuss an unrelated issue that has been neatly tucked into this bill. The issue is timely access to quality hospital care in our Nation's communities.

The Majority says we don't need any regular legislative process with this bill because everyone knows what's in it. Well, my staff received this 285-page bill at 11:20 a.m. yesterday. Even with full knowledge of what went into previous versions of this legislation, it isn't reasonable to expect that people will be able to gain a good understanding of the new bill with that sort of time constraint. I would also note that since the last time the House voted on an SCHIP bill, we've added more than 60 new Members.

This is politics as usual, and it should give every new Member great pause before voting for this bill, or any bill. I don't believe that any of our new Members comes from a background where they were expected to approve a major policy on the basis of the idea that, well, it's been here before, so we don't need to read it or understand it. In fact, didn't most of us run against that sort of deceptive politics in Washington?

I want to point out to the new Members that your vote today could also cause hospitals in your district to close. Hospitals that are under construction now and intended to serve your constituents soon may never see a patient. And why will that happen? Because a few Members of your conference with clout believe physicians in your communities shouldn't own hospitals. They say that the people who care for and about their communities, who have a personal stake in the care that is delivered, those people should not be trusted.

We have had no hearings on the issue of physician ownership of hospitals in the last two Congresses. The Health Subcommittee did have one hearing last year to discuss health disparities and we heard from a physician from Louisiana. His story illustrates what can happen when physicians are able to help their communities. After Katrina, hospitals were closing and residents couldn't get care. The doctors in these communities made a difference by coming together to make sure people could continue to receive health care. Why on earth would we want to eliminate people's ability to serve their community?

Why are the opponents of physician-owned hospitals so antagonistic? I'm not sure, because these hospitals provide higher quality care at lower costs than other hospitals. They have higher patient satisfaction rates and don't experience workforce shortages like other hospitals do.

I offered an amendment along with Congressman JOHNSON and Dr. BURGESS to strike the section that was written to eliminate physician-owned hospitals. Unfortunately, the Rules Committee rejected that idea. Congressman BOREN and Congresswoman JACKSON-LEE proposed a very fair amendment that would have delayed the implementation of Section 623 to July 1, 2010, so hospitals that are currently under construction could finish being completed and serve patients. That amendment also was rejected.

Last week, the House changed the rules on motions to recommit stating we could continue to have the committee and amendment process to voice our concerns. Madam Speaker, this has had neither, and it is a shame because the provision of quality hospital care is too important to be eliminated due to some philosophical bent of a couple of your senior Members.

New Members, this is an early to important test: do you vote your district or do you vote your leadership? Do you vote your hospitals or do you vote for a policy that was concocted in private in Washington.

Madam Speaker, in 1997, the Republican Congress enacted the State Children's Health Insurance Program to help children's families near poverty. But now, true to their big government agenda, the Democrat Congress wants to send the President-elect a massive increase in the SCHIP Program that will usher in a new era of socialized medicine in America.

This bill will take a program designed to help children near the poverty level and expand it to include families with incomes of up to $84,000 a year.

And Democrats will pay for this middle class entitlement with a 61 cent—$1 per pack tax increase on cigarettes.

Let's provide health insurance for children of the poor, but let's reject a liberal Democratic Congress attempt to create middle class entitlements on the backs of American smokers.

Since Congress has already reauthorized and fully funded SCHIP through March 31, 2009, we should work in a bipartisan manner to thoughtfully develop a longer-term reauthorization of the State Children's Health Insurance Program.

While I have been pleased to support SCHIP in the past, and continue to support its original intention to cover needy children who do not qualify for Medicaid, the bill being considered today hardly resembles the bipartisan compromise reached in 1997.

My Republican colleagues and I are eager to work with Democrats—as we did more than 10 years ago—to ensure that needy children receive health care coverage. As the program expands, health care for needy children is jeopardized. Republicans will work tirelessly to see that every currently eligible child is covered first and that taxes are not raised on the poorest among us.

The Democrats' SCHIP bill spends billions of dollars to substitute private health insurance coverage with government-run healthcare coverage. The Democrats' SCHIP bill taxes the poor to benefit the middle class. The bill uses the funding gained from taxing the poor to pay for expanding SCHIP eligibility to higher-income families. The Democrats' SCHIP bill focuses on enrolling higher-income kids instead of low-income, uninsured kids. The Democrats' SCHIP bill enables illegal aliens to fraudulently enroll in Medicaid and SCHIP.

Short of finding at least 22.4 million new smokers (the number required to adequately fund SCHIP) Democrats will be forced to either kick millions of children off of health insurance or raise taxes on all of us by tens of billions of dollars.

It is irresponsible to fund a children's health program, particularly one targeted at vulnerable children, with a declining revenue stream.

The revenue to fund this expansion will soon disappear, causing all of us to pay more in taxes.

The percentage of Americans who smoke has been dropping for decades. And research and logic both show that raising the prices of cigarettes will lead to less smoking, and therefore less revenue.

The Democrat expansion of SCHIP takes money from taxpayers in States like Indiana to pay for middle class children in wealthier States.

I oppose this legislation and urge my colleagues to do the same.

Mr. LARSON of Connecticut. Madam Speaker, I rise today in support of the reauthorization of SCHIP, an important piece of legislation that has become even more necessary now than it was when we started working on it 2 years ago. I commend my colleagues, Congressman PALLONE, Congressman WAXMAN, the dean of the House, Congressman JOHN DINGELL, Congressman RANGEL, Congressman STARK, and many others for their tireless efforts on this bill.

Madam Speaker, by passing this bill today we will provide health care for 11 million children. This is not just a bipartisan achievement, it is the right thing to do.

With the economic downturn and some of the worst unemployment numbers we've seen in decades, rising health insurance costs are making it increasingly difficult for families to afford health care for their children. States faced with the constitutional responsibility of balancing their budgets have been cutting programs that provide children with access to health care. Some states have already cut thousands of children from their CHIP programs and more States are considering drastic action. By reauthorizing SCHIP, we will enable States to prevent the loss in health coverage for many of these children and allow more uninsured families to participate in the program. In Connecticut alone this legislation will mean thousands of our 43,000 uninsured children will now be covered.

One story that has been brought to my attention is the story of the Farr family in Manchester, CT. Joseph and Danielle Farr are in their early thirties. They are hardworking citizens who have a young child soon to turn 1. They have a household income that is just $15 above Medicaid. But they qualify for SCHIP, which they call a ''godsend'' for their family.

The Farrs just learned that Joe is likely to be laid off from his job in March—a story familiar to many Americans. But, thanks to SCHIP, their son will continue to get the health care he needs. By reauthorizing SCHIP we will make sure that families like the Farrs will continue to have health care for their child even if they do fall victim to the economic downturn.

This bill will increase outreach efforts targeted at children currently eligible but not enrolled in the program and also give pregnant women access to health care through SCHIP. While we still have many more miles to travel on the road to fulfilling the promise of health care reform, this, Madam Speaker, is a downpayment on that effort. I am proud to support this legislation and urge my colleagues to stand with us, to stand with our children, and pass this bill.

Ms. LEE of California. Madam Speaker, I rise in strong support of H.R. 2, the State Children's Health Insurance Program (SCHIP) Reauthorization bill.

I want to thank Chairman WAXMAN and Chairman PALLONE and all the staff for their work in ensuring that this bill moves forward as one of our highest priorities in the 111th Congress.

Today we will take the long overdue step to expand health insurance coverage to over 11 million children throughout the country.

As our Nation remains mired in the depths of the worst economic crisis since the Great Depression, the action we take now could not be more important or more necessary.

The fact is that the economic policies of the outgoing administration have left our Nation in worse shape than we were 8 years ago.

Today, more people are living in poverty, more people are living without health insurance, and more people are unemployed than they were 8 years ago.

