long time. They were on 24-hour moni-
toring for a very, very long time.
If a doctor had come to me and said
to me, Mr. GRAYSON, we can save your
children but it will cost a million dol-
ars, I would have said okay.
If a doctor had said, Mr. GRAYSON, we
can save your children, but it is going
to cost your right arm, I would have
said okay because the life of a child is
more important than money. And yet
in America we have 25,000 children who
die every year without reaching their
first birthday.
This bill will cover 4 million children
with health care who otherwise won’t
have it. I turn to the other side of the
aisle and I say: Let’s save those lives,
let’s choose life.

STOP BAILOUT BONUSES
(Mr. SAM JOHNSON of Texas asked
and was given permission to address
the House for 1 minute.)
Mr. SAM JOHNSON of Texas. Madam
Speaker, last week Americans learned
of 50,000 new layoffs in just one day. We
also heard another startling fact: that
the financial industry bailed out by
Uncle Sam paid $18 billion in bonuses.
That is just appalling.
The $18 billion payout in 2008 ranks
as the sixth highest in bonus history
and compares with 2004, a banner year,
on Wall Street.
As a supporter of free enterprise, I
back performance-based bonuses for a
job well done.
Banks just barely getting by, thanks
to taxpayer bailout money, have no
business paying bonuses. With our
economic sliding deeper into recession,
this reckless decision to pay bonuses
showcases the disgraceful behavior of
greed and arrogance of Wall Street
that Americans detest. It is flat irre-
sponsible.
Let’s stop the bailout bonus bonanza
now.

RECKLESS SPENDING
(Mr. BURGESS asked and was given
permission to address the House for 1
minute and to revise and extend his
remarks.)
Mr. BURGESS. Madam Speaker, the
American people understand the need
for a stimulus. They understand the
need for job creation. What they don’t
understand is why we are pursuing this
reckless path of aimless spending.
Now we have heard it over and over
again. Elections have consequences,
they won, and we understand that. We
also hear the need for bipartisan bills.
But I have to ask you, Madam Speaker,
doesn’t legislation also have con-
sequences?
We often ask ourselves what makes a
bill bipartisan? Is it just because we all
have a chance to vote one way or the
other and for that reason it is a bipar-
tisan effort even if you vote against it
or for it.
In reality, a bipartisan bill begins at
its inception where the ideas are talked
about among Members and typically
amongst their staff. Certainly it in-
volves hearings and markups at the
subcommittee level, and certainly it
involves hearings and markups at the
full committee level. But many of the
bills we hear before fail to achieve
that lofty goal.
We are about to pass a stimulus bill
that will vastly increase Medicaid
spending, but at the same time in this
great wash of cash, we can do nothing
to provide adequate payments to pro-
viders. That would have been a bipar-
tisan effort.

CHILDREN’S HEALTH INSURANCE
PROGRAM REAUTHORIZATION
ACT OF 2009
Mr. POLIS of Colorado. Madam
Speaker, by direction of the Com-
mittee on Rules, I call up House Reso-
Lution 107 and ask for its immediate
consideration.
The Clerk read the resolution, as fol-
ows:
H. Res. 107
Resolved, That upon adoption of this
resolution it shall be in order to take
from the Speaker's table the bill (H. R. 2)
to amend title XXI of the Social Security
Act to extend and improve the Children’s Health
Insurance Program, and for other purposes,
with the Senate amendment thereto, and to
consider in the House, without intervention
of any point of order except those arising
under clause 10 of rule XXI, a motion offered
by the chair of the Committee on Energy and
Commerce or his designee that the House
concur in the Senate amendment. The Sen-
ate amendment and the motion shall be con-
sidered as read. The motion shall be debat-
able for one hour equally divided among
and controlled by the chair and ranking minor-
ity member of the Committee on Energy and
Commerce and the chair and ranking minor-
ity member of the Committee on Ways and
Means. The previous question shall be con-
sidered as ordered on the motion to adoption
without intervening motion.
The SPEAKER pro tempore. The gen-
tleman from Colorado is recognized for
1 hour.
Mr. POLIS of Colorado. Madam
Speaker, for the purposes of debate
only, I yield the customary 30 minutes
to the gentleman from Texas and my
colleague on the Rules Committee, Mr.
SESSIONS. All time yielded during con-
side the rule is for debate only.

GENRAL LEAVE
Mr. POLIS of Colorado. I ask unani-
ous consent that all Members may
have 5 legislative days within which
to revise and extend their remarks and
insert extraneous material into the
RECORD.
The SPEAKER pro tempore. Is there
objection to the request of the gen-
tleman from Colorado?
There was no objection.
Mr. POLIS of Colorado. Madam
Speaker, I yield myself such time as I
may consume.
Madam Speaker, House Resolution
107 provides for consideration of the
Senate amendment to H. R. 2, the
Children’s Health Insurance Program Reau-

I rise in support of House Resolution
107, the Children’s Health Insurance
Program Reauthorization Act. I again
wish to thank Speaker PELOSI who has
been an unrelenting champion on this
important issue. I also want to thank
Chairman RANGEL and Chairman DIX-
ON, whose experience was vitally
needed in the 110th Congress, and Chair-
man WAXMAN and all of my colleagues
for their leadership on this issue in this
Congress, and I want to recognize ev-
everyone’s efforts to bring this bill to
work while it is today.
Although I began my House service
only a few weeks ago, I have received
hundreds of letters from constituents
who have serious concerns about
health care cost and coverage. Too
often is the story of hardworking,
low-income moms and dads forced to
choose between buying groceries and
visiting their family doctor. I have
heard from those who have either lost
their health care coverage or feared
that they will lose it because they sim-
ply can’t afford it.

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

Stop the bailout bonus bonanza.

Reckless spending.

General leave.

There was no objection.

It is a fiscally responsible way to not
only extend the number of children in our
Nation who will receive health care, but
to improve the quality of that care. This
bill relieves the bur-
den of taxpayers who currently sub-
sidize millions of costly and inefficient
uninsured emergency room visits. By
encouraging preventative care for chil-
dren who lack insurance today, we can
actually reduce costs from the system
and provide healthier outcomes for
young people.

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

I support extending 70,000 children in
my home State of Colorado wake up
without health insurance. That is
170,000 too many. This bill will change
that terrible statistic for the better by
February 4, 2009

CONGRESSIONAL RECORD — HOUSE

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

Madam Speaker, the epidemic of the uninsured is a consequence of our struggling economy, it is a component of it. Under a new administration, with the political will of this new Congress, we have the power to set this particular wrong right. A healthy economy is supported by healthy people. Providing health care insurance for millions of uninsured Americans is an important beginning to keeping our people and our economy healthy. But it is just a beginning.

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

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

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

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

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

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

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

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

On January 12 of this year, my Republican colleagues and myself sent to President Speaker Pelosi, which I would like included in the RECORD, a letter outlining what Republicans would like to see the majority party, the Democrats, consider before expanding the current SCHIP program.

On this morning, have received no answer, no answer, to a forthright and open letter. In responding to this, we are simply asking today on the floor of the House of Representatives for the opportunity not only to be heard but also to make sure that the newest Members of this body have a chance to know the facts of the case. And in reauthorizing this program, the first priority should be, should be, to make sure that our Nation's poorest uninsured children are covered. The intent of the program is that. And we must first fulfill that goal.

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

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

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

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

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

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

In the days where Congress is faced with a second $350 billion financial services bailout and a proposed $1.2 trillion stimulus package, the Federal Government in any financial shape to be financing health care costs for children who are already receiving priority health insurance? Once again, the test of common sense and cost effectiveness would fail this legislation. That is a moment when before we recklessly increases entitlement spending by at least $73.3 billion over the next 10 years. That is increasing it due to the new entitlements. That is neither cost effective nor common sense. This expansion will allow SCHIP to grow at an annual rate of 23.7 percent over the next 5 years. Once again, not cost effective and not common sense. Based on the Treasury Department's financial report, the government has $56 trillion in unfunded liabilities, the largest in the world, including the Federal Government's health care program. Why not do something that would be for the Nation's poorest children rather than
trying to push 2.4 million more children, unless you have a political agenda rather than a public policy agenda?

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

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

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

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

The American people deserve to know how their hard-earned tax dollars will stimulate the economy, not government spending where Washington gets to decide which projects will get funded and which will not. The results are clear. The American people have confidence, not only in Congress, but in their own individual Member of Congress who casts that vote.

If expanding SCHIP to families making $80,000 a year isn’t enough, as this bill does, last week my Democrat colleagues voted in favor of making Wall Street millionaires and billionaires, like the former Lehman Brothers CEO, plausible, trying to force American taxpayers to pay for free health care for the very same executives who helped create the financial crisis in the stimulus package able to get this help?

Adding another trillion dollars to the Federal deficit and swelling the number of persons dependent on subsidized, government-run health care is hazardous to the health of the American people. Americans want a long-term solution. Do my friends on the other side of the aisle, such as the former Lehman Brothers CEO, who casts that vote.

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

The American people hate waste in government. The Democrats, who are the majority party, are spending like never before, delaying the real access to care problem in the American economy for another burden to place on our grandchildren.

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The American people hate waste in government. The Democrats, who are the majority party, are spending like never before, delaying the real access to care problem in the American economy for another burden to place on our grandchildren.

So what’s next? A $32.3 billion expansion of SCHIP, and finally, the massive omnibus which is expected this week or next.

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

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

I came to Congress to protect the American taxpayer, which is why I encourage my colleagues to oppose this rule and the underlying legislation.
Madam Speaker, I reserve the balance of my time.

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

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

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

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

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

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

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

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

Mr. BURGESS. I do urge my colleagues to look long and hard before voting on this rule today, and I urge a “no” vote on the Rule. The fact is, Madam Speaker, that over half of the country has not had an opportunity to participate in this debate. 40 percent of this country is represented by Republican Members. We have not had input into this bill. 12 percent of this Congress is new. They have had no input into this bill. That leaves over half the country who haven’t been part of this debate.

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

You have to show your ID before you cash a check at the grocery store. Why don’t we ask someone to show proper identification before they sign up for this benefit?

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

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

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

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

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

Mr. POLIS of Colorado. Madam Speaker, a brief history on the SCHIP legislation and why this is so critical for us to pass here today. This rule before the House would permit the House to concur in the Senate amendment by majority vote, and the sooner we get past this point, the sooner we get past that point, the better for the American people.

In July of 2007 the House considered H.R. 3162 to reauthorize and amend...
SCHIP and the bill passed. In September 2007 the House considered H.R. 976 to reauthorize and amend SCHIP. The bill passed. The Senate also passed the bill and it was presented to President Bush and received a veto. In October 2007, the House again tried to reauthorize SCHIP. 3963 was the House bill. Passed the House, passed the Senate. The President again vetoed the bill and the House was unable to override the veto.

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

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

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

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

Mr. SESSIONS. Madam Speaker, at this time I would like to yield 15 minutes to the gentleman from Marietta, Georgia, Dr. GINGREY.

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

The Democratic majority has once again brought forward a closed rule that only tramples on the rights of the minority and in the process weakens the principle of the American Dream. The House has a duty to work in a bipartisan manner to improve this bill.

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

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

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

Therefore, Madam Speaker, I urge all my colleagues to oppose the closed rule. The SPEAKER pro tempore. The time of the gentleman has expired.

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

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

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

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

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

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

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

Madam Speaker, I reserve the balance of my time.

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

Mr. DREIER. Let me say, Madam Speaker, that getting the American economy back on track is priority number one, and we are still creating an opportunity for us to ensure that the dollars get to those who are truly in need.

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

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

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

Mr. POLIS of Colorado. Madam Speaker, with regard to the delivery of the services, most SCHIP and Medicaid beneficiaries receive service delivery through private doctors and through private management care plans, not through government. When we are talking about how the service is delivered, we are talking about an important aspect of what insurance and what coverage allows. Yes, separately, we certainly hope that we will be able to address universal coverage, in rural areas in particular, as an important component of health care in this country.
With regard to income limits, this bill does provide that if a State covers children in families of three with income over $52,800, which is 300 percent of the poverty rate, then the States get the regular Medicaid match rate. There are, in fact, income provisions in the bill, which prevents payments to individuals not lawfully residing in the United States. So I believe that the issues that have been raised by my colleagues are addressed in the bill.