As always, it is the most vulnerable, the children, who suffer the greatest during tough economic times like these.

Passage of the SCHIP legislation today will at least help to make life a little easier for 4 million more children who will receive health coverage under this expanded program.

Although I strongly support this legislation, I believe it can still be improved, most immediately by removing the citizenship verification requirements that remain in this bill.

Ultimately we must move our Nation towards a universal health care system to cover all children and all Americans. Nonetheless this bill is an important step forward.

Madam Speaker, the Nation's children have waited far too long for this moment. I urge my colleagues to pass this bill.

Ms. JACKSON-LEE of Texas. Madam Speaker, I rise today in strong support for the ''Children's Health Insurance Program Reauthorization Act of 2009.'' 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 can bring 4 million children into the fold. Today 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 percent of uninsured children (under 19 years of age) in the 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 percent, of Texans are uninsured compared to 15.3 percent of the general U.S. population.

Data show that virtually all the net reduction in SCHIP enrollment has been among children in families with incomes below 150 percent FPL. The number of below-poverty children has dropped by more than 68 percent, and the number of children between 101–150 percent FPL has dropped by more than one-third since September 2003. I want to share with you just some of the scary health statistics that are affecting children:

74 percent of uninsured children eligible for SCHIP or Medicaid but not enrolled.

11 percent of uninsured children in families not eligible for Medicaid or SCHIP with incomes below.

15 percent of uninsured children in families with incomes over 300 percent of the Federal poverty level who are ineligible for Medicaid and SCHIP.

90 percent of uninsured children that come from families where at least one parent works.

50 percent 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.

In the great State of Texas, there is a young man named Jason who had SCHIP health insurance for years, and the coverage was life saving.

When he was in a car accident over a year ago, SCHIP covered his treatment and all the medical bills. His family needs SCHIP because they cannot afford private health coverage. The parents work hard, but the father's employment in pest control is seasonal and provides only about $35,000 annually. Jason's mother is wheelchair-bound with multiple sclerosis and has significant health care expenses.

When Jason lost SCHIP a year ago, his mother suspected they had been denied because of the 2003 Ford truck the family purchased so that she could transport her wheelchair. Prior to last year, she had never had problems renewing coverage, and the family's income had not change. But the income guidelines had changed.

New SCHIP guidelines that took effect in December 2005 do not count children over 18 years of age as family members. Although their full-time student daughter lives at home, she is not counted as part of the family, and, as a result, they are about $50 a month above the income limit for a family of three. So now the entire family is uninsured. This lack of coverage means that when Jason gets sick or hurt, they have to delay paying other bills to pay for medical care.

Lack of coverage also has affected Jason's performance in school. He has been sick quite a bit in the past few years with allergies and has missed many days of school because his eyes become swollen and he is unable to breathe. School officials had reprimanded the mother about his absences but now realize that Jason has some serious health issues. Finally we will be able to help people like Jason and assuage his mothers concerns. We are able to insure those who need it most.

PHYSICIAN-OWNED HOSPITALS

Sadly, there is one portion of this bill I did have some trouble with, the restrictions on physician-owned hospitals. Yesterday, my dear friend from Oklahoma, Congressman BOREN, and I were able to voice a very real concern that we had with the prohibition on physician-owned hospitals.

As the bill was originally written there was a provision in the bill that would have drastically affected the quality of care available to Houston residents and people in urban communities across the entire country.

JACKSON-LEE AMENDMENT

Yesterday, I put forth an amendment that would have exempted General Acute Care Full Service Physician-Owned Hospitals from section 1877 of the Social Security Act, as added by section 623 in SCHIP. There is no direct evidence that demonstrates that overutilization of services and improper self-referrals are in any more excess at General Acute Care Full Service Physician-Owned Hospitals.

My amendment would have exempted responsible and efficient physician-owned hospitals to develop, purchase, sell, and/or transfer their interests.

BOREN/JACKSON-LEE AMENDMENT

My amendment with Congressman BOREN would have provided an extension for the January 1, 2009 grandfather clause for physician-owned hospitals to allow physician-owned hospitals currently under construction to be completed.

At least 85 hospitals across the Nation have been affected. Boren/Jackson-Lee does not differentiate between General Acute Care, Full Service, and Specialty Hospitals.

The exceptions that exist to grandfather in certain physician owned hospitals are inadequate and will affect more than 85 hospitals

that are currently in development and under construction. It will also restrict sales and transfers of many responsible physician-owned hospitals.

In my district of Houston, TX the population has grown close to 4.5 million people, and there are only approximately 16,000 beds available in the city. Eliminating physician ownership in general acute care hospitals would only contribute to this ever growing problem.

While many specialty hospitals are accused of turning away uninsured and Medicaid patients and practicing only profitable healthcare, responsible physician-owned hospitals do just the opposite.

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.

While Members of the Texas delegation have continued to support general acute-care hospitals and their future development; we still believe that general acute-care hospitals still need to be able to:

Maintain a minimum number of physicians available at all times to provide service;

Provide a significant amount of charity care;

Treat at least 1/6 of its outpatient visits for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment;

Maintain at least ten full time interns or residents-in-training in a teaching program;

Advertise or present themselves to the public as a place which provides emergency care;

Serve as a disproportionate share provider, serving a low income community with a disproportionate share of low income patients; and

Have at least 90 hospital beds available to patients.

This issue is of the utmost importance to me because I, like others in the Democratic Caucus, have hospitals and hospital systems such as University Hospital Systems of Houston in my district that would have been greatly affected by this provision.

ST. JOSEPH MEDICAL CENTER

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 its doors would remain open, I was able to help a hospital corporation, in partnership with physicians, which has 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. Without language that specifically addresses this distinction, this project too will come to an end.

Sadly, it remains unclear if CHIP provides for physician-owned hospitals to still be considered grandfathered if have a sale or transfer at the same ownership rate or at a different physician-ownership rate.

Between December 2007 and December 2008, the U.S. economy shed about 2.6 million jobs, while Texas made significant gains. Texas' nonfarm employment registered a stable 2.1 percent growth rate over the year, even as the Nation's job losses reached their worst level since 2003. CBO forecasts the following:

A marked contraction in the U.S. economy in calendar year 2009, with real (inflation adjusted) gross domestic product (GDP) falling by 2.2 percent;

A slow recovery in 2010, with real GDP growing by only 1.5 percent;

An unemployment rate that will exceed 9 percent early in 2010.

The U.S. Bureau of Labor Statistics announced on November 21, 2009, that October's unemployment rate was 6.5 percent, a jump of 0.4 percent, which was double what most economists expected and its highest level in 14 years. 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 3 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 health care is not sacrificed.

Madam Speaker, my faith is renewed in the process that is so often maligned in the media. Thoughtful and deliberate actions were taken to improve this legislation that would not only help the children of my district and many others across the nation, but also it was able to address concerns that many of us, myself included have on these specialty hospitals.

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. LEVIN. Madam Speaker, some of the issues we debate in Congress are complicated. This one is quite simple. Americans want the children of this country covered by health insurance.

The State Children's Health Insurance Program currently covers about 7 million children, including 114,000 kids in my home State of Michigan. However, there are still about 9 million children in our country who are uninsured. This is unconscionable. No mother should have to worry about whether she can pay for the health care her child needs. No father should have to take his son to the emergency room because he does not have insurance to visit a primary care doctor. No society should allow a child to go without the security health insurance provides.

Congress passed two SCHIP bills last session. Both pieces of legislation were bipartisan, and both cleared the House and Senate with large majorities. Unfortunately, President Bush vetoed these bills.

As economic conditions have worsened over the course of the last year and more and more children have lost health insurance, this bill has become even more vital to ensuring that children do not fall through the cracks of our current health care system. The legislation under consideration today would extend coverage to another 4 million low-income children. It is an important step toward the goal of ensuring that all Americans, especially children, have the quality and affordable health care they need.