Mr. BOUSTANY. We also need to limit the crowd-out of private coverage and target the neediest children for enrollment first. We need to help poor children first. I know we can do better. Oppose this rule. Oppose this bill. Mr. POLIS of Colorado. Madam Speaker, another story from Colorado is about someone who I know first-hand had the Kids First Act.

Mr. POLIS of Colorado. Madam Speaker, I would also like to discuss that SCHIP will take dental care, alleviating the most common childhood disease—tooth decay. I cannot help but remember a story that was told to me when I was visiting a free dental clinic in Boulder, Colorado that provides services to those who are uninsured. The story is about a young girl who was in the third grade. Due to the lack of dental care and poor dental hygiene practices at home, her teeth had actually rotted out. This is when she was a young girl. She had received no care for that as well. As a result, she was very, very shaky, and was constantly in pain. Her diet suffered. She suffered malnutrition because of the condition of her teeth. Fortunately, the community there was able to help her, but there are hundreds of thousands of young people across the country who suffer from no or from poor quality dental care, which has vast ramifications as well.

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

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

I would like to yield 1 minute to the gentlewoman from Fort Worth, Texas (Mr. GRANGER). Madam Speaker, I rise in opposition to the rule for the consideration of the SCHIP bill we will be considering later today.

Mr. GRANGER. Madam Speaker, I yield the gentleman an additional 15 seconds.

Mr. BOUSTANY. We need to consider the difference now is we are sending it to a President who has indicated that he is, in fact, willing to sign it and, indeed, is willing to do so. This is when I was visiting a free dental clinic in Boulder, Colorado that provides services to those who are uninsured. The story is about a young girl who was in the third grade. Due to the lack of dental care and poor dental hygiene practices at home, her teeth had actually rotted out. This is when she was a young girl. She had received no care for that as well. As a result, she was very, very shaky, and was constantly in pain. Her diet suffered. She suffered malnutrition because of the condition of her teeth. Fortunately, the community there was able to help her, but there are hundreds of thousands of young people across the country who suffer from no or from poor quality dental care, which has vast ramifications as well.

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

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

Mr. POLIS of Colorado. Madam Speaker, I am the last speaker for this
The gentleman representing the Florida side, I would like to reserve my time until the gentleman has closed for his side and has yielded back his time.

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

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

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

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

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

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

I yield back the balance of my time.

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

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

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

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

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

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

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

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

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

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

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

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

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

We are on a different path now. I thank the many members who championed SCHIP as an initiative that works within a broader health care system that leaves many unable to afford health care in America, especially Speaker Pelosi, who never gave up and kept the promise that in the first days of a new Congress with a new President, the health of America’s kids and the pocketbooks of hard-working families would be paramount.

Mr. POLIS of Colorado. I yield back the balance of my time, and I move the previous question on the resolution. The previous question was ordered. The resolution was agreed to.

A motion to reconsider was laid on the table.

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

The SPEAKER pro tempore. The Clerk will read the title of the bill.

The Clerk read the title of the bill.

The text of the Senate amendment is as follows:

Senate amendment:

Strike all after the enacting clause and insert the following:

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

(a) SHORT TITLE.—This Act may be cited as the “Children’s Health Insurance Program Reauthorization Act of 2009”.

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

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

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

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

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

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

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

TITLe 1—FINANCING

Subtitle A—Funding

Sec. 101. Extension of CHIP.
Sec. 102. Allocations for States and territories for fiscal years 2009 through 2013.
Sec. 103. Child Enrollment Contingency Fund.
Sec. 104. CHIP performance bonus payment to offset additional enrollment costs resulting from enrollment and reenrollment efforts.
Sec. 105. Two-year initial availability of CHIP allotments.

Sec. 106. Redistribution of unused allotments.

Sec. 107. Option for qualifying States to receive the enhanced portion of the CHIP matching rate for Medicaid coverage of certain children.

Sec. 108. One-time appropriation.

Sec. 109. Improving funding for the territories under CHIP and Medicaid.

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

Sec. 111. State option to cover low-income pregnant women under CHIP through a State plan amendments.

Sec. 112. Phase-out of coverage for nonpregnant childless adults under CHIP; conditions for coverage of parents.

Sec. 113. Elimination of counting Medicaid child presumptive eligibility costs against title XXI allotment.

Sec. 114. Limitation on matching rate for States that propose to cover children with effective family income that exceeds 300 percent of the poverty line.

Sec. 115. State authority under Medicaid.

TITLE II—OUTREACH AND ENROLLMENT

Subtitle A—Outreach and Enrollment Activities

Sec. 201. Grants and enhanced administrative funding for outreach and enrollment.

Sec. 202. Increased outreach and enrollment of Indians.

Sec. 203. State option to rely on findings from the Implementation Agency lane agency to conduct simplified eligibility determinations.

Subtitle B—Reducing Barriers to Enrollment

Sec. 211. Verification of declaration of citizenship or nationality for purposes of eligibility for Medicaid and CHIP.

Sec. 212. Reducing administrative barriers to enrollment.

Sec. 213. Model of Interstate coordinated enrollment and coverage process.

Sec. 214. Permitting States to ensure coverage without a 5-year delay of certain children and pregnant women under the Medicaid program and CHIP.

TITLE III—REDUCING BARRIERS TO QUALITY AND CARE AND HEALTH OUTCOMES

Sec. 301. Child health quality improvement activities for children enrolled in Medicaid or CHIP.

Sec. 302. Improved availability of public information regarding enrollment of children in CHIP and Medicaid.

Sec. 303. Application of prospective payment system for services provided by Federally-qualified health centers and rural health clinics.

Sec. 304. Premium assistance for States that have implemented, by the end of fiscal year 2009, a 2-year legislative session, each year of the session shall be considered to be a separate regular session of the State legislature.

Sec. 305. Clarification of coverage of services provided through school-based health centers.

Sec. 306. Medicaid child CHIP Payment and Access Commission.

TITLE VI—PROGRAM INTEGRITY AND OTHER MISCELLANEOUS PROVISIONS

Subtitle A—Program Integrity and Data Quality

Sec. 401. Child health quality improvement activities.

Sec. 501. Dental benefits.

Sec. 402. Improved availability of public information regarding enrollment of children in CHIP and Medicaid.

Sec. 403. Application of certain managed care quality safeguards to CHIP.

Sec. 404. Application of prospective payment system for services provided by Federally-qualified health centers and rural health clinics.

Sec. 505. Clarification of coverage of services provided through school-based health centers.

Sec. 506. Medicaid child CHIP Payment and Access Commission.

TITLE VII—REVENUE PROVISIONS

Sec. 601. Payment error rate measurement ("PERM").

Sec. 602. Improving data collection.

Sec. 603. Updated Federal evaluation of CHIP.

Sec. 604. Access to results from GAO audits and GAO evaluations.

Sec. 605. No Federal funding for illegal aliens; disallowance for unauthorized expenditures.

Subtitle B—Miscellaneous Health Provisions

Sec. 611. Deficit Reduction Act technical corrections.

Sec. 612. References to title XXI.

Sec. 613. Provisions for enhancing new health opportunity account demonstration programs.

Sec. 614. Adjustment in computation of Medicaid FMAP to disregard an extraordinary employer pension contribution.

Sec. 615. Clarification of treatment of regional medical care systems.

Sec. 616. Extension of Medicaid DSH allotments for Tennessee and Hawaii.

Sec. 617. GAO report on Medicaid managed care payment rates.

Subtitle C—Other Provisions

Sec. 621. Outreach regarding health insurance options available to children.

Sec. 622. Sense of the Senate regarding access to affordable and meaningful health insurance coverage.

TITLE VIII—FINANCING

Subtitle A—Funding

Sec. 801. EXTENSION OF CHIP.

Section 2104(a) (42 U.S.C. 1397d(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 2009";

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

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

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

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

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

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

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

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

Sec. 802. ALLOTMENTS FOR STATES AND TERRITORIES FOR FISCAL YEARS 2009 THROUGH 2013.

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

(1) in subsections (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:

"(7) $1,000,000,000 for each of fiscal years 2009 through 2013..."

Sec. 803. ALLOTMENTS FOR FISCAL YEARS 2009 THROUGH 2013.

"(1) FOR FISCAL YEAR 2009—

(A) FOR THE 50 STATES AND THE DISTRICT OF COLUMBIA..."
“(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 of Federal payments 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 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 Secretary to the State for the Commonwealths and Territories—

“(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph and paragraph (4), the Secretary shall, before March 31, 2009, submit a revised projection described in subparagraph (A)(ii) of each of the Commonwealths and Territories described in subsection (c)(2) 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 1998 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’.

“(B) ALLOTMENT INCREASE FACTOR.—In the case of a qualifying State described in paragraph (2) of section 2105(p), 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) the amount of the 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 determined under paragraph (5) for fiscal year 2010.

“(ii) REBASING IN FISCAL YEAR 2011.—For fiscal year 2011, the allotment of the Secretary by not later than March 31, 2009.

“(I) AMOUNT OF THE ALLOWMENT.—The amount in this subparagraph for a State is equal to the Federal payments to the State that are attributable to (and countable towards) the actual 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 years 2010 and 2011, multiplied by the allotment increase factor under paragraph (5) for fiscal year 2013.

“(II) FIRST HALF.—The first half is the appropriation for such period under section 108 of the Children’s Health Insurance Program Reauthorization Act of 2009, multiplied by the sum of—

“(i) the amount made available under subsection (a)(15)(A); and

“(ii) the amount made available under subsection (a)(15)(B).

“(III) PRO RATION 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, if in the case of fiscal year 2011, 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.

“(III) 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.—I plus the percentage increase in the projected per capita amount of National Health Expenditures for 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 involved, plus 1 percentage point.

“(B) POPULATION GROWTH FACTOR.—I plus the percentage increase (if any) in the population of children in the State from July 1 in the preceding 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.

“(IV) 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 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 2011.

“(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 eligible individuals or benefit expansions 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 increase factor for such fiscal year.

“(V) AVAILABILITY OF AMOUNTS FOR SEMI-ANNUAL PERIODS IN FISCAL YEAR 2011.—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 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:

“(b) CHILD ENROLLMENT CONTINGENCY FUND.—

“(I) 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 appropriation for payments under this subsection.

“(II) 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—

“(1) 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

“(2) 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 the fiscal year or period.

“(III) 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.

“(IV) AVAILABILITY OF EXCESS FUNDS FOR PERFORMANCE BONUSES.—Any amounts in excess of the aggregate cap described in subparagraph (B), shall not exceed 20 percent of the amount made available under subsection (a) for the fiscal year or period.

“(V) CHILD ENROLLMENT CONTINGENCY FUND PAYMENT.—

“(A) IN GENERAL.—If a State’s expenditures under this title in fiscal year 2009, fiscal year
SEC. 104. CHIP PERFORMANCE BONUS PAYMENT TO OFFSET ADDITIONAL ENROLLMENT AND RETENTION COSTS RESULTING FROM ENROLLMENT AND RETENTION EFFECTS.

Section 2105(a) (42 U.S.C. 1396t(a)) is amended by adding at the end the following new paragraph:

"(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 amount of Federal expenditures that would be made available for a fiscal year, under this subparagraph (F) 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.—For purposes of 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); and"

"(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 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 (as determined under clause (I) or (II)) for fiscal year 2009 is equal to the average per capita expenditures (including both State and Federal financial participation) under such plan for the fiscal year for the average income children enrolled in the average monthly caseload for purposes of this paragraph during fiscal year 2008, increased by the percentage increase in the projected per capita amount of National Health Expenditures (as estimated by the Secretary) for fiscal year 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 (II)) 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 distribution from the Fund for a 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 section 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 amount of Federal expenditures available for the State in such fiscal year or period."

"(G) Application of commonwealth and territory description.—The 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 is in effect a description 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 eligibility, and of amount, payment, under this paragraph."

(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.—The number of child enrollees for a State under title XIX for the fiscal year described in clause (i)(II) and 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 3.5 percentage points;"

"(IV) Amount for above baseline Medicaid child enrollment costs.—Subject to subparagraph (E), the amount described in this subsection 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)) for the State and fiscal year under title XIX, 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)(i)) for the State and fiscal year under title XIX, 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 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; and"

"(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 clause (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)."
shall also be available, without fiscal year limitation, for making payments under this paragraph.

(2) UNOBLIGATED NATIONAL ALLOTMENT.—

(a) 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 Secretary, if any such amount appropriated under subsection (a)(3) or (b)(2) of section 1111 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 amount appropriated under subsection (a)(16)(A) and under section 100 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 1111 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 1111 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 fiscal year ending in the fiscal year in the case of the fiscal year 2006, 2007, and 2008 allotments) that is not expended or redistributed under section 2104(a)(1) during the second preceding fiscal year in the case of allotments that are available for obligation.

(iii) EXCESS CHILD ENROLLMENT CONTINGENCY FUND.—As of October 1 of each of fiscal years 2010 through 2012, any unexpended amount that is unobligated for expenditure by the State through the end of the fiscal year in which they are redistributed.

(iv) UNEXPENDED TRANSITIONAL COVERAGE BLOCK GRANT FOR NONPRONTINANCED CHILDLESS ADULTS.—As of October 1, 2011, any amounts set aside for such fiscal year that are not expended by September 30, 2011.

(iii) PROPORTIONAL REDUCTION.—If the sum of the amounts otherwise payable under this paragraph for such 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 proportionately.

(I) QUALIFYING CHILDREN DEFINED.—

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

(ii) ELIGIBILITY DETERMINATION.—The State shall determine in the case of a child the child is determined to be eligible for medical assistance under title XIX.

(iii) EXCLUSION.—Such term does not include any children for whom the State has made an election under subsection (f) of section 1902 of title XIX.

(iii) 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 other provisions of this title.

(I) APPLICATION TO STATES THAT IMPLEMENT A MEDICAID EXPANSION FOR CHILDREN AFTER FISCAL YEAR 2009.—In the case of a State that provides coverage under section 1115 of the Children’s Health Insurance Program Reauthorization Act of 2009 for any fiscal year after fiscal year 2009,

(II) LIMITATION.—A child described in clause (I) of this paragraph shall not be counted as a child for purposes of this subparagraph.

(III) ELIGIBILITY DETERMINATION.—The State shall determine in the case of a child the child is determined to be eligible for medical assistance under title XIX.

(IV) ELIGIBILITY DETERMINATION.—The Secretary, that the projected expenditures under the State plan under title XIX for such fiscal year are not contained in the amount of the Federal medical assistance percentage for such fiscal year.

(V) 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 in-person interviews, unless such 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.

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

(IV) PREMATURE ASSISTANCE SUBSIDIES.—The State is implementing the option of providing premium assistance subsidies under section 1920A(e)(3), or the option of providing premium assistance subsidies under section 1920A(e)(4).

SEC. 105. TWO-YEAR INITIAL AVAILABILITY OF CHIP ALLOTMENTS.

Section 1920(e)(4) (42 U.S.C. 1397dd(e)(4)) is amended—

(1) IN GENERAL.—Except as provided in paragraph (2), amounts allotted to a State pursuant to this section.

(2) AVAILABILITY OF AMOUNTS REDISTRIBUTED.—Amounts redistributed to a State under subsection (I) 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(d) (42 U.S.C. 1397dd(d)) is amended—

(2) SHORTFALLS DESCRIBED.—For purposes of paragraph (1), with respect to a fiscal year, a shortfall State described in this subparagraph is a State with a child health plan approved under the title for which the State makes payments 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 (a)(3) or (b)(2) of section 1111 for such fiscal year that is unobligated;

(iii) the amount of the State’s allotment for the fiscal year;

(B) PROPrITION R.—If the amount available for redistribution under paragraph (a) for a fiscal year is 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 must 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 May 31 of the following 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 YEARS BEGINNING AFTER FISCAL YEAR 2008.—Paragraph 2104(k)(2) (42 U.S.C. 1397dd(k)(2)) is amended—

(A) in the heading, by striking the first two quarters of; and

(B) by inserting 2008, or 2009, and inserting “September 30”.

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

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

(A) in paragraph (1), as amended by section 201(b)(1) of Public Law 110–173, (A) by inserting, after Notwithstanding any other provision of law, and (B) by striking 2008, or 2009, and inserting “or 2008”;

and

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

“(2) By the end of the following fiscal year, the payment shall not be taken into account in applying subsection (1) (as increased in accordance with paragraphs (1), (2), and (3) of this subsection) to such commonwealth or territory for such fiscal year.”.

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

SEC. 111. STATES PROVIDING MEDICAID COVERAGE OF CERTAIN LOW-INCOME PREGRANANT 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 provisions of this section, a State may elect through an amendment to its State child health plan to provide targeted low-income pregnant women with pregnancy-related assistance as follows:

“(1) Minimum income eligibility levels for pregnant women and children.—The State has established income eligibility levels for pregnant women and children that—

(A) are at least 185 percent of the Federal poverty level for children and 133 percent of the Federal poverty level for pregnant women;

(B) are not lower than the income levels specified under paragraph (4)(A); and

(C) are not lower than the income levels specified under subsection (e) (as increased in accordance with paragraphs (1), (2), and (3) of this subsection).

“(b) Expenditures described.—For purposes of subparagraph (A), the expenditures described in this paragraph are expenditures made after the date of the enactment of this paragraph and 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 title, but do not exceed the Medicaid applicable income level.

“(c) Repeal of limitation on availability of fiscal year 2009 allotments.—Paragraph (2) of section 201(b)(1) 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, $11,700,000,000 to accompany the allotment made for the period beginning on October 1, 2008, and ending on March 31, 2009, 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(m), as added by section 112) for the first 6 months of fiscal year 2013 in the same manner as allotments are provided for under subsection (a)(16)(A) of such section 2104 and subject to the same terms and conditions of such allotments provided from such subsection (a)(16)(A).

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

A fiscal year 2007 allotment under section 2105(g) (42 U.S.C. 1397dd(g)) is amended—

(A) by striking the first two quarters of; and

(B) by inserting “March 31” and inserting “September 30”.

SEC. 110. DISTRIBUTION OF UNUSED ALLOTMENTS FOR YEARS BEGINNING AFTER FISCAL YEAR 2008.

(A) In General.—Section 2105(g)(2) (42 U.S.C. 1397dd(g)) is amended—

(B) EXPENDITURES DESCRIBED.—For purposes of subparagraph (A), the expenditures described in paragraph (1)(A), as amended by section 201(b)(1) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173), are expenditures made after the date of the enactment of this paragraph and 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 with family income without covering pregnant women with higher family income disregards specified under subsection (a)(16)(A) and considering applicable income levels.

SEC. 202. APPLICABILITY OF EXISTING LIMITATIONS ON ENROLLMENT CAPS.

(a) In General.—Subtitle B—Focus on Low-Income Children and Pregnant Women.
“(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 available to provide child health assistance to a child or, if applicable, 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.

“(2) CLARIFICATION OF AUTHORITY TO PROVIDE POSTPARTUM SERVICES.—Any State that provides child health assistance under any applicable existing waiver, unless otherwise modified in such period, shall be deemed to comply with the requirement to provide child health assistance or other health benefits coverage to a nonpregnant childless adult during the period in which the waiver applies, if provided under the State plan under title XIX, but only through December 31, 2009.

“(2)(C) APPLICATION OF ENHANCED FMAP.—The enhanced FMAP determined under section 1115(b) shall apply to expenditures under an applicable existing waiver for the provision of child health assistance or other health benefits coverage to a nonpregnant childless adult during the period beginning on the date of the enactment of this subsection and ending on December 31, 2009.

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

“(A) IN GENERAL.—Each State for which coverage under an applicable existing waiver is terminated under paragraph (2)(A) may submit, not later than September 30, 2009, an application to the Secretary for a waiver under section 1115 of the State plan under title XIX to provide medical assistance to a nonpregnant childless adult whose coverage was 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) not later than 180 days after the date of submission of the application.

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

“(i) in the case of fiscal year 2010, exceed expenditures for medical assistance under title XIX for all such adults to not exceed the total amount of payments made to the State under paragraph (2)(B) for fiscal year 2009, increased by the percentage increase, if any, in the projected nominal per capita amount of National Health Expenditures for 2010 over 2009, as most recently published by the Secretary;

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

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

“(1) TWO-YEAR PERIOD; AUTOMATIC EXTENSION.

“(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 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

“(ii) notwithstanding the terms and conditions of an applicable existing waiver, the provisions of paragraphs (2) and (3) shall apply for any fiscal year 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 1115(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 first fiscal quarter of fiscal year 2010 and during fiscal years 2011 and 2012; and

“(D) 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 percentage of the State’s allotment under section 2104(m)(4) not used for purposes of any fiscal year beginning on or after January 1, 2010, in determining the period to which the waiver applies, the individuals eligible to be covered by the waiver, and the amount of the Federal payment under this title.

“(E) LIMITATION ON WAIVER USE.—Any State that requests an extension under clause (i) shall, to the extent that the extension is renewed, agree that the extension shall be used only to provide child health assistance or other health benefits coverage to a parent of a targeted low-income child; and

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

“(i) (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.

“(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 percentage of the State’s allotment under section 2104(m)(4) not used for purposes of any fiscal year beginning on or after January 1, 2010, in determining the period to which the waiver applies, the individuals eligible to be covered by the waiver, and the amount of the Federal payment under this title.

“(ii) The Secretary shall not on or after the date of 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

“(iii) The Secretary shall not, for purposes of any fiscal year beginning on or after January 1, 2010, in determining the period to which the waiver applies, the individuals eligible to be covered by the waiver, and the amount of the Federal payment under this title, extend any applicable existing waiver beyond September 30, 2011.

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

“(i) The Secretary shall not on or after the date of 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) (A) NO NEW CHIP WAIVERS.—Notwithstanding any other provision of this title, except as provided in this subsection.

“(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 percentage of the State’s allotment under section 2104(m)(4) not used for purposes of any fiscal year beginning on or after January 1, 2010, in determining the period to which the waiver applies, the individuals eligible to be covered by the waiver, and the amount of the Federal payment under this title.

“(ii) The Secretary shall not on or after the date of 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

“(iii) The Secretary shall not, for purposes of any fiscal year beginning on or after January 1, 2010, in determining the period to which the waiver applies, the individuals eligible to be covered by the waiver, and the amount of the Federal payment under this title, extend any applicable existing waiver beyond September 30, 2011.

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

“(i) The Secretary shall not on or after the date of 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) The Secretary shall not, for purposes of any fiscal year beginning on or after January 1, 2010, in determining the period to which the waiver applies, the individuals eligible to be covered by the waiver, and the amount of the Federal payment under this title, extend any applicable existing waiver beyond September 30, 2011.
“(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—

“(a) the State meets either of the following benchmarks described in subparagraph (B) or (C) of paragraph (3) for fiscal year 2012; or

“(b) the State met either of the coverage benchmarks described in subparagraph (B) or (C) of paragraph (3) for fiscal year 2012; and

“(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 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 (i) for a fiscal year set aside under this paragraph for a fiscal year in which the total amount set aside under such paragraph for a fiscal year has been paid to the State.

“(vii) 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 expenditure standards of targeted low-income children on the date of enactment of the Children’s Health Insurance Program Reauthorization Act of 2009.

“(viii) 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 2013;

“(ii) implemented 1 or more of the enrollment and retention provisions described in section 2105(a)(2) for such fiscal year; and

“(iii) submitted a 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 largest third 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 the performance bonus payment under section 2105(a)(2) for the most recent fiscal year applicable under such section.

“(D) RULES OF CONSTRUCTION.—Nothing in this subsection shall be construed as prohibiting a State from applying 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 paragraph (2)—

“(1) IN GENERAL.—The term ‘applicable existing waiver’ means a waiver, experimental, pilot, or demonstration project under section 1115, a legal guardian.

“(2) APPLICABLE WAIVERS.—For purposes of this paragraph—

“(A) CHILDREN with RESOURCES at LEVELS up TO 300 PERCENT of the FEDERAL POVERTY LINE.—The term ‘qualified provider’ also includes a legal guardian.

“(B) NONPREGNANT CHILDLESS ADULT.—The term ‘nonpregnant childless adult’ has the meaning given such term by section 1905(b).”

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

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

“(1) 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 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 Ways and Means of the House of Representatives, including recommendations (if any) for changes in legislation.

“(b) HIGH-PERFORMING STATE.—The term ‘high-performing State’ means a 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 an application for an approved State plan amendment or waiver to provide, medical assistance to a child who could be covered by the State under title XXI.

“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. 1396a et seq.), as amended by section 111, is amended by adding at the end the following new paragraph:

“(c) OUTREACH AND ENROLLMENT GRANTS; NONCAREER STAFF.—(1) IN GENERAL.—From the amounts appropriated under subsection (g), subject to paragraph (2), the Secretary shall award grants to eligible grantees for years beginning with fiscal year 2009 through 2013 to conduct outreach and enrollment efforts that are designed to increase the enrollment and participation of eligible children and families under title XXI.