President-elect Obama strongly supports this SCHIP legislation. I can think of no better beginning to the next 4 years than to send the new President this critical investment in children's health. I urge my colleagues to vote for passage of H.R. 2, the Children's Health Insurance Program Reauthorization Act of 2009.

Mr. POSEY. Mr. Speaker, I rise to express both my support for the State Children's Health Insurance Program, SCHIP, and my reservations about the particular SCHIP bill, H.R. 2, that is before us today. I would also add that I am pleased to support an alternative version that will be offered as a substitute today. This alternative focuses SCHIP on low income children and addresses the problems with the underlying bill.

Our nation faces very serious financial challenges. The Congressional Budget Office, CBO, projects that this year's Federal budget deficit will be nearly $1.2 trillion dollars. In other words one out of every three dollars that the Federal Government will spend this year will be borrowed from future generations. Given that our children and grandchildren will have to pay back everything that this generation borrows, we must give the greatest scrutiny to each and every dollar that is spent.

I am committed to working to assist lower-income children who lack insurance. SCHIP was established as a bipartisan program to insure children in families too poor to pay for insurance but not poor enough to qualify for Medicaid. If that was what the bill before us did, I would be voting for it. Unfortunately, H.R. 2 goes well beyond focusing specifically on these children.

H.R. 2 expands SCHIP to extend taxpayer subsidies to the children of those living in, for example, New Jersey and making more than $80,000 per year, 400 percent of the poverty level.

The CBO estimates that 2.4 million of the new enrollees in SCHIP will be children who simply dropped private coverage to enroll in SCHIP. Given our massive Federal deficit, does it make sense to borrow money from our children and grandchildren in order to enroll in SCHIP children who currently have other private insurance?

H.R. 2 continues to allow states to enroll single adults in SCHIP. Over 600,000 are enrolled in the SCHIP program and three states have more adults enrolled in SCHIP than children. This is particularly troubling given that in many states with large numbers of adults enrolled in SCHIP, many qualified children remain uninsured. This is a misappropriation of limited resources and children should not have to sit on the sidelines while able-bodied adults take their benefits.

H.R. 2 also repeals safeguards that were put in place to ensure that illegal immigrants were not enrolled in taxpayer subsidized SCHIP. Removing these safeguards will actually encourage illegal immigration by offering taxpayer funded benefits to people who bypass our laws and enter the U.S. illegally. In a sense, it gives foreign nationals an incentive to break our immigration laws.

Finally, in an admission by the sponsors of H.R. 2 that the bill is unaffordable, the bill assumes that millions of children will be dropped

from the SCHIP program in 2013 in order to meet the technical requirements of Federal budget rules. Does anyone really believe that the Congress would kick millions of people out of SCHIP in 2013? It's time for this Congress to be honest with the American people and this bill does not meet that test. By employing this budget gimmick, the sponsors of H.R. 2 are admitting that the bill is unaffordable.

I am fully supportive of legislation that would focus on ensuring that lower income children are able to enroll in SCHIP. This bill falls far short of that goal.

In conclusion let me say that we have until March 31 to reauthorize SCHIP. Congress should use that time wisely to further examine the effectiveness of this program to date and address these shortcomings. I am disappointed that this 286-page bill is being rushed to the House floor under a closed process that denies Members of the House the opportunity to have an up or down vote on amendments that would address these concerns. I believe that America's children deserve better.

Mr. ABERCROMBIE. Madam Speaker, I rise today to address an issue raised by my colleagues regarding Hawaii's Keiki Care program as a reason not to expand SCHIP. It was suggested earlier today that the Keiki (meaning ''child'') Care program was cancelled due to perceived crowd-out, a situation where parents drop their children's private insurance in order to enroll into a free government program.

I have supported the State Legislature's efforts to expand health care coverage for children and followed the implementation of Keiki Care closely. The statements made about a crowd-out problem leading to the program's demise were baseless. The Keiki Care program had no problems with crowd-out. First of all, it was intentionally designed to prevent such behavior in requiring that children who wish to enroll must be uninsured continuously for 6 months. Secondly, if parents were indeed hoping to drop their insurance and wait 6 months to enroll, then Keiki Care would have seen a spike in enrollment. Blue Cross Blue Shield Hawaii, the health insurance provider for Keiki Care, did not see any spikes in enrollment and have no evidence to believe crowd-out occurred.

Furthermore, there was little incentive for parents to switch to the Keiki Care program from any private health plan. The health insurance plan offered under Keiki Care was basic preventative care. This means that parents would have had to pay for expanded care costs out of pocket. In looking closer at the Keiki Care program, it is evident that a parent with a full coverage plan for their child would have no incentive to drop a private insurance for this basic, prevention-centered plan.

The State Administration has given various explanations regarding the decision to end Keiki Care, including a growing budget deficit. However, the facts about the program are clear. There was never a problem regarding crowd-out and if continued, the program would have helped to cover more of Hawaii's uninsured children. Therefore, Madam Speaker, it is my hope that by clarifying the details regarding Keiki Care, it will no longer be used as a rationale that has no basis in fact against SCHIP or other efforts to expand health insurance to children and the uninsured.

Mr. BACA. Madam Speaker, I rise today in strong support of H.R. 2, to extend and improve the Children's Health Insurance Program.

Families in my district in San Bernardino, California, are struggling to make ends meet and bring food to the table.

Congress must answer to these and other families across America.

SCHIP is a vital component of our country's health system, allowing for individual states to take care of our most vulnerable, America's children.

A facility in my district, the Community Hospital of San Bernardino is about to rip apart at the seams.

Without SCHIP, they will either have to turn away or eat the cost of 4,000 families enrolled in Healthy Families, California's version of SCHIP.

If SCHIP is not reauthorized, these alarming figures will jump even higher, further jeopardizing their ability to provide care for our community.

This problem is even worse when you consider the impact of the recession, and the growing number of unemployed and without health insurance.

I urge my colleagues to help these families, do the responsible thing and vote for SCHIP.

Mr. DINGELL. Madam Speaker, I stand in strong support of H.R. 2, the Children's Health Insurance Program, CHIP, Reauthorization Act of 2009.

In 1997, a Republican Congress and Democratic President passed a landmark program to reach children who had fallen through the cracks of our healthcare system. These kids weren't poor enough to qualify for Medicaid, and their parents—most of whom worked—couldn't afford health insurance. The CHIP program has proven to be a major success—covering more than 7 million children who otherwise would not have health coverage.

Last year, my colleagues and I tried, on two occasions, to reauthorize this program and expand it to provide care for many more kids in need of its services. Unfortunately, President Bush stood in our way—not once, but twice. I am confident President-elect Obama has his priorities straight and will do what President Bush refused to do—provide much needed health care for our nation's children.

The current economic crisis increases the importance of the CHIP program. More than 1 million children have lost their health coverage because their parents were laid off and lost their employer-based coverage over the past year.

This is especially true in Michigan, which has over 150,000 children uninsured. While Michigan has one of the lowest rates of uninsured children in the country, I fear that the number of uninsured will worsen as Michigan's unemployment rate continues to increase. Recent reports suggest that Michigan's unemployment rate will reach 11.3 percent by the end of the year.

H.R. 2 is critical in this regard because it not only will continue to provide coverage for the 7 million kids already participating in the CHIP program, but will extend health care to 4 million more.

H.R. 2 is for every child out there who needs a vaccination, a cavity filled, chemotherapy, insulin, antidepressants and more life sustaining health care.

This bill is a great first step as we begin our work to reform the nation's health care system and provide health coverage for 47 million uninsured Americans. I look forward to working with my colleagues, Senator Daschle, and President-elect Obama to continue the work. We will not stop until all Americans have access to quality, affordable healthcare.

I encourage all of my colleagues to vote for the children in your district, and for all of America's children. Vote for H.R. 2, the Children's Health Insurance Program, CHIP, Reauthorization Act of 2009.