“(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) ELIGIBILITY REQUIREMENTS.—

(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 or unenrolled children, including such children residing 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 (a) shall be used by the Secretary to support 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 require. 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 accessing child health assistance or medical assistance;

(3) specific quality or outcomes performance measures to evaluate the effectiveness of activities conducted 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 section (c)(4)(B); and

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

(e) MAINTENANCE OF EFFORT FOR STATES AWARDED GRANTS; NO MATCH REQUIRED FOR ANY ELIGIBLE ENTITY AWARDED A GRANT.—

(1) STATE MAINTENANCE OF EFFORT.—In the case of a State that is awarded a grant under this section, the State shall, for each year of the enrollment activities under this section, maintain a State child health plan that shall not be less than the State share of such funds expended in the fiscal year preceding the first fiscal year for which such grant is awarded.

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

(2) LOCAL MAINTENANCE OF EFFORT.—The term ‘eligible entity’ means a State that—

(A) 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 accessing child health assistance or medical assistance;

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

(3) ELIGIBLE ENTITY.—The term ‘eligible entity’ means—

(4) AN ENTITY.—An entity that—

(a) is a Federally-qualified health center (as defined in section 1905(o)(2)(B));

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

(c) 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 (21 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.

(2) 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. 1605).

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

(4) 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 sections 2105, 2106, and 2107, with respect to expenditures for outreach activities in accordance with subsections (a)(1)(D)(iii) and (c)(2)(C) of that section.

(5) 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—

(A) the establishment of partnerships with the Secretary of Education and the Secretary of Agriculture to develop national campaigns to inform the eligibility criteria for the assistance programs each Secretary administers that often serve the same children;

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

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

(D) 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;

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

(F) other such outreach initiatives as the Secretary determines would increase public awareness of the programs under this title and title XIX.

(b) ENHANCED ADMINISTRATIVE FUNDING FOR TRANSLATION OR INTERPRETATION SERVICES UNDER CHIP AND MEDICAID.—

(1) CHIP.—Section 2105(a)(1) (42 U.S.C. 1397e(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)(i), 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 or language was found necessary by the Secretary for the proper and efficient administration of the State plan and;

(2) MEDICAID.—

(A) IN GENERAL.—Section 1903(a)(2) (42 U.S.C. 1396a(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 and the attribution of 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.—

(1) IN GENERAL.—Section 2106(c)(11) of such Act (42 U.S.C. 1397hh(c)(11)) is amended by inserting ‘(through community health workers and others)’ after ‘Outreach’;

(2) IN FEDERAL EVALUATION.—Section 2106(c)(11)(B) of such Act is amended by inserting ‘(such as through community health workers and others)’ after ‘including practices’;
SEC. 1193. IMPROVED ACCESS TO, AND DELIVERY OF, HEALTH CARE FOR INDIGENOUS Populations.—

(a) AGREEMENTS FOR SERVICES.—In order to improve the accessibility of Indians residing on or near a reservation to obtain benefits under the Medicaid and State children’s health insurance programs established under Title XIX, the State 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, enrollment, and translation services when such services are appropriate.

(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed to affect arrangements entered into between States and the Indian Health Service, Indian Tribes, Tribal Organizations, or Urban Indian Organizations for such services, 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, and 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.

SEC. 203. STATE OPTION TO RELY ON FINDINGS MADE IN DETERMINING ELIGIBILITY.

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

(1) IN GENERAL.—The Secretary, acting through the Centers for Medicare & Medicaid Services (in this subsection referred to as the “CMS”), shall enter into agreements with States to establish 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 percentage of the Federal poverty level that exceeds the highest income threshold applicable under this title and for child health assistance under title XXI.

(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed to affect arrangements established under grants, contracts, or agreements entered into under section 1397ee(c)(2) is amended by adding at the end the following:

“(d) IN GENERAL.—With respect to a child whose eligibility for medical assistance under this title, the State shall rely on a finding made by an Express Lane agency. If the child appears eligible for such assistance based on an income finding by an Express Lane agency, the State shall provide notice that the child may qualify for lower premium payments if evaluated by the State using its regular policies and procedures for procedures for requesting such an evaluation.

(III) COMPLIANCE WITH SCREEN AND ENROLL REQUIREMENTS.—The requirement under subparagraph (A) shall be construed as affecting arrangements entered into 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 1127(a).”.

SEC. 303. STATE OPTION TO RELY ON FINDINGS MADE IN DETERMINING ELIGIBILITY.

(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.—Under this clause, the State shall determine eligibility for medical assistance under this title or for child health assistance under title XXI, including determining income eligibility for medical assistance under this title.

(b) RULES OF CONSTRUCTION.—Any action otherwise permitted under this title to the child by a minimum of 30 percentage points or, at State option, a higher percentage of the Federal poverty level that exceeds the highest income threshold applicable under this title and for child health assistance under title XXI.

(c) OPTIONS FOR SATISFYING THE SCREEN AND ENROLLMENT.—Under this clause, a State may apply the requirements of section 1902(a)(46)(B) or 2102(b)(3) (relating to screen and enroll) to children enrolled 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.

(d) IN GENERAL.—Under this clause, a State may apply the requirements of section 1902(a)(46)(B) or 2102(b)(3) (relating to screen and enroll) to children enrolled 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.

(e) IN GENERAL.—Under this clause, the State shall determine whether the child should be enrolled in medical assistance under this title or for medical assistance under this title and for child health assistance under title XXI or for medical assistance under this title and for child health assistance under title XXI.

(f) IN GENERAL.—Under this clause, the State shall determine whether the child should be enrolled in medical assistance under this title or for medical assistance under this title and for child health assistance under title XXI or for medical assistance under this title and for child health assistance under title XXI.

(g) IN GENERAL.—Under this clause, the State shall determine whether the child should be enrolled in medical assistance under this title or for medical assistance under this title and for child health assistance under title XXI or for medical assistance under this title and for child health assistance under title XXI.

(h) IN GENERAL.—Under this clause, the State shall determine whether the child should be enrolled in medical assistance under this title or for medical assistance under this title and for child health assistance under title XXI or for medical assistance under this title and for child health assistance under title XXI.
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 1902(a)(17) to any individual who is not entitled to medical assistance (as defined in section 1902(a)(17)).

(2) EXPRESS LANE AGENCY.—(A) DEFINITION.—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) for a State is that the State agrees to—

(ii) 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;

(iii) provide such additional training to the employees of the State Medicaid agency or the State CHIP agency (as applicable) to demonstrate to the satisfaction of the Secretary the specific corrective actions implemented by the State to improve upon such error rate; and

(iv) enters into, or is subject to, an interagency agreement limiting the disclosure of information disclosed for purposes of determining an error rate in any manner other than the reducibility, or penalize the State on the basis of such error rate in any manner other than the reduction of payments provided for under clause (B).

(C) 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 findings relied on by the State.

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

(1) 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

(2) authorizing a State Medicaid agency that otherwise applies to the 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 or CHIP plan.

(2) ADDITIONAL DEFINITIONS.—In this paragraph:

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

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

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

(D) ELECTRONIC TRANSMISSION OF INFORMATION.—Section 902 (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 title XIX or child health assistance under title XXI verify such information using an electronic data interchange to the Secretary, a State Medicaid plan or the State CHIP plan may rely on information and data elements as the Secretary determines to be appropriate for such purposes."
from an Express Lane agency (as defined in subsection (e)(13)(F)), or from another public entity, then the applicant’s signature under penalty of perjury shall not be required as to such data or any other data required by the Secretary under subparagraph (A) for an individual enrolled in the Medicaid or CHIP program, and such other programs as the Secretary may specify.

(i) 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) IN GENERAL.—Section 1902(g)(4)(B) is amended by adding at the end the following new subparagraph:

“(II) by adding at the end the following new subparagraph (C):”;

(2) Data regarding enrollment in insurance programs established under section 1902(e)(13)(F)), or from another public entity, then the applicant’s signature under penalty of perjury shall not be required as to such data or any other data required by the Secretary under subparagraph (A) for an individual enrolled in the Medicaid or CHIP program, and such other programs as the Secretary may specify.

(i) 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) IN GENERAL.—Section 1902(g)(4)(B) is amended by adding at the end the following new subparagraph:

“(II) by adding at the end the following new subparagraph (C):”;

(2) Data regarding enrollment in insurance programs established under section 1902(e)(13)(F)), or from another public entity, then the applicant’s signature under penalty of perjury shall not be required as to such data or any other data required by the Secretary under subparagraph (A) for an individual enrolled in the Medicaid or CHIP program, and such other programs as the Secretary may specify.

(i) 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) IN GENERAL.—Section 1902(g)(4)(B) is amended by adding at the end the following new subparagraph:

“(II) by adding at the end the following new subparagraph (C):”;

(2) Data regarding enrollment in insurance programs established under section 1902(e)(13)(F)), or from another public entity, then the applicant’s signature under penalty of perjury shall not be required as to such data or any other data required by the Secretary under subparagraph (A) for an individual enrolled in the Medicaid or CHIP program, and such other programs as the Secretary may specify.

(i) 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) IN GENERAL.—Section 1902(g)(4)(B) is amended by adding at the end the following new subparagraph:

“(II) by adding at the end the following new subparagraph (C):”;

(2) Data regarding enrollment in insurance programs established under section 1902(e)(13)(F)), or from another public entity, then the applicant’s signature under penalty of perjury shall not be required as to such data or any other data required by the Secretary under subparagraph (A) for an individual enrolled in the Medicaid or CHIP program, and such other programs as the Secretary may specify.

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

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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) IN GENERAL.—Section 1902(g)(4)(B) is amended by adding at the end the following new subparagraph:

“(II) by adding at the end the following new subparagraph (C):”;

(2) Data regarding enrollment in insurance programs established under section 1902(e)(13)(F)), or from another public entity, then the applicant’s signature under penalty of perjury shall not be required as to such data or any other data required by the Secretary under subparagraph (A) for an individual enrolled in the Medicaid or CHIP program, and such other programs as the Secretary may specify.

(i) 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) IN GENERAL.—Section 1902(g)(4)(B) is amended by adding at the end the following new subparagraph:

“(II) by adding at the end the following new subparagraph (C):”;

(2) Data regarding enrollment in insurance programs established under section 1902(e)(13)(F)), or from another public entity, then the applicant’s signature under penalty of perjury shall not be required as to such data or any other data required by the Secretary under subparagraph (A) for an individual enrolled in the Medicaid or CHIP program, and such other programs as the Secretary may specify.

(i) 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) IN GENERAL.—Section 1902(g)(4)(B) is amended by adding at the end the following new subparagraph:

“(II) by adding at the end the following new subparagraph (C):”;

(2) Data regarding enrollment in insurance programs established under section 1902(e)(13)(F)), or from another public entity, then the applicant’s signature under penalty of perjury shall not be required as to such data or any other data required by the Secretary under subparagraph (A) for an individual enrolled in the Medicaid or CHIP program, and such other programs as the Secretary may specify.

(i) 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) IN GENERAL.—Section 1902(g)(4)(B) is amended by adding at the end the following new subparagraph:

“(II) by adding at the end the following new subparagraph (C):”;

(2) Data regarding enrollment in insurance programs established under section 1902(e)(13)(F)), or from another public entity, then the applicant’s signature under penalty of perjury shall not be required as to such data or any other data required by the Secretary under subparagraph (A) for an individual enrolled in the Medicaid or CHIP program, and such other programs as the Secretary may specify.

(i) EFFECTIVE DATE.—The amendments made by this section are effective on the date of the enactment of this Act.
bears to the total submissions made for comparision 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 inconsistent 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 by realigning the left margins of clauses (i) and (ii), respectively, 2 ems to the left.
(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—
(1) 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
(2) the Secretary shall provide 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 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 such 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 (3)(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.

(3) CONFORMING AMENDMENTS.—Section 1903(a)(4) (42 U.S.C. 1396b(a)(4)) is amended—
(i) by striking “plus” at the end of subparagraph (B) and inserting “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 operation of 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 1902(a)(46)(B) (42 U.S.C. 1396b(a)(46)(B)) is amended—
(A) by redesignating clause (c) as clause (v); and
(B) by inserting after clause (iv), the following new clause:

“(v) Except as provided in subclause (I), a document furnished by a 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).