Mr. LANGEVIN. Madam Speaker, I rise today in strong support of H.R. 2, the Children's Health Insurance Program Reauthorization Act. This legislation represents a crucial and long overdue investment in the health and wellbeing of our nation's most valuable assets—our children.

Since 1997, the State Children's Health Insurance Program (SCHIP) has successfully provided health coverage to millions of low income children across the country who would not otherwise be able to access these services. I have been especially proud of the Rite Care program in my home state of Rhode Island, which covered approximately 24,000 children last year under both the SCHIP and Medicaid programs. However, too many children and their families remain without access to proper health services. We must reaffirm our commitment at the federal level to ensure states have the means to address the health care needs of our constituents, particularly in the midst of an economic crisis that has resulted in dramatic increases in unemployment levels.

H.R. 2 will ensure health coverage for a total of 11 million American children by reauthorizing SCHIP for four and a half years and extending coverage to an additional 4 million uninsured children who are currently eligible for, but not enrolled in, SCHIP and Medicaid. Two-thirds of uninsured children are eligible for coverage through SCHIP and Medicaid, but better outreach and adequate funding are needed to identify and enroll them. This bill provides $100 million in grants for new outreach activities to states, local governments, schools, community-based organizations and other safety-net providers. It also improves SCHIP by ensuring dental coverage for children, mental health services on par with medical and surgical benefits, as well as improved access to private coverage options through premium assistance subsidies.

Finally, H.R. 2 reauthorizes and improves SCHIP without adding to our ballooning federal deficit. Since the cost of the bill is completely offset, it will allow us to make a much-needed investment in the health of our children without requiring them to pay for it in the future.

As many of my colleagues know, universal access to health care has been a top priority of mine throughout my tenure in Congress. I can think of no better place to start than by guaranteeing that children across the country receive the health care services they both require and deserve. I, therefore, urge all of my colleagues to support passage of this measure.

Mr. PALLONE. Madam Speaker, I yield back the balance of my time.

The SPEAKER pro tempore. All time for debate has expired.

Pursuant to House Resolution 52, the bill is considered read and the previous question is ordered.

The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

MOTION TO RECOMMIT

Mr. DEAL of Georgia. Madam Speaker, I have a motion at the desk.

The SPEAKER pro tempore. Is the gentleman opposed to the bill?

Mr. DEAL of Georgia. I am in its current form.

Mr. WAXMAN. Madam Speaker, I reserve a point of order.

The SPEAKER pro tempore. A point of order is reserved.

The Clerk will report the motion to recommit.

The Clerk read as follows:

Mr. Deal of Georgia moves to recommit the bill, H.R. 2, to the Committee on Energy and Commerce with instructions to report the same back to the House forthwith with the following amendment:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the ''SCHIP Full Funding Extension Act of 2009''.

SEC. 2. EXTENDING SCHIP FUNDING THROUGH FISCAL YEAR 2015.

(a) THROUGH FISCAL YEAR 2015.—

(1) IN GENERAL.—Section 2104 of the Social Security Act (42 U.S.C. 1397dd), as amended by section 201 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173), is amended—

(A) in subsection (a)(11), by striking ''and 2009'' and inserting '', 2009, 2010, 2011, 2012, 2013, 2014, and 2015''; and

(B) in subsection (c)(4)(B), by striking ''through 2009'' and inserting ''through 2015''.

(2) AVAILABILITY OF EXTENDED FUNDING.—Funds made available from any allotment made from funds appropriated under subsection (a)(11) or (c)(4)(B) of section 2104 of the Social Security Act (42 U.S.C. 1397dd) for fiscal year 2009, 2010, 2011, 2012, 2013, 2014, or 2015 shall not be available for child health assistance for items and services furnished after September 30, 2015.

(b) EXTENSION OF TREATMENT OF QUALIFYING STATES.—

(1) IN GENERAL.—Section 2105(g)(1)(A) of the Social Security Act (42 U.S.C. 1397ee(g)(1)(A)), as amended by section 201(b) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173), is amended by striking ''or 2009'' and inserting ''2009, 2010, 2011, 2012, 2013, 2014, or 2015''.

(2) CONFORMING AMENDMENT.—Section 201(b) of such Public Law is amended by striking paragraph (2).

(c) ADDITIONAL ALLOTMENTS TO MAINTAIN SCHIP PROGRAMS THROUGH FISCAL YEAR 2015.—Section 2104 of the Social Security Act (42 U.S.C. 1397dd) is amended by striking subsection (l) and inserting the following new subsections:

''(l) ADDITIONAL ALLOTMENTS TO MAINTAIN SCHIP PROGRAMS FOR FISCAL YEAR 2009.—

''(1) APPROPRIATION; ALLOTMENT AUTHORITY.—For the purpose of providing additional allotments described in subparagraphs (A) and (B) of paragraph (3), there is appropriated, out of any money in the Treasury not otherwise appropriated, such sums as may be necessary, not to exceed $3,000,000,000 for fiscal year 2009.

''(2) SHORTFALL STATES DESCRIBED.—For purposes of paragraph (3), a shortfall State described in this paragraph 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 Federal share amount of the projected expenditures under such plan for such State for fiscal year 2009 will exceed the sum of—

''(A) the amount of the State's allotments for each of fiscal years 2007 and 2008 that will not be expended by the end of fiscal year 2008;

''(B) the amount, if any, that is to be redistributed to the State during fiscal year 2009 in accordance with subsection (i); and

''(C) the amount of the State's allotment for fiscal year 2009.

''(3) ALLOTMENTS.—In addition to the allotments provided under subsections (b) and (c), subject to paragraph (4), of the amount available for the additional allotments under paragraph (1) for fiscal year 2009, the Secretary shall allot—

''(A) to each shortfall State described in paragraph (2) not described in subparagraph (B), such amount as the Secretary determines will eliminate the estimated shortfall described in such paragraph for the State; and

''(B) to each commonwealth or territory described in subsection (c)(3), an amount equal to the percentage specified in subsection (c)(2) for the commonwealth or territory multiplied by 1.05 percent of the sum of the amounts determined for each shortfall State under subparagraph (A).

''(4) PRORATION RULE.—If the amounts available for additional allotments under paragraph (1) are less than the total of the amounts determined under subparagraphs (A) and (B) of paragraph (3), the amounts computed under such subparagraphs shall be reduced proportionally.

''(5) RETROSPECTIVE ADJUSTMENT.—The Secretary may adjust the estimates and determinations made to carry out this subsection as necessary on the basis of the amounts reported by States not later than November 30, 2008, on CMS Form 64 or CMS Form 21, as the case may be, and as approved by the Secretary.

''(6) ONE-YEAR AVAILABILITY; NO REDISTRIBUTION OF UNEXPENDED ADDITIONAL ALLOTMENTS.—Notwithstanding subsections (e) and (f), amounts allotted to a State pursuant to this subsection for fiscal year 2009, subject to paragraph (5), shall only remain available for expenditure by the State through September 30, 2009. Any amounts of such allotments that remain unexpended as of such date shall not be subject to redistribution under subsection (f).

''(m) ADDITIONAL ALLOTMENTS TO MAINTAIN SCHIP PROGRAMS FOR FISCAL YEAR 2010.—

''(1) APPROPRIATION; ALLOTMENT AUTHORITY.—For the purpose of providing additional allotments described in subparagraphs (A) and (B) of paragraph (3), there is appropriated, out of any money in the Treasury not otherwise appropriated, such sums as may be necessary, not to exceed $4,000,000,000 for fiscal year 2010.