(2) With respect to those federally recognized Indian tribes located within States having an international border whose membership includes Indians who are citizens of the United States, the Secretary shall, after consulting with such tribes, issue regulations authorizing the presentation of such other forms of documentary evidence, if appropriate) that the Secretary determines to be satisfactory documentary evidence of citizenship or nationality for purposes of satisfying the requirements of this section.

(2) NONAPPLICATION OF ADMINISTRATIVE EXPENDITURES CAP.—Section 1903(a)(4)(B) (42 U.S.C. 1396b(a)(4)(B)) is amended—
(i) by redesignating subparagraph (D) as subparagraph (E); and
(ii) by inserting after subparagraph (D) the following new subparagraph:

“(E) pursuant to the application of section 1902(e)(4) (and, in the case of 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 payments described in clause (I) of section 1902(a)(46)(B) shall take effect as if included in the enactment of section 1902(a)(46) as amended by this section.

(4) IN GENERAL.—Section 1903(c)(2) (42 U.S.C. 1396b(c)(2)) is amended—
(i) by adding to the end the following new sentence: “Notwithstanding the preceding sentence, in the case of an individual 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.”.

(c) APPLICATION OF DOCUMENTATION SYSTEM TO UTES.—
(1) IN GENERAL.—Section 1903(x)(2) (42 U.S.C. 1396b(x)) is amended—
(A) by redesignating clause (v) as clause (vi);
(B) by inserting after clause (iv), the following new clause:

“(v) Except as provided in subclause (I), a document furnished by a 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).

(2) NONGOVERNMENTAL AGENCIES.—The State shall provide each nongovernmental agency conducting administrative functions of the State plan with sufficient information and continuing assistance necessary to fulfill the requirements of this section.

(3) NONAPPLICATION OF ADMINISTRATIVE EXPENDITURES CAP.—Section 1903(a)(4)(B) (42 U.S.C. 1396b(a)(4)(B)) is amended—
(i) by redesignating subparagraph (D) as subparagraph (E); and
(ii) by adding at the end the following new subparagraph:

“(F) in the case of an individual 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.”.

(d) EFFECTIVE DATE.—
(1) IN GENERAL.—Except as provided in subparagraph (B), the amendments made by this section shall take effect on January 1, 2010.

(B) TECHNICAL AMENDMENTS.—The amendments made by—
(i) paragraphs (1), (2), and (3) of subsection (b) shall take effect as if included in the enactment of section 6036 of the Deficit Reduction Act of 2005 (Public Law 109-36); 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 109-342; 120 Stat. 2996).

(2) RESTORATION OF ELIGIBILITY.—In the case of an individual who had been determined to be ineligible for medical assistance under a State Medicaid plan, including any waiver of such plan, the Secretary, as a result of the application of the requirements of this section, shall—
(i) treat the individual as eligible for medical assistance under the State Medicaid plan, including any waiver of such plan, as if the individual had not been determined to be ineligible for medical assistance under such plan;
(ii) provide the individual with MAHP and Health Care Coverage under section 1397ee(c), as amended by section 114(a), is amended by adding at the end the following new sentence: “Notwithstanding the preceding sentence, in the case of an individual 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.”.

(e) TECHNICAL AMENDMENTS.—Section 1903(c)(2) (42 U.S.C. 1396b(x)) is amended—
(A) in subparagraph (B)—
(i) by redesigning the left margin of the matter preceding clause (I) 2 ems to the left;

(B) in subparagraph (C)—
(i) by redesigning the left margin of the matter preceding clause (I) 2 ems to the left;

(C) 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.

(C) 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.

(C) 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.

(C) 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.

(C) 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.
(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 (I) of section 1902(w) of the Social Security Act (42 U.S.C. 1396w(b)(2)(B)(v)) as added by subsection (b)(1)(B), an individual who is a member of a federally-recognized Indian tribe described in such subclause (I) of such 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 (2) 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) DECREASE 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 insurance 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, including the descriptions of such barriers identified in such subparagraph.

(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 retrofitting eligibility for children and pregnant women for medical assistance under title XIX or 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 continuous coverage of low-income children under the Medicaid program and the Children's Health Insurance Program (CHIP) provided by a State, 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, for whatever reason, 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 foster further improvements to coordinate the enrollment, retention, and coverage under CHIP and Medicaid of children described in subsection (a).

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

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

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

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

"(4) A State may elect (in a plan amendment under this title) to provide medical assistance to any child 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 the 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 benefit under section 125(b)(1)(B) of the Internal Revenue Code of 1986; or

(3) MEDICAID AND CHIP.

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

"(E) Paragraph (4) of section 1903(v) (relating to the availability of coverage by a result of an election by the State under subparagraph (A) of clause (i)), or (f) subparagraphs (C) and (D) of section 2110(b)(1)(C), the State shall provide for each target 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 the 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 benefit under section 125(b)(1)(B) of the Internal Revenue Code of 1986; or

(1) 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 the 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 benefit under section 125(b)(1)(B) 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.—

(1) 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 of the employee under qualified employer-sponsored coverage and the employee contribution required for enrollment of the child in the qualified employer-sponsored coverage, less any applicable premium cost-sharing adjustment, applied—

(i) to 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);

(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 providing any employee with a premium assistance subsidy.

(D) APPLICATION OF SECONDARY PAYOR RULES.—The State shall be a secondary payor for any item or service 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.—

(1) IN GENERAL.—Notwithstanding section 2106(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 2106(c).
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) 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.

"(G) APPLICATION TO PARENTS.—If a State provides child health assistance or health benefits coverage to parents of a targeted low-income child under section 2103(b) or benchmark-equivalent coverage that meets the requirements of section 2103(b)(2), the State may provide premium assistance subsidies for enrollment of targeted low-income children in such group health plans or 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 cost-sharing protection provided under the State child health plan under subparagraph (E).

"(H) 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 administrative expenditures, for providing coverage under such plan for all such children or families.

"(J) OPT-OUT PERMITTED FOR ANY MONTH.—A 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 a manner that ensures continuity of coverage for the child in qualified employer-sponsored coverage, except that 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, 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 the cost-sharing protection provided under the State child health plan under subparagraph (E).

"(K) 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(b)(2) for employees described in clause (i).

"(L) CLARIFICATION OF PAYMENT FOR ADMINISTRATIVE EXPENSES.—Nothing in this subparagraph shall be construed as permitting payment 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.

"(M) NO EFFECT ON PREMIUM ASSISTANCE WAIVER PROGRAMS.—Nothing in this paragraph shall be construed as permitting an individual to obtain premium assistance under section 1906 or 1906A, a waiver described in paragraph (2)(B) or (3), or a waiver approved under section 1115, or other options prior to the date of enactment of the Children’s Health Insurance Program Reauthorization Act of 2009.

"(N) NOTICE OF AVAILABILITY.—If a State elects to provide, in whole or in part, premium assistance 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; and

"(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.

"(O) APPLICATION TO QUALIFIED EMPLOYER-SPONSORED BENCHMARK COVERAGE.—If a group health plan or health insurance coverage offered by the individual’s family 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(b)(2), the State may provide premium assistance subsidies for enrollment of targeted low-income children in such group health plans or 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 cost-sharing protection provided under the State child health plan under subparagraph (E).

"(P) COORDINATION WITH MEDICARE.—In the case of an individual who receives child health assistance through a State plan under title XIX and who voluntarily elects to receive a premium assistance subsidy under this section, the provisions of section 1903(a) shall apply and shall supersede any other provisions of this paragraph that are inconsistent with such section.

"(Q) DETERMINATION OF COST-EFFECTIVENESS FOR PREMIUM ASSISTANCE OR PURCHASE OF FAMILY COVERAGE.—(A) IN GENERAL.—Subject to paragraph (2), in this paragraph, the term ‘qualified employer-sponsored coverage’ means employer-sponsored coverage, group health plan or health insurance coverage offered through an employer—

"(A) that qualifies as creditable coverage as a qualified employer-sponsored coverage under paragraph (3)(A)(ii) of section 1916A of the Public Health Service Act; or

"(B) for which the employer contributes to the premium for such coverage at least 40 percent; and

"(C) that is offered to all individuals in a manner that would be considered a nondiscriminatory eligibility classification under paragraph (3)(A)(ii) of section 1916A of the Internal Revenue Code of 1986 (but determined without regard to clause (i) of subparagraph (B) of paragraph (2)).

"(Q) APPLICATION TO QUALIFIED EMPLOYER-SPONSORED BENCHMARK COVERAGE.—If a group health plan or health insurance coverage offered by the individual’s family 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(b)(2), the State may provide premium assistance subsidies for enrollment of targeted low-income children in such group health plans or 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 cost-sharing protection provided under the State child health plan under subparagraph (E).

"(R) 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).

"(S) NOTICE OF AVAILABILITY.—If a 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, the State shall provide for payment of

"(T) PREMIUM ASSISTANCE SUBSIDY.—In this section, the term ‘premium assistance subsidy’ means the amount of the employer 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.

"(U) VOLUNTARY PARTICIPATION.—(I) 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.

"(V) BENEFICIARIES.—No subsidy shall be provided to an individual under age 19 under this section unless the individual or the individual’s parent, guardian, or legal representative elects such a subsidy. A State may not require such an election as a condition of receipt of medical assistance. Such election is not required for an individual under age 19 (or the individual’s parent) being or remaining eligible for medical assistance under this title, for enrollment in qualified employer-sponsored coverage under this section.

"(W) 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 (excluding the amount otherwise reimbursable under the State plan under this title and otherwise payable by the individual’s or parent’s eligibility for medical assistance under the State plan, except insofar as section
(a) AMENDMENTS TO EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—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:

"(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 XIX of such Act, shall jointly develop national and State-specific model notices for purposes of subparagraph (A). Such model notices shall include information regarding how an employer may 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 employer may provide employers with such model notices so as to enable employers to timely comply with the requirements of subparagraph (A)."
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 shall disclose to the State, upon request, information about the benefits available under the group health plan in sufficient specificity, as determined by the Secretary of Health and Human Services in consultation with the Secretary of Labor, that is necessary for the purpose of the group health plan. The plan shall disclose to the State, upon request, information about the benefits available under the group health plan in sufficient specificity, as determined by the Secretary of Health and Human Services in consultation with the Secretary of Labor, that is necessary for the purpose of the group health plan. The plan shall disclose to the State, upon request, information about the benefits available under the group health plan in sufficient specificity, as determined by the Secretary of Health and Human Services in consultation with the Secretary of Labor, that is necessary for the purpose of the group health plan.

(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 or partnerships, that employ or have employed representatives and certified human resource and payroll professionals;

(VI) plan administrators and plan sponsors of group health plans referred to 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 administrative support to the Working Group.

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

(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)(ii) of the Employee Retirement Income Security Act of 1974, and the Secretary of Labor shall provide such notices to employers, not later than 1 year after the date of enactment of this Act, and each employer shall provide the initial model 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 employers that maintain group health plans and employee-resident for premium assistance under a Medicaid plan under title XIX of such Act and coverage under a State child health plan, shall provide the employer's health insurance issuer offering group health insurance coverage to employees who are eligible, but not enrolled, for coverage under terms of the plan or (if an employer if the dependent is eligible, but not enrolled, for coverage under terms of the plan if either of the following conditions is met:

(1) TERMINATION OF MEDICAID OR CHIP COVERAGE.—The employer 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 such an employer 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 under such plan after the date of termination of such coverage.

(2) 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 any such coverage under a 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 less than 90 days after the date coverage under such plan is determined to be eligible for such assistance.

(3) COORDINATION WITH MEDICAID AND CHIP.

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

(A) IN GENERAL.—Each employer that maintains a group health plan in a State that provides medical assistance under a 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 health coverage under a group health plan, shall provide to each employee of the employee's 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)(ii) of the Employee Retirement Income Security Act of 1974.

(B) OPTION TO PROVIDE CONCURRENT WITH PROVISION OF PLAN MATERIALS TO EMPLOYEE.—

(1) To the extent to which materials notified the employee of health plan eligibility, concurrent with materials provided to the employee in connection with an open season or other enrollment period 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.
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 determined under regulations of the Secretary of Health and Human Services in consultation with the Secretary that require use of the model cardiovascular disease risk assessment 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 section 1221(b)(1), (2), or (3) of title 20 of United States Code) concerning the cost-effectiveness of the State providing medical or child health assistance entities that enter into contracts with such group health plan and in order for the State to provide supplemental benefits required under paragraph (a)(3)(C) in consultation with other auditors.