''(2) SHORTFALL STATES DESCRIBED.—For purposes of paragraph (3), a shortfall State described in this paragraph 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 Federal share amount of the projected expenditures under such plan for such State for fiscal year 2010 will exceed the sum of—

''(A) the amount of the State's allotments for each of fiscal years 2008 and 2009 that will not be expended by the end of fiscal year 2009;

''(B) the amount, if any, that is to be redistributed to the State during fiscal year 2010 in accordance with subsection (f); and

''(C) the amount of the State's allotment for fiscal year 2010.

''(3) ALLOTMENTS.—In addition to the allotments provided under subsections (b) and (c), subject to paragraph (4), of the amount available for the additional allotments under paragraph (1) for fiscal year 2010, the Secretary shall allot—

''(A) to each shortfall State described in paragraph (2) not described in subparagraph (B) such amount as the Secretary determines will eliminate the estimated shortfall described in such paragraph for the State; and

''(B) to each commonwealth or territory described in subsection (c)(3), an amount equal to the percentage specified in subsection (c)(2) for the commonwealth or territory multiplied by 1.05 percent of the sum of the amounts determined for each shortfall State under subparagraph (A).

''(4) PRORATION RULE.—If the amounts available for additional allotments under paragraph (1) are less than the total of the amounts determined under subparagraphs (A) and (B) of paragraph (3), the amounts computed under such subparagraphs shall be reduced proportionally.

''(5) RETROSPECTIVE ADJUSTMENT.—The Secretary may adjust the estimates and determinations made to carry out this subsection as necessary on the basis of the amounts reported by States not later than November 30, 2010, on CMS Form 64 or CMS Form 21, as the case may be, and as approved by the Secretary.

''(6) AVAILABILITY; NO REDISTRIBUTION OF UNEXPENDED ADDITIONAL ALLOTMENTS.—Notwithstanding subsections (e) and (f), amounts allotted to a State pursuant to this subsection for fiscal year 2010, subject to paragraph (5), shall only remain available for expenditure by the State through September 30, 2010. Any amounts of such allotments that remain unexpended as of such date shall not be subject to redistribution under subsection (f).

''(n) APPLICATION TO FISCAL YEARS 2011, 2012, 2013, 2014, OR 2015.—

''(1) IN GENERAL.—Subject to paragraph (2), subsection (m) shall apply to each of fiscal years 2011, 2012, 2013, 2014, or 2015 in the same manner such subsection applies to fiscal year 2010.

''(2) APPLICATION.—In applying subsection (m) under paragraph (1) with respect to—

''(A) fiscal year 2011—

''(i) each reference to a year or date in such subsection shall be deemed a reference to the following year or to one year after such date, respectively; and

''(ii) the reference to '$4,000,000,000' in paragraph (1) of such subsection shall be deemed a reference to '$5,000,000,000';

''(B) fiscal year 2012—

''(i) each reference to a year or date in such subsection shall be deemed a reference to the second following year or to two years after such date, respectively; and

''(ii) the reference to '$4,000,000,000' in paragraph (1) of such subsection shall be deemed a reference to '$6,000,000,000';

''(C) fiscal year 2013—

''(i) each reference to a year or date in such subsection shall be deemed a reference to the third following year or to three years after such date, respectively; and

''(ii) the reference to '$4,000,000,000' in paragraph (1) of such subsection shall be deemed a reference to '$6,000,000,000';

''(D) fiscal year 2014—

''(i) each reference to a year or date in such subsection shall be deemed a reference to the fourth following year or to four years after such date, respectively; and

''(ii) the reference to '$4,000,000,000' in paragraph (1) of such subsection shall be deemed a reference to '$7,000,000,000'; and

''(E) fiscal year 2015—

''(i) each reference to a year or date in such subsection shall be deemed a reference to the fifth following year or to five years after such date, respectively; and

''(ii) the reference to '$4,000,000,000' in paragraph (1) of such subsection shall be deemed a reference to '$7,000,000,000'.''.

SEC. 3. OPTION FOR QUALIFYING STATES TO RECEIVE THE ENHANCED PORTION OF THE SCHIP MATCHING RATE FOR MEDICAID COVERAGE OF CERTAIN CHILDREN.

Section 2105(g) of the Social Security Act (42 U.S.C. 1397ee(g)) is amended—

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

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

''(4) OPTION FOR CERTAIN ALLOTMENTS.—

''(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 fiscal year (beginning with fiscal year 2009) (insofar as the allotment is available to the State under subsection (e) 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, and whose family income equals or exceeds 133 percent of the poverty line but does not exceed the Medicaid applicable income level.''.

SEC. 4. REQUIRING OUTREACH AND COVERAGE BEFORE EXPANSION OF ELIGIBILITY.

(a) STATE PLAN REQUIRED TO SPECIFY HOW IT WILL ACHIEVE HEALTH BENEFITS COVERAGE FOR 90 PERCENT OF LOW-INCOME CHILDREN.—

(1) IN GENERAL.—Section 2102(a) of the Social Security Act (42 U.S.C. 1397bb(a)) is amended—

(A) in paragraph (6), by striking ''and'' at the end;

(B) in paragraph (7), by striking the period at the end and inserting ''; and''; and

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

''(8) how the State for each fiscal year (beginning with fiscal year 2010) will achieve, through eligibility and benefits provided for under the plan and otherwise, a rate of health benefits coverage (whether private or public) for low-income children in the State that is at least 90 percent.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to State child health plans for fiscal years beginning with fiscal year 2010.

(b) LIMITATION ON PROGRAM EXPANSIONS UNTIL LOWEST INCOME ELIGIBLE INDIVIDUALS ENROLLED.—Section 2105(c) (42 U.S.C. 1397dd(c)) is amended by adding at the end the following new paragraph:

''(8) LIMITATION ON INCREASED COVERAGE OF HIGHER INCOME CHILDREN.—For child health assistance furnished in a fiscal year beginning with fiscal year 2010:

''(A) SPECIAL RULES FOR PAYMENT FOR CHILDREN WITH FAMILY INCOME ABOVE 200 PERCENT OF POVERTY LINE.—In the case of child health assistance for a targeted low-income child in a family the income of which exceeds 200 percent (but does not exceed 300 percent) of the poverty line applicable to a family of the size involved no payment shall be made under this section for such assistance unless the State demonstrates to the satisfaction of the Secretary (in accordance with any methodology established by the Secretary) that the State has met the 90 percent retrospective coverage test specified in subparagraph (B) for the previous fiscal year.

''(B) 90 PERCENT COVERAGE TEST.—The 90 percent retrospective coverage test specified in this subparagraph is, for a State for a fiscal year, that on average for any 3-consecutive month period during the fiscal year, at least 90 percent of low-income children residing in the State have health benefits coverage (whether private or public).

''(C) GRANDFATHER.—Subparagraphs (A) and (B) shall not apply to the provision of child health assistance—

''(i) to a targeted low-income child who is enrolled for child health assistance under this title as of September 30, 2009;

''(ii) to a pregnant woman who is enrolled for assistance under this title as of September 30, 2009, through the completion of the post-partum period following completion of her pregnancy; and

''(iii) for items and services furnished before October 1, 2009, to an individual who is not a targeted low-income child and who is enrolled for assistance under this title as of September 30, 2009.

''(D) PROMULGATION OF METHODOLOGY.—Not later than July 1, 2009, the Secretary shall issue regulations that establish a methodology by which States meet the requirements of subparagraph (A).

''(E) DETERMINATION OF INCOME BASED ON GROSS FAMILY INCOME WITHOUT DISREGARDS OR EXCLUSIONS.—

''(i) IN GENERAL.—For purposes of this paragraph, the family income shall be determined under subparagraph (A) (and under subparagraph (B) for purposes of determining who is a low-income child, as defined in section 2110(c)(4)) based on gross family income.

''(ii) GROSS FAMILY INCOME DEFINED.—

''(I) IN GENERAL.—Subject to subclause (II), in this subparagraph, the term 'gross family income' means, with respect to an individual, gross income (as defined by the Secretary in regulations) for the members of the individual's family. For purposes of the previous sentence, in defining 'gross income' the Secretary shall, to the maximum extent practicable, include income from whatever source, other than amounts deducted under section 62(a)(1) of the Internal Revenue Code of 1986.

''(II) INCOME DISREGARDS AUTHORIZED.—A State may provide, through a State plan amendment and with the approval of the Secretary, for the disregard from gross family income of one or more amounts so long as the total amount of such disregards for a family does not exceed $250 per month, or $3,000 per year.''.

SEC. 5. SCHIP GROSS INCOME ELIGIBILITY CEILING.

(a) APPLICATION OF SCHIP ELIGIBILITY CEILING.—

(1) IN GENERAL.—Section 2110 of the Social Security Act (42 U.S.C. 1397jj) is amended—

(A) in subsection (b)(1)—

(i) by striking ''and'' at the end of subparagraph (B);

(ii) by striking the period at the end of subparagraph (C) and inserting ''; and''; and

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

''(D) whose gross family income (as defined in subsection (c)(9)) does not exceed 300 percent of the poverty line.''; and

(B) in subsection (c), by adding at the end the following new paragraph:

''(9) GROSS FAMILY INCOME.—

''(A) IN GENERAL.—Subject to subparagraph (B), the term 'gross family income' means, with respect to an individual, gross income (as defined by the Secretary in regulations) for the members of the individual's family. For purposes of the previous sentence, in defining 'gross income' the Secretary shall, to the maximum extent practicable, include income from whatever source, other than amounts deducted under section 62(a)(1) of the Internal Revenue Code of 1986.

''(B) INCOME DISREGARDS AUTHORIZED.—A State may provide, through a State plan amendment and with the approval of the Secretary, for the disregard from gross family income of one or more amounts so long as the total amount of such disregards for a family does not exceed $250 per month, or $3,000 per year.''.

(2) DENIAL OF FEDERAL MATCHING PAYMENTS FOR STATE SCHIP EXPENDITURES FOR INDIVIDUALS WITH GROSS FAMILY INCOME ABOVE 300 PERCENT OF THE POVERTY LINE.—Section 2105(c) of the Social Security Act (42 U.S.C. 1397ee(c)), as amended by section 4(b), is amended by adding at the end the following new paragraph:

''(9) DENIAL OF PAYMENTS FOR EXPENDITURES FOR CHILD HEALTH ASSISTANCE FOR INDIVIDUALS WHOSE GROSS FAMILY INCOME EXCEEDS 300 PERCENT OF THE POVERTY LINE.—No payment may be made under this section, for any expenditures for providing child health assistance or health benefits coverage under a State child health plan under this title, including under a waiver under section 1115, with respect to an individual whose gross family income (as defined in section 2110(c)(9)) exceeds 300 percent of the poverty line.''.

(b) EFFECTIVE DATE; TRANSITION.—

(1) IN GENERAL.—Subject to paragraph (2), the amendments made by this section shall apply to payments made for items and services furnished on or after the first day of the first calendar quarter beginning more than 90 days after the date of the enactment of this Act.

(2) TRANSITION.—The amendments made by—

(A) subsection (a)(1) shall not apply to an individual who was receiving, or was determined eligible to receive, child health assistance or health benefits coverage under a State child health plan under title XXI of the Social Security Act, including under a waiver under section 1115 of such Act, as of the day before the date of the enactment of this Act, until such date as the individual is determined ineligible using income standards or methodologies in place as of the day before the date of the enactment of this Act; and

(B) subsection (a)(2) shall not apply to payment for items and services furnished to an individual described in clause (i);

SEC. 6. TIME FOR PAYMENT OF CORPORATE ESTIMATED TAXES.

(a) 5-YEAR PERIOD.—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 19 percentage points.

(b) 10-YEAR PERIOD.—Notwithstanding section 6655 of the Internal Revenue Code of 1986—

(1) the amount of any required installment of corporate estimated tax which is otherwise due in July, August, or September of 2018 shall be 130 percent of such amount, and

(2) the amount of the next required installment after the installment referred to in paragraph (1) shall be appropriately reduced to reflect the amount of the increase by reason of paragraph (1).

Mr. WAXMAN (during the reading). Madam Speaker, I ask unanimous consent that the motion to recommit be considered read, and I also withdraw my point of order.

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

There was no objection.

The SPEAKER pro tempore. Reservation of the point of order is withdrawn.

The gentleman from Georgia is recognized for 5 minutes in support of his motion.

Mr. DEAL of Georgia. Madam Speaker, the Republican motion to recommit replaces what I consider to be a deeply flawed bill that has been offered and also has improvements to the SCHIP proposal that we are considering.

Unlike H.R. 2, the Republican motion to recommit fully funds SCHIP program for the next 7 years, not 4½ years as the underlying bill would do, and thereby ensures that needy families and those with low incomes will be covered and eligible under SCHIP through fiscal year 2015. According to the Congressional Budget Office, the motion to recommit will not cause a single SCHIP enrolled child to lose his or her health care coverage.

Unlike the bill that is under consideration, H.R. 2, the motion to recommit puts poor children first by holding States accountable for not finding and enrolling their low-income, uninsured children. Each year, States would be required to report to the Secretary of HHS how they intend to ensure that at least 90 percent of their children with family incomes under $40,000 per year have quality health care coverage in either a public or private health care plan. States would also be required to demonstrate that they have met this 90 percent coverage target before they are able to shift their enrollment activities to higher income families.

Unlike H.R. 2, the motion to recommit maintains the requirement in current law that States verify the identity and citizenship status of Medicaid and SCHIP applicants and prevents illegal aliens and other unqualified individuals from fraudulently gaining access to these taxpayer-funded programs.

Unlike H.R. 2, the Republican motion to recommit preserves limited SCHIP dollars for low-income, uninsured children by preventing States from abusing the income-disregard loophole that is in the current law and would be continued under the underlying bill.

Unlike H.R. 2, the Republican motion to recommit Federal funds will be reserved for families with incomes under 300 percent of the Federal poverty level, which is currently $63,600 for a family of four.

This motion to recommit is compliant with the majority's PAYGO rules by asking corporations with assets in excess of $1 billion to shift some estimated tax payments due in fiscal year 2009 to fiscal year 2018.

The majority has repeatedly used this short-term shifting of funding to meet the 5-year PAYGO requirements, and we're using it today to comply with the majority's PAYGO requirements without raising taxes.

Fully paid for without increasing taxes on the American people is what this motion to recommit would provide. And unlike the underlying bill, H.R. 2, the Republican recommit motion will actually allow President-elect Obama to keep his promise to the American people of not increasing their taxes.

We believe that these fundamental changes from the underlying bill not only improve it, but extend the life of it for a full 7-year period and is altogether appropriate, and does not include increasing taxes on the American people.

We believe in the SCHIP program. We think that it should be properly applied in States and applied primarily to those who are low-income, poor families first rather than going up the economic scale of eligibility.

For these reasons, I would urge this body to adopt the motion to recommit and to pass a bill for a 7-year period that fully funds and assures States and families that their children will be covered.

Madam Speaker, I yield back the balance of my time.

Mr. PALLONE. Madam Speaker, I rise in opposition to the motion to recommit.

The SPEAKER pro tempore. The gentleman from New Jersey is recognized for 5 minutes.

Mr. PALLONE. Madam Speaker, it wasn't enough that President Bush vetoed two children's health bills that would have made great advances in children's health. Now my Republican colleagues are trying to undermine the coverage gains that would be made in this bill.

This proposal being put forward by my Republican colleagues isn't a way to put poor kids first. It's a way to stop States from moving forward to help additional uninsured children.

The CHIP bill already puts poor kids first by targeting enrollment bonuses only to the poorest kids, those in Medicaid. Eight in ten newly insured children under CHIP have incomes below current eligibility levels. The Republican proposal is simply a way to stop States from moving forward.