TITLE IV—STRENGTHENING QUALITY OF CARE AND HEALTH OUTCOMES

SEC. 401. CHILD HEALTH QUALITY IMPROVEMENT ACT 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 1119 the following new section:

“SEC. 1198. 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, 2011, the Secretary shall identify and publish for government, purchasers, and child health care providers a set of national 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.

“(B) 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 further their transparency and utilization of core 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.

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

“(F) developing, validating, and testing a portfolio of 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 established 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 standardized manner that permits comparison of quality and data at a State, plan, and provider level;

“(D) periodically updated; and

“(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; and

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

“(2) 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) provide technical assistance to States to assist them in the furthering of core child health quality measures in administering the State plans under titles XIX and XXI.

“(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).

“(F) engaging public and private health care providers in the development and refinement of measures used by public and private health care providers.

“(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) develop a standardized format for reporting information and procedures and approaches that encourage States to use the initial core measure—

“(C) lasting impact on the quality of pediatric health care under titles XIX and XXI.

“(2) ADOPTION OF BEST PRACTICES IN IMPLEMENTING QUALITY MEASURES PROGRAM.—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.

“(a) DEVELOPMENT OF AN INITIAL CORE SET OF MEASURES PROGRAM.—Not later than January 1, 2011, and every 3 years thereafter, the Secretary shall—

“(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 established 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 standardized manner that permits comparison of quality and data at a State, plan, and provider level;

“(D) periodically updated; and

“(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; 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) provide technical assistance to States to assist them in the furthering of core child health quality measures in administering the State plans under titles XIX and XXI.

“(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).

“(F) engaging public and private health care providers in the development and refinement of measures used by public and private health care providers.

“(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.
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 (f). A demonstration project conducted under grants awarded under this subsection shall be conducted every 3 years.

(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 for grants to eligible entities to carry out demonstration projects.

(5) CHILDOOD OBESITY DEMONSTRATION PROJECTS.—
(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 and disseminate an evidence-based model for reducing childhood obesity.

(2) ELIGIBILITY ENTITIES.—For purposes of this section, 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. An eligible entity shall be used to carry out this subsection.

(2) USE OF FUNDS.—An eligible entity awarded a grant under this subsection shall use the funds awarded under this subsection to carry out the following activities:

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

(i) forming partnerships with entities, including schools and other facilities providing care, that will carry out programs or activities that are designed to reduce childhood obesity;

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

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

(iv) providing education and training to educations regarding how to promote a healthy lifestyle and a healthy school environment for children;

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

(vi) planning and implementing healthy lifestyle classes or programs for parents or guards; and

(vii) State or local departments of health.

(3) 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 carried out in any 1 fiscal year; and

(B) demonstration projects funded under grants awarded under this subsection shall be conducted every 3 years.

(4) REPORT.—The Secretary shall annually report to the appropriate committees of the Congress on—

(A) the number of eligible entities that received grants under this subsection; and

(B) the number of eligible entities that received grants under this subsection that achieved significant improvements in the quality of children’s health care.

(5) PROVISIONS.—The Secretary shall ensure that—

(A) each demonstration project conducted under this subsection—

(i) forms partnerships with entities, including schools and other facilities providing care, to—

(I) provide education and training to educators regarding how to promote a healthy lifestyle and a healthy school environment for children;

(II) develop and implement a healthy lifestyle curriculum or program with an emphasis on healthy eating behaviors and physical activity;

(III) plan and implement healthy lifestyle classes or programs for parents or caregivers; and

(IV) State or local departments of health.

(ii) evidence-based provider-based models which improve the delivery of children’s health care services under titles XIX or XXI among States with large rural areas, and among States with large rural areas.

(B) the number of eligible entities that received grants under this subsection.

(6) DEFINITION OF PEDIATRIC QUALITY MEASURE.—In this subsection, the term ‘pediatric quality measure’ means a measure 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, that is applicable to the health care services for children; or

(7) ANNUAL STATE REPORTS REGARDING 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—

(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) 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. 1396d-7 and 2103 of such Act (42 U.S.C. 1396d-7, 1397c).

(2) PUBLICATION.—Not later than September 30, 2010, and annually thereafter, the Secretary shall publish a report or 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 improve the quality of care and make publicly available the information reported by States under paragraph (1). A demonstration project conducted under this subsection shall be carried out by—

(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 carried out in any 1 fiscal year, and

(B) demonstration projects funded under grants awarded under this subsection shall be conducted every 3 years 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 for grants to eligible entities to carry out demonstration projects.

(5) CHILDOOD OBESITY DEMONSTRATION PROJECTS.—
(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 and disseminate an evidence-based model for reducing childhood obesity.

(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 consortium or partnerships described in any of subparagraphs (A) through (G).

(2) USE OF FUNDS.—An eligible entity awarded a grant under this subsection shall use the funds awarded under this subsection to carry out the following activities:

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

(i) forming partnerships with entities, including schools and other facilities providing care, that will carry out programs or 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;

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

(iv) providing education and training to educations regarding how to promote a healthy lifestyle and a healthy school environment for children;

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

(vi) 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

(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

(v) 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—

(A) 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 Secretary 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 grant;

(D) that develop comprehensive plans that include a strategy for extending program activities developed under grants in the years following the fiscal year 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 multisector, 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

(G) that submit plans that exhibit multisector, 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 this Act, the Secretary shall submit to the Congress a program design that 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 this Act, the Secretary shall submit to the Congress a program design that the Secretary determines to be appropriate, on the design, conduct, and evaluation of the demonstration.

“(C) FEDERALLY-QUALIFIED HEALTH CENTER.—The term ‘Federally-qualified health center’ has the meaning given that term in section 1905(h)(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. 1391).

“(C) SELF-ASSESSMENT.—The term ‘self-assessment’ means—

“(i) includes questions regarding—

“(I) behavioral risk factors;

“(II) needed preventive and screening services; and

“(III) target individual’s preferences for receiving follow-up information;

“(ii) assessing 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) provide any target individual with information, feedback, health coaching, and recommendations regarding—

“(I) the results of a self-assessment given to the individual;

“(II) behavioral modification based on the self-assessment; and

“(III) any need for clinical preventive and screening services or other health care services including medical nutrition therapy.

“(ii) 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) behavioral modification based on the self-assessment; and

“(III) any need for clinical preventive and screening services or other health care services including medical nutrition therapy.

“(iii) to provide the information described in clause (I) to the health care provider, if designated by the target individual to receive such information.

“(B) AUTHORIZATION OF AMENDMENTS.—There shall be appropriated to carry out this subsection, $25,000,000 for the period of fiscal years 2009 through 2013.

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

“(A) IN GENERAL.—Not later than January 1, 2010, the Secretary, in consultation 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) INCREASED MATCHING RATE FOR COLLECTION AND REPORTING ON CHILD HEALTH MEASURES.—Section 9103(a)(3)(A) (42 U.S.C. 1396a(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)(6)) of so much of the sums expended during such fiscal year (as forming part of the payments required of the State 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 paragraph (1) 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”;

“(2) by adding at the end the following new subsection:

“(c) INFORMATION REQUIRED FOR INCLUSION IN ANNUAL STATE REPORTS.—The State shall include the following information in the annual report required under subsection (a):

“(1) Eligibility criteria, enrollment, and retention in the eligible group 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.

“(2) Data regarding denials of eligibility and redeterminations of eligibility.

“(3) Data regarding access to primary and specialty services, access to networks of care, care coordination, and care coordination State child health plan, adopting quality care and consumer satisfaction measures included in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys.

“(4) 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 effectiveness 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 plans;

“(5) If the State child health plan, including measures such as 12-month continuous eligibility, self-declaration of income for applications or renewals, or presumptive eligibility.

“(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 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 subsection (a) of title XIX of the Social Security Act, as added by subsection (a)(2).
(2) TRANSITION PERIOD FOR STATES.—Each State shall submit a report under subsection (a) of title XIX 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 monitoring managed care entities, and managed care organizations under title XIX of such Act.

SEC. 403. APPLICATION OF CERTAIN MANAGED CARE QUALITY SAFEGUARDS TO CHIP.—

(a) 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) through dental care that is transition to the report

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

(ii) in paragraph (1), by inserting “at least” after “that is”;

(ii) in paragraph (5) as paragraphs (7); and

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

(5) DENTAL BENEFITS.—

(A) IN GENERAL.—The child health assistance provided under Medicaid and CHIP 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) LIMITATION.—A State may limit the amount that is transition to the report

(3) E FFECTIVE DATE.—The amendments made by this section apply to contract years beginning on or after July 1, 2009.

TITLE V—IMPROVING ACCESS TO BENEFITS

SEC. 501. DENTAL BENEFITS.

(a) COVERED BENEFITS.—

(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)” and inserting “paragraphs (5) and (7) of subsection (c)”;

(ii) in paragraph (1), by inserting “at least” after “that is”;

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

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

(5) DENTAL BENEFITS.—

(A) IN GENERAL.—The child health assistance provided under Medicaid and CHIP 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) LIMITATION.—A State may limit the amount that is transition to the report

(B) LIMITATION.—A State may limit the amount that is transition to the report

(i) in paragraph (5) as paragraphs (7).
and (d)(2) of section 201, is amended by inserting after subparagraph (B) the following new subparagraph (and redesignating the succeeding subparagraphs accordingly):

“(C) Section 2106(c)(1) (relating to limiting FQHC contracting for provision of dental services),”;

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

(e) REPORTING INFORMATION ON DENTAL CARE.—

(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 2106(e)” after “receiving dental services,”;

(2) CHIP.—Section 2108 (42 U.S.C. 1397a) 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 1906(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 group, race and ethnicity, gender, and geographic region;

(B) for children within each such age group, information about the type of dental services that were provided to children who received any dental care during the calendar year;

(C) the age of the group 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 ENROLLMENT IN MANAGED CARE PLANS.—The information under paragraph (1) shall include information on such children's access to oral health care, including preventive and restorative dental care under the State plan.

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

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

(1) 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, 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 under Medicaid and the State child health plan (or waiver) under CHIP, and shall ensure that such list is updated at least quarterly;

(2) work with States to include, not later than 6 months after the date of the enactment of this Act, a description of the dental services provided under each State plan (or waiver) under Medicaid and each State child health plan (or waiver) under CHIP on such Insure Kids Now website, and shall ensure that such list is updated at least annually.

(g) PROVISION OF STATUS OF EFFORTS TO IMPROVE DENTAL CARE IN REPORTS ON THE QUALITY OF CHILDREN'S HEALTH CARE UNDER MEDICAID AND CHIP.—

(1) IN GENERAL.—Section 1139A(a), as added by section 501(a)(1), is amended by striking 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 “health services,”;

(h) GAO STUDY AND REPORT.—

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

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

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

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

(ii) information on such children’s access to networks of care and 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 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 policies 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 1905(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.

“(B) DEEMED TO THE EXTENT TO THE EXTENT THAT A STATE CHILD HEALTH PLAN INCLUDES COVERAGE WITH RESPECT TO AN INDIVIDUAL DESCRIBED IN SECTION 1906(a)(4)(B) AND COVERED UNDER THE STATE PLAN UNDER SECTION 1905(a)(4)(B) (RELATING TO MEDICAID OR CHIP), IT SHALL BE DEEMED TO THE EXTENT TO THE EXTENT THAT A STATE CHILD HEALTH PLAN INCLUDES COVERAGE WITH RESPECT TO AN INDIVIDUAL DESCRIBED IN SECTION 1905(a)(4)(B) (RELATING TO MEDICAID OR CHIP), IT SHALL BE DEEMED TO SATISFY THE REQUIREMENTS OF SUBPARAGRAPH (A).

“(6) C ONFORMING AMENDMENTS.—Section 2103 (42 U.S.C. 1397cc) is amended by adding at the end the following new paragraph:

“(6) 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 this subsection shall take effect on or after October 1, 2009.