Unfortunately, the reality of today is that these moderate income families who would be excluded under this motion are struggling to make ends meet, too. Health costs have been rising much faster than income over the past decade. A family at 300 percent of poverty, for example, earning $52,800 a year—these so-called rich folks, according to Republicans—now spend an average of 19 percent of their income on premiums for employer-sponsored coverage if they even have access to it. Ten years ago, that same family was only spending 11 percent of income on premiums for their employer plan.

The CHIP bill moves us forward. It's the largest investment in children's health since the original CHIP law was passed in '97. And this Congress will do more for children, and it's an excellent step forward.

Now I want to mention that research shows that no means tested program reaches 90 percent of the individuals or families eligible for it. Moreover, there is not reliable State-by-State data to even measure participation rates accurately among the States.

While the Bush administration initially attempted to establish measures like Mr. DEAL is talking about, leading independent academic and research institutions discredited the Bush administration's target rate, such as CBO and the Urban Institute, and the Bush administration has moved away from its initial administrative directive of enforcing such limits on States the way this motion would do.

So again, the point is we need to move forward. This is simply a rouse essentially to gut the bill for those moderate-income families that would benefit for it.

I would urge my colleagues to oppose this motion to recommit. Let's move the bill as originally proposed. It will do great things for America's children.

Madam Speaker, I yield back the balance of my time.

The SPEAKER pro tempore. Without objection, the previous question is ordered on the motion to recommit.

There was no objection.

The SPEAKER pro tempore. The question is on the motion to recommit.

The question was taken; and the Speaker pro tempore announced that the noes appeared to have it.

Mr. DEAL of Georgia. 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.

Pursuant to clause 9 of rule XX, the Chair will reduce to 5 minutes the minimum time for any electronic vote on the question of passage.

The vote was taken by electronic device, and there were—yeas 179, nays 247, not voting 7, as follows:

[Roll No. 15]

YEAS—179

Aderholt	Bright	Conaway
Akin	Broun (GA)	Crenshaw
Alexander	Brown (SC)	Culberson
Austria	Brown-Waite, Ginny	Davis (KY)
Bachmann	Burgess	Deal (GA)
Bachus	Burton (IN)	Dent
Barrett (SC)	Buyer	Diaz-Balart, L.
Bartlett	Calvert	Diaz-Balart, M.
Barton (TX)	Camp	Dreier
Biggert	Campbell	Duncan
Bilbray	Cantor	Ehlers
Bilirakis	Cao	Emerson
Bishop (UT)	Capito	Fallin
Blackburn	Carter	Flake
Blunt	Cassidy	Fleming
Boehner	Castle	Forbes
Bonner	Chaffetz	Fortenberry
Bono Mack	Coble	Foxx
Boozman	Coffman (CO)	Franks (AZ)
Boustany	Cole	Frelinghuysen
Brady (TX)		Gallegly

Garrett (NJ)
Gerlach
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)
King (NY)
Kingston
Kirk
Kline (MN)
Lamborn
Lance
Latham
LaTourette
Latta
Lee (NY)
Lewis (CA)
Linder
Lucas
Luetkemeyer
Lummis
Lungren, Daniel E.
Mack
Manzullo
Marchant
Marshall
McCarthy (CA)
McCaul
McClintock
McCotter
McHenry
McHugh
McIntyre
McKeon
McMorris Rodgers
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Minnick
Moran (KS)
Murphy, Tim
Myrick
Neugebauer
Nunes
Olson
Paul
Paulsen
Pence
Petri
Pitts
Platts
Poe (TX)
Posey
Price (GA)
Putnam
Radanovich
Rehberg
Reichert
Roe (TN)
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Rooney
Ros-Lehtinen
Roskam
Royce
Ryan (WI)
Scalise
Schmidt
Schock
Sensenbrenner
Sessions
Shadegg
Shimkus
Shuster
Simpson
Smith (NE)
Smith (TX)
Souder
Stearns
Taylor
Terry
Thompson (PA)
Thornberry
Tiahrt
Tiberi
Turner
Upton
Walden
Wamp
Westmoreland
Whitfield
Wilson (SC)
Wittman
Wolf
Young (AK)
Young (FL)

NAYS—247

Abercrombie
Ackerman
Adler (NJ)
Altmire
Andrews
Arcuri
Baca
Baird
Baldwin
Barrow
Bean
Becerra
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boccieri
Boren
Boswell
Boyd
Brady (PA)
Braley (IA)
Brown, Corrine
Buchanan
Butterfield
Capps
Capuano
Cardoza
Carnahan
Carney
Carson (IN)
Castor (FL)
Chandler
Childers
Clarke
Clay
Cleaver
Clyburn
Cohen
Connolly (VA)
Cooper
Costa
Costello
Courtney
Crowley
Cuellar
Cummings
Dahlkemper
Davis (AL)
Davis (CA)
Davis (IL)
Davis (TN)
DeFazio
DeGette
Delahunt
DeLauro
Dicks
Dingell
Doggett
Donnelly (IN)
Doyle
Driehaus
Edwards (MD)
Edwards (TX)
Ellison
Ellsworth
Engel
Eshoo
Etheridge
Farr
Fattah
Filner
Foster
Frank (MA)
Fudge
Giffords
Gillibrand
Gonzalez
Gordon (TN)
Grayson
Green, Al
Green, Gene
Griffith
Grijalva
Gutierrez
Hall (NY)
Halvorson
Hare
Harman
Hastings (FL)
Heinrich
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
Kirkpatrick (AZ)
Kissell
Klein (FL)
Kosmas
Kratovil
Kucinich
Langevin
Larsen (WA)
Larson (CT)
Lee (CA)
Levin
Lewis (GA)
Lipinski
LoBiondo
Loebsack
Lofgren, Zoe
Lowey
Luján
Lynch
Maffei
Maloney
Markey (CO)
Markey (MA)
Massa
Matheson
Matsui
McCarthy (NY)
McCollum
McDermott
McGovern
McMahon
McNerney
Meek (FL)
Meeks (NY)
Melancon
Michaud
Miller (NC)
Miller, George
Mitchell
Mollohan
Moore (KS)
Moore (WI)
Moran (VA)
Murphy (CT)
Murphy, Patrick
Murtha
Nadler (NY)
Napolitano
Neal (MA)
Nye
Oberstar
Obey
Olver
Ortiz
Pallone
Pascrell
Pastor (AZ)
Payne
Perlmutter
Perriello
Peters
Peterson
Pingree (ME)
Polis (CO)
Pomeroy
Price (NC)
Rahall
Rangel
Reyes
Richardson
Rodriguez
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
Shuler
Sires
Skelton
Slaughter
Smith (NJ)
Smith (WA)
Space
Speier
Spratt
Stark
Stupak
Sutton
Tanner
Tauscher
Teague
Thompson (CA)
Thompson (MS)
Tierney
Titus
Tonko
Towns
Tsongas
Van Hollen
Velázquez
Visclosky
Walz
Wasserman Schultz
Waters
Watson
Watt
Waxman
Weiner
Welch
Wexler
Wilson (OH)
Woolsey
Wu
Yarmuth

NOT VOTING—7

Boucher
Conyers
Herseth Sandlin
Sherman
Snyder
Solis (CA)
Sullivan

□ 1435

Mr. HALL of New York, Ms. FUDGE, Ms. LORETTA SANCHEZ of California, Messrs. CARNEY, SIRES, FARR, Ms. SPEIER, and Mr. RAHALL changed their vote from ''yea'' to ''nay.''

Messrs. ROSKAM, NUNES, CANTOR, LaTOURETTE, ROGERS of Kentucky, and GERLACH changed their vote from ''nay'' to ''yea.''

So the motion to recommit was rejected.