(h) 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), for expenditures related to transitioning to compliance with the requirements 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 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 shall report to Congress not later than October 1, 2011, to 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 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 period following the last month for which the premium has been paid.”;

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

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

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

“(8) AVAILABILITY OF COVERAGE FOR ITEMS AND SERVICES FURNISHED THROUGH SCHOOL-BASED HEALTH CENTERS.—Nothing in this title shall be construed as limiting a State’s ability to provide child health assistance for covered items and services that are furnished through school-based health centers (as defined in section 2101(c)(9)).”;

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

“(9) SCHOOL-BASED HEALTH CENTER.—

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

(i) is located in or near a school facility of a school district or board of an Indian tribe or tribal organization;
“(ii) is organized through school, community, and health provider relationships;
“(iii) is administered by a sponsoring facility;
“(iv) provides through health professionals primary health care to children in accordance with State and local law, including laws relating to licensure and certification; and
“(v) satisfies such other requirements as a State may establish for the operation of such a clinic.

“(B) SPONSORING FACILITY.—For purposes of subparagraphs (A)(ii), (A)(iii), and (A)(iv), the term ‘sponsoring facility’ includes any of the following:
“(i) A hospital.
“(ii) A public health department.
“(iii) A nonprofit health care agency.
“(iv) A school or school system.
“(v) A program administered by the Indian Health Service or the Bureau of Indian Affairs operated by an Indian tribe or a tribal organization.

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

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

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

“(B) DUTIES.—

“(1) REVIEW OF ACCESS POLICIES AND ANNUAL REPORT—MACPAC shall—

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

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

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

“(D) by not later than June 1 of each year (beginning with 2010), submit a report to Congress containing an examination of issues affecting children’s access to covered items and services, except the implications of changes in health care delivery in the United States and in the market for health care services on such programs.

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

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

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

“(ii) payment methodologies; and

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

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

“(C) OTHER ACCESS POLICIES.—The effect of other Federal and non-Federal policies on access to covered items and services, including policies relating to transportation and language barriers.

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

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

“(5) AGENDA AND ADDITIONAL REVIEWS.—MACPAC shall consult periodically with the maintaining the recommendation of the appropriate committees of Congress regarding MACPAC’s agenda and progress towards achieving the agenda. MACPAC may conduct ad hoc reviews of such report, as MACPAC deems appropriate.

“(6) AVAILABILITY OF REPORTS.—MACPAC shall transmit to the Secretary a copy of each report submitted under paragraph (1), each report submitted under paragraph (2), and each report submitted under paragraph (3). MACPAC shall include, by member, the results of that vote in the report containing the recommendation.

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

“(8) VOTING AND REPORTING REQUIREMENTS.—With respect to each recommendation contained in a report submitted under paragraph (1), each report submitted under paragraph (2), and each report submitted under paragraph (3), MACPAC shall include, by member, the results of that vote in the report containing the recommendation.

“(9) MEMBERSHIP—

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

“(2) QUALIFICATIONS.—(A) IN GENERAL.—The membership of MACPAC shall include individuals who have had direct experience as enrollers or parents of enrollees in Medicaid or CHIP and individuals with national recognition for their expertise in Federal safety net health programs, health finance and economics, actuarial science, health facility management, health plans and integrated delivery systems, reimbursement of health facilities, health information technology, pedi- atric physicians, dentists, and other providers of non-Federal health services, the health care of children, and the conduct of the work of MACPAC (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5)).

“(B) DIRECTOR AND STAFF; EXPERTS AND CON- SULTANTS.—Subject to such review as the Comptroller General of the United States deems necessary to assure the efficient administration of MACPAC, MACPAC may—

“(i) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General of the United States) to assist in the performance of its duties from appropriate Federal departments and agencies;

“(ii) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of MACPAC (without regard to such section of the Ethics in Government Act of 1978 (Public Law 95–521)).

“(3) TERMS.—

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

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

“(C) COMPENSATION.—While serving on the business of MACPAC (including travel time), a member of MACPAC shall be entitled to compensation at the per diem equivalent of the rate provided for an individual engaged in an appointment under section 5375 of title 5, United States Code, and while so serving away from home and the member’s regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of MACPAC. Physicians serving as personnel of MACPAC may be provided a physician comparability allowance by MACPAC in the same manner as Government physicians may be provided such an allowance by an agency under section 5948 of title 5, United States Code, and for such purpose subsection (i) of such section shall be interpreted in the same manner as it applies to the Tennessee Valley Authority. For purposes of payment (other than pay of members of MACPAC) and employment benefits, rights, and privileges, all personnel of MACPAC shall be treated as if they were employees of the United States Senate.

“(D) CHAIRMAN; VICE CHAIRMAN.—The Com- pty member of MACPAC, at the time of appointment of the member as Chairman and a member as Vice Chairman for that term of appointment, except that the Comptroller General of the Chairmanship or Vice Chairmanship, the Comptroller General of the United States may designate another member of the Senate for purposes of applying title I of United States Code, or the Ethics in Government Act of 1978 (Public Law 95–521).

“(E) MEETINGS.—MACPAC shall meet at the call of the Chairman.

“(F) DIRECTOR AND STAFF; EXPERTS AND CON- SULTANTS.—Subject to such review as the Com- pty member of MACPAC, at the time of appointment of the member as Chairman and a member as Vice Chairman for that term of appointment, except that the Comptroller General of the Chairmanship or Vice Chairmanship, the Comptroller General of the United States may designate another member of the Senate for purposes of applying title I of United States Code, or the Ethics in Government Act of 1978 (Public Law 95–521).
SECTION 601. PAYMENT ERROR RATE MEASUREMENT ("PERM").

(a) EXPENDITURES RELATED TO COMPLIANCE WITH THE PERM REQUIREMENTS.—Section 2106(c) (42 U.S.C. 1397ee(c)), as amended by section 301(a), is amended by adding at the end the following:

"(i) PAYMENT ERROR RATE MEASUREMENT (PERM) REQUIREMENTS.—The Secretary shall establish 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 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") for any final rule until after the date that is 6 months after the date on which a new final rule (as in effect on the date of enactment of this Act and implementing such requirements in accordance with the requirements of subsection (c)) is in effect for all States.

(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) clearly define criteria for errors for both States and providers; and

(2) include—

(A) review contractors; or

(B) the requirements described in section 1903(b)(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 implementing such process.

SEC. 602. IMPROVING DATA COLLECTION.

(a) INCREASED APPROPRIATION.—Section 1909(b)(2) (42 U.S.C. 1397t(b)(2)) is amended by striking "$10,000,000 for fiscal year 2009" and inserting "$20,000,000 for fiscal year 2009".

(b) USE OF ADDITIONAL FUNDS.—Section 1909(b) (42 U.S.C. 1397t(b)), as amended by section 301(a), is amended by adding at the end the following:

"(1) Redesignate paragraph (2) as paragraph (4); and

(2) Insert 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 State Estimates of Births with respect to the purposes described in subparagraph (B)."

SEC. 603. PROGRAM INTEGRITY AND OTHER MISCELLANEOUS PROVISIONS.

Subtitle A—Program Integrity and Data Collection.

SECTION 609. PAYMENT ERROR RATE MEASUREMENT ("PERM").

(a) PAYMENT ERROR RATE MEASUREMENT (PERM) REQUIREMENTS.—The Secretary shall establish 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) in no case to be less than 90 percent."

(b) 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:

"(i) PAYMENT ERROR RATE MEASUREMENT (PERM) REQUIREMENTS.—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.

(c) STATE OPTION TO APPLY PERM DATA.—A State may elect for purposes of determining the erroneous excess payments for medical assistance and the error rate ratio applicable to the State for a fiscal year beginning after the date of enactment of this Act, to apply 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)."

(d) STATE OPTION TO APPLY MEQC DATA.—For purposes of satisfying the requirements of subparagraph (a), the Secretary shall develop and implement a data collection strategy for the State utilizing the MEQC requirements as determined by the Secretary.

SEC. 604. PROGRAM INTEGRITY AND OTHER MISCELLANEOUS PROVISIONS.

Subtitle B—Other Program Integrity Provisions.

SEC. 605. PAYMENT ERROR RATE MEASUREMENT ("PERM").

(a) PAYMENT ERROR RATE MEASUREMENT (PERM) REQUIREMENTS.—The Secretary shall establish 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) in no case to be less than 90 percent."

(b) 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:

"(i) PAYMENT ERROR RATE MEASUREMENT (PERM) REQUIREMENTS.—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.

(c) STATE OPTION TO APPLY PERM DATA.—A State may elect for purposes of determining the erroneous excess payments for medical assistance and the error rate ratio applicable to the State for a fiscal year beginning after the date of enactment of this Act, to apply 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)."

(d) STATE OPTION TO APPLY MEQC DATA.—For purposes of satisfying the requirements of subparagraph (a), the Secretary shall develop and implement a data collection strategy for the State utilizing the MEQC requirements as determined by the Secretary.
Section 605. NO FEDERAL FUNDING FOR ILLEGAL ALIENS; DISABILITY FOR UNAUTHORIZED EXPENDITURES.

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

Subtitle B—Miscellaneous Health Provisions

Section 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)—

(i) in the matter before clause (1), by striking “Notwithstanding any other provision of this title” and inserting “Notwithstanding standing section 1902(a)(1) (relating to stateliness), section 1902(a)(1)(D) (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 clause (i)” and inserting “provides” and inserting “coverage that’’;

(2) by striking “(ii)” and inserting the following:

(iii) 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); and

(b) PUBLICATION OF PROVISIONS AFFECTED.—

(1) In general.—The Secretary of Health and Human Services shall, not later than 30 days after the date of approval of this Act, publish a list of the provisions of this Act, as amended by section 6044(a) of the Deficit Reduction Act of 2005, that apply in order to enable the State to carry out the plan and reason for each such determination. Whenever feasible, the methodology for making such determinations is made, and shall publish such list in the Federal Register and not later than 30 days after such determination.

(2) 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.

Section 612. REFERENCES TO TITLE XXI.

Section 704 of the Medicare, Medicaid, and SCHIP Balanced Budget Act of 1999, as enacted into law by division B of Public Law 106–113 (113 Stat. 1501–402) is repealed.

Section 613. PROHIBITING INITIATION OF NEW MEDICAID 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–a).
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” mean the Small Business Administration and the Administrator thereof, respectively;

(2) the term “discretionary loan program” means a development company participating in the program under title V of the Small Business Investment Act of 1958 (15 U.S.C. 635 et seq.);

(3) the term “discretionary revolving loan fund” means the program established under title IX of the Social Security Act (42 U.S.C. 1396 et seq.);

(4) the term “Medicare-relevant executive” means the Service Corps of Retired Executives authorized by section 80(b)(1) of the Small Business Act (15 U.S.C. 637(b)(1));

(5) the term “men’s business center” 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 development center described in section 21 of the Small Business Act (15 U.S.C. 648); and

(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.);

(b) ESTABLISHMENT OF TASK FORCE.—

(1) ESTABLISHMENT.—The Administrator, the Secretary of Health and Human Services, and the State Children’s Health Insurance Program established under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) shall establish a task force to conduct a nationwide campaign of education and outreach for small business concerns regarding the availability of coverage for children through the following insurance options:—

(i) the Medicaid program, and the State Children’s Health Insurance Program,

(ii) the Children’s Health Insurance Program established under title XVII of the Social Security Act (42 U.S.C. 1396aa et seq.),

(iii) the Small Business Health Care Reimbursement Program, and

(iv) the Health Insurance Premium Assistance 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 section shall include—

(A) efforts to educate the owners of small business concerns about the availability 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 insurance 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 the Federal-State Plan system described in section 25B of the Internal Revenue Code of 1986;

(D) efforts to educate the owners and employees of small business concerns regarding the availability of the hotline operated as part of the Medicare Information System 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 Administrator, 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 association or small business group;

(C) designate outreach programs at regional offices of the Department of Health and Human Services to work with district offices of the Administrator.

(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 Administrator.

(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 Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate 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 Americans.

(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 decrease their employer contributions, lower benefits, and raise co-pays 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 options for employees of small businesses and individuals by—

(A) facilitating pooling mechanisms, including pooling across State lines, and

(B) providing assistance to small businesses and individuals, including financial assistance and tax incentives, for the purchase of private insurance coverage.