The result of the vote was announced as above recorded.

The SPEAKER pro tempore. The question is on the passage of the bill.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

RECORDED VOTE

Mr. CARDOZA. Madam Speaker, I demand a recorded vote.

A recorded vote was ordered.

The SPEAKER pro tempore. This is a 5-minute vote.

The vote was taken by electronic device, and there were—ayes 289, noes 139, not voting 6, as follows:

[Roll No. 16]

AYES—289

Abercrombie
Ackerman
Adler (NJ)
Altmire
Andrews
Arcuri
Austria
Baca
Baird
Baldwin
Barrow
Bean
Becerra
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boccieri
Bono Mack
Boren
Boswell
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
Gillibrand
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)
Kissell
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)
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
Shuler
Simpson
Sires
Skelton
Slaughter
Smith (NJ)
Smith (WA)
Space
Speier
Spratt
Stark
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)

NOES—139

Aderholt
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
Campbell
Cantor
Carter
Cassidy
Chaffetz
Coble
Coffman (CO)
Cole
Conaway
Crenshaw
Culberson
Davis (KY)
Deal (GA)
Dreier
Duncan
Fallin
Flake
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	Mica	Scalise
Kline (MN)	Miller (FL)	Schmidt
Lamborn	Miller, Gary	Schock
Latham	Myrick	Sensenbrenner
Latta	Neugebauer	Sessions
Lewis (CA)	Nunes	Shadegg
Linder	Olson	Shimkus
Lucas	Paul	Shuster
Luetkemeyer	Pence	Smith (NE)
Lummis	Pitts	Smith (TX)
Lungren, Daniel E.	Poe (TX)	Souder
	Posey	Stearns
Mack	Price (GA)	Terry
Manzullo	Putnam	Thornberry
Marchant	Radanovich	Tiahrt
Marshall	Roe (TN)	Walden
McCarthy (CA)	Rogers (KY)	Wamp
McCaul	Rogers (MI)	Westmoreland
McClintock	Rohrabacher	Whitfield
McHenry	Rooney	Wilson (SC)
McKeon	Roskam	Wittman
McMorris Rodgers	Royce	
	Ryan (WI)	

NOT VOTING—6

Boucher	Sherman	Solis (CA)
Meeks (NY)	Snyder	Sullivan

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). There are 2 minutes remaining on this vote.

□ 1445

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

Stated for:

Mr. MEEKS of New York. Madam Speaker, on Rollcall No. 16, I was avoidably delayed and just missed the vote. Had I been present, I would have voted "aye."

□ 1445

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. HOLDEN). Pursuant to clause 8 of rule XX, the Chair will postpone further proceedings today on a motion to suspend the rules on which a recorded vote or the yeas and nays are ordered, or on which the vote is objected to under clause 6 of rule XX.

Any record vote on the postponed question will be taken later.

REQUIRING COMMITTEES TO INVESTIGATE REPORTS OF WASTE, FRAUD, ABUSE, OR MISMANAGEMENT

Mr. CARDOZA. Mr. Speaker, I move to suspend the rules and agree to the resolution (H. Res. 40) amending the Rules of the House of Representatives to require each standing committee to hold periodic hearings on the topic of waste, fraud, abuse, or mismanagement in Government programs which that committee may authorize, and for other purposes, as amended.

The Clerk read the title of the resolution.

The text of the resolution is as follows:

H. RES. 40

Resolved, That clause 2 of rule XI of the Rules of the House of Representatives is amended by adding at the end the following new paragraphs:

''(n)(1) Each standing committee, or a subcommittee thereof, shall hold at least one hearing during each 120-day period following the establishment of the committee on the topic of waste, fraud, abuse, or mismanagement in Government programs which that committee may authorize.

''(2) A hearing described in subparagraph (1) shall include a focus on the most egregious instances of waste, fraud, abuse, or mismanagement as documented by any report the committee has received from a Federal Office of the Inspector General or the Comptroller General of the United States.

''(o) Each committee, or a subcommittee thereof, shall hold at least one hearing in any session in which the committee has received disclaimers of agency financial statements from auditors of any Federal agency that the committee may authorize to hear testimony on such disclaimers from representatives of any such agency.

''(p) Each standing committee, or a subcommittee thereof, shall hold at least one hearing on issues raised by reports issued by the Comptroller General of the United States indicating that Federal programs or operations that the committee may authorize are at high risk for waste, fraud, and mismanagement, known as the 'high-risk list' or the 'high-risk series'.''.

SEC. 2. Clause 1(d)(3) of rule XI of the Rules of the House of Representatives is amended by adding at the end the following new sentence: ''That section shall also delineate any hearings held pursuant to clauses 2(n), (o), or (p) of this rule.''.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from California (Mr. CARDOZA) and the gentleman from California (Mr. DREIER) each will control 20 minutes.

The Chair recognizes the gentleman from California (Mr. CARDOZA).

GENERAL LEAVE

Mr. CARDOZA. Mr. Speaker, I ask unanimous consent that all Members have 5 legislative days within which to revise and extend their remarks and to include extraneous material on House Resolution 40.

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

There was no objection.

Mr. CARDOZA. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, make no mistake about it, these are tough times for our country. The United States is facing an economic disaster unlike anything we have seen since the Great Depression.

In the coming weeks, there will surely be differences of opinion as to how to best address the ailments of our Nation. But one thing is certain: Now, more than ever, it is time to ensure that government spends the taxpayers' money wisely.

For the first 6 years of the Bush administration, there was virtually no oversight by the Republican-led Congress. This led to rampant fraud and abuse, and billions of dollars of taxpayer dollars that were squandered by the administration, particularly regarding Iraq reconstruction and the response to Katrina.

Beginning in January of 2007, the Democratic Congress turned a new page and took numerous steps to begin changing the way we do business by restoring accountability and oversight. House Resolution 40, introduced by my very good friend and fellow Blue Dog colleague, the gentleman from Tennessee (Mr. TANNER), and myself, simply adds another layer to the rigorous oversight measures that we have already established.

This resolution amends the House rules to require each standing committee to hold at least three hearings per year on waste, fraud and abuse under each respective committee's jurisdiction. It requires a hearing in the event that an agency's auditor issues a disclaimer that the agency's financial statements are not in order. It also requires a hearing if an agency under that respective committee's jurisdiction has a program deemed by the GAO to be at high risk for waste, fraud and abuse.

Mr. Speaker, at the request of my friends on the other side of the aisle, there are two other stipulations. First, that the resolution shall be considered in light of existing House rules governing the conduct of committee hearings, including hearings held in executive session and the treatment of executive session materials; and, second, to require that committee activities reports identify the hearings held under the resolution.

Friends, plain and simple, it is now time to audit America's books. This resolution will add another level of accountability by shining light on the most egregious cases of government waste.

I would add, Mr. Speaker, that I am very encouraged by President-elect Obama's statements regarding his intent to pore through the budget line-by-line to eliminate wasteful spending. However, while I take the President-elect at his word, this resolution demonstrates that this Democratic Congress will not turn a blind eye to government waste simply because there is now a Democratic administration. Free passes are over, and we must build upon increased oversight and accountability efforts.

We have an opportunity to reinvent government and adhere to the fiscal accountability measures that Blue Dogs have long advocated. This will require tough decisions. But given these challenging economic times, cutting out waste, fraud and abuse must be among our top priorities in this Congress. All this requires is some bureaucratic soul-searching.

I ask my colleagues on both sides of the aisle to join the Blue Dogs in this quest.

Mr. Speaker, I reserve the balance of my time.

Mr. DREIER. Mr. Speaker, I yield myself such time as I may consume, and I very gladly rise in strong support of this resolution, and, more importantly, in the bipartisan spirit in which it has been shaped.

The basic idea behind this resolution, as my friend has said, is to ensure that committees are fulfilling their oversight duties and fully addressing the