TITLE VII—REVENUE PROVISIONS

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

(a) CIGARS.—Section 5701(a) of the Internal Revenue Code of 1986 is amended—

(1) by striking “$1.828 cents per thousand (1.594 cents per thousand on cigars removed during 2000 or 2001)” in paragraph (1) and inserting “$5.33 per thousand (4.52 cents per thousand on cigars removed during 2000 or 2001)”;

(2) by striking “20.719 percent (18.063 percent” in paragraph (1) and inserting “52.75 percent”;

(3) by striking “$8.75 per thousand (42.50 cents per thousand on cigars removed during 2000 or 2001)” in paragraph (2) and inserting “$40.26 cents per thousand”;

(4) by striking “20.719 percent (18.063 percent” in paragraph (2) and inserting “52.75 percent”;

(b) CIGARETTES.—Section 5701(b) of such Code is amended—

(1) by striking “$19.50 per thousand ($17 per thousand on cigarettes removed during 2000 or 2001)” in paragraph (1) and inserting “$50.33 per thousand (4.52 cents per thousand on cigarettes removed during 2000 or 2001)”;

(2) by striking “$40.95 per thousand ($35.70 per thousand on cigarettes removed during 2000 or 2001)” in paragraph (1) and inserting “$138.75 per thousand (4.52 cents per thousand on cigarettes removed during 2000 or 2001)”;

(3) by striking “40.26 cents per thousand (18.063 percent” in paragraph (2) and inserting “52.75 percent”;

(4) by striking “$8.75 per thousand (42.50 cents per thousand on cigarettes removed during 2000 or 2001)” in paragraph (2) and inserting “$40.26 cents per thousand”.

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or 2001)'' in paragraph (2) and inserting "$10.69 per thousand,
(c) CIGARETTE PAPERS.—Section 5701(c) of such Code is amended by striking "1.22 cents (1.96 cents on tobacco papers removed during 2000 or 2001)" and inserting "1.15 cents.
(d) CIGARETTE TUBES.—Section 5701(d) of such Code is amended by striking "2.44 cents (2.12 cents on cigarette tubes removed during 2000 or 2001)" and inserting "6.30 cents.
(e) SMOKELESS TOBACCO.—Section 5701(e) of such Code is amended by striking "by paragraph (1) and inserting "by paragraph (1) and inserting "$1.31, and
(f) ROLL-YOUR-OWN TOBACCO.—Section 5701(g) of such Code is amended by striking "$1.0969 cents (95.67 cents on roll-your-own to- bacco removed during 2000 or 2001)" and inserting "$2.6311 cents.
(2) EFFECTIVE DATE.—The amendment made by this section shall apply to tobacco products, processed tobacco, cigarette paper, or cigarette tubes, not likely to maintain operations in compliance with this chapter, or
(B) has been convicted of a felony violation of any provision of Federal 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.
(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on the date of 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 processed tobacco", after "tobacco products.
(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply to articles removed after the date of the enactment of this Act.
The opportunity before us today is to make basic health insurance available to 11 million low-income children who would otherwise have no insurance. We know that without health insurance many children go without the health care they need to grow, to learn, and to compete in the community.

The bill before us will extend the current program for 4½ years, ensuring that States will be able to maintain coverage for the 7 million kids now enrolled and to extend coverage to an additional 4.1 million uninsured low-income children.

The bill is fully paid for. It will cost $33 billion over the next 5 years, fully offset by a 62-cent per pack increase in the cigarette tax.

The Senate made a few minor changes, adding a new option for CHIP to provide dental care for privately insured children and creating a new commission to evaluate provider payments and access in CHIP and Medicaid.

The Senate provision closing a loophole in Medicare that allows physicians to refer patients to hospitals where they have ownership interest. We will continue to work on that matter.

While this is short of our ultimate goal of health reform, it is a down payment, and it is an essential start. We need to pass this bill. We need to do so now.

I urge my colleagues to vote for this bill and send it to the President for his signature.

I reserve the balance of my time.

Mr. DEAL of Georgia. Madam Speaker, I recognize myself for 1 minute.

Madam Speaker, we’re here today to have another debate about SCHIP, another incident of where we have a bill that’s come over from the Senate slightly different than came from the House. In the case of this SCHIP bill, I don’t recall hearing anyone on it. I don’t recall there being a hearing last year before we had the vote.

So, let us simply say from the Republican perspective that we’re very supportive of continuing the State Children’s Health Insurance Program. We do think that it should be limited to families that are under 200 percent of poverty. We do think this is a children’s health program. It ought to be for children. And we do think that there should be a verification so make sure that the program benefits go to citizens of the United States.

None of those things are in this bill. So we would oppose the bill and hope at the appropriate time the House would also oppose it.

With that, I reserve the balance of my time.

Mr. WAXMAN. Madam Speaker, I still continue to reserve our time.

Mr. BARTON of Texas. Madam Speaker, I yield myself 1½ minutes.

I rise in strong support of H.R. 2, as amended by the Senate. This is the same bill, by and large, that we passed in the House by an overwhelming bipartisan majority a few weeks ago.

Mr. DEAL of Georgia. Madam Speaker, I thank the gentleman for yielding.

I think it would be appropriate for us to review what the SCHIP program is designed and was originally designed to do and where it is in light of what this bill attempts to do.

First of all, it stands for the State Children’s Health Insurance Program. States call it by a variety of different names at the State level. In my State, it is called PeachCare. You would imagine that we would do that in Georgia, but it was originally designed in 1997 as a 10-year program—it was a block grant program—designed to fill in the need of children who live in families that are above the Medicaid poverty level eligibility but are still below 200 percent of poverty, and that in that capacity was a worthwhile and useful program.

During its 10-year initial lifespan as the legitimate needs of the 200 percent of poverty and below, recognizing that some States had already far exceeded that limit, but nevertheless allowing them to be grandfathered in and provide enough money so that no State runs out of money to cover the eligible children.

Unfortunately, the bill before us today continues to take a step, in my opinion, in the wrong direction. We talk about the millions of children that are supposedly going to be enrolled as new enrollees in the program, and yet when we look at those figures, we find that about 2.5 million of those so-called new enrollees will be children who are already enrolled in private health insurance plans, but because their family is now eligible for the government to pay for their health care, it is anticipated that their families will simply take them off of the private insurance and put them on the taxpayer-paid program of SCHIP. I don’t think that’s what most Americans in this country want this program to be.

Couple that with the fact that we have no provision in this bill that requires States—The SPEAKER pro tempore. The time of the gentleman has expired.
Mr. BARTON of Texas. I yield the gentleman 1 additional minute.

Mr. DEAL of Georgia. There is no provision in this bill that requires States to go out and make the extra effort to enroll children who are eligible for SCHIP. Medicaid, or the current SCHIP program under its current authorization of up to 200 percent of poverty but are still unenrolled.

In fact, it is estimated that about a quarter of the children who are eligible are simply not enrolled in the current program. These are the children that are at the lowest levels of poverty but are not covered. They should be the part that are our first incentive. The Republican version of this incentivizes States to take that extra effort to enroll those children first before they started going up the poverty level and enrolling children in higher income families, many of whom already have private insurance.

I thank the gentleman for yielding.

Mr. WAXMAN. Madam Speaker, I'm pleased at this time to yield 3 minutes to the gentleman from Washington State (Mr. MCDERMOTT).

Mr. MCDERMOTT. Madam Speaker, I rise in support of the SCHIP reauthorization legislation and want to thank the Speaker, Ms. PELOSI, for her leadership in bringing this bill to the floor. H.R. 2 clearly says that change has arrived for our country and our children.

Instead of the veto pen that was used last year by the outgoing President to deny health care to children, our new President will sign this legislation and, in so doing, will write a new chapter in America's commitment to our children and our future.

H.R. 2 is a real down payment on our efforts to ensure universal access to affordable health care for all Americans. It builds on successful models that have provided access to millions of children nationwide.

Health care should be a right, not a privilege for the rich in America. This legislation affirms the commitment of a new Congress to serve all the people, not merely those who have the means to pay any price for health care while the Nation pays a steep price by not covering its children.

H.R. 2 represents an additional 4 million children that will have access to health care that will provide access to preventive health care, and this alone means America will raise healthier children who grow to become healthier and more productive adults.

The American people have spoken. They want a more compassionate response to our Nation's problems. Today, we are voting with our heads and our hearts to do just that. This is not about ideology or party. It is about providing health care to children. H.R. 2 represents real change.

I am proud of my own State that took the lead before SCHIP was put in place in 1994. Three years before the enactment of SCHIP, Washington State expanded coverage to children up to 200 percent of the Federal poverty line. That was a huge commitment, and clearly, my State took the lead. As a result, we have fewer children uninsured, we have a healthier population, and more integrated primary care. It's working for us in Washington State, it's working for us in, our State, and it recognizes that what worked for Washington State will work across the country.

Thirty million dollars was the commitment we made. H.R. 2 rewards those States that knew that they were on the right path early on that providing quality affordable health care to children was a sound, humane investment, but also, it expands a successful program to cover more uninsured children and working families.

The present economic difficulties in this country are going to make this program even more important than they've ever been in the past. This bill provides greater flexibility and will allow States to respond more urgently and more urgently to the health needs of low-income working families.

I'm grateful also that this legislation includes important access for legal immigrants who are currently denied coverage, children who are born in the United States and are U.S. legal citizens. In Washington State, we have provided coverage for these children, but the State is doing this alone without the full partnership of the Federal Government. H.R. 2 corrects this error and will allow Washington State to maintain coverage for more than 5,000 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. BARTON of Texas. Madam Speaker, I yield 2 minutes to a distinguished member of the committee, Dr. GINGREY of Georgia.

Mr. GINGREY of Georgia. I appreciate the gentleman yielding, and I regretfully rise to oppose H.R. 2. I do not oppose the original legislation—which I think the bill was a very good bill and as a physician Member and a compassion for wanting to extend health care to our children—my concern with the bill with the reauthorization is that it doesn't really limit it to those children that need it the most, those, say, under 200 percent or between 100 and 200 percent of the Federal poverty level. This now bill actually allows that to go up to 300 percent.

But, Madam Speaker, there is an even bigger problem. This is a situation that some States use called—well, they're loopholes, really, and they call them income disregards. I think there are 3 States. Madam Speaker, who utilize that loophole that just simply says to couples or families, if you're not eligible, that is, you make more than 300 percent of the Federal poverty level—well, what is that, about $65,000 a year for a family of 4—we will simply disregard the income that you make between 300 and 400 percent of the Federal poverty level and say, we're not going to count that. Let's consider—wink, wink, nod, smoke and mirrors, shell game—not count a certain block of income.

And I had an amendment—which I thought was a very good amendment; unfortunately it's a closed rule—but that amendment would simply say that there will be income disregards only in the amount of a maximum of $3,000 a year or $250 a month. Only income disregards may be something like child care or something of that sort.

But to completely disregard, that's where we get into this crowd-out situation. Madam Speaker, where people whose children are already covered in the private market, they're going to drop that, clearly they're going to drop it, though they can afford it so they can get on the government dole. And, as was pointed out earlier, a lot of physicians are not going to take the SCHIP patient because of the reimbursement.

Mr. HOYER. Madam Speaker, I thank the gentleman for bringing this bill to the floor in a timely fashion. I'm pleased that we're going to pass this bill, we're going to send it to the President, and he's going to sign it.

Atul Gawande, a surgeon and writer on health care policy, recently described our medical system like this:
“American health care is an appallingly patched-together ship, with ... fifteen percent of the passengers thrown over the rails just to keep it afloat.”

If you can afford health care in America, you are doing better physically than the world to get sick. You will be treated to the best hospitals by the most skilled doctors with the latest technology. However, if you're one of the Americans thrown overboard, if you're one of the 45 million uninsured Americans in a checkerboard of poverty, you might be better off in some other places in the world. Every other developed nation has figured out how to cover all of its citizens. Every one but ours.

We're here today to start fixing that. Actually, we've been fixing that in a number of ways—Medicaid, Medicare, other programs that we've adopted—to patch the holes, however, that still exist in the leaking ship to make it into the vessel of carrying every passenger, every American.

We can't patch every hole today, but if I could pick just one leak to stop, it would be the hold where we keep our sick children. If you asked me for the most important one—of a single health care dollar, I would put it towards covering more children.

I don't say that out of a misplaced sentimentality; I say it because it's well-established that childhood is the most medically pivotal time of life. A child who lives through the first years without a doctor's care, without regular checkups, without immunizations, and without booster shots is in for a lifetime of health danger. That child will live sicker and die sooner. In adulthood, he or she will be a less productive worker. And in old age, he or she will help swell the costs of our entitlement programs.

That is the logic behind the final passage of this bill, which brings into the State Children's Health Insurance Program, as has been said already, four million children who are eligible but not yet enrolled.

Very frankly, as a result of the veto of the legislation we passed in the last Congress, four million children went to bed last night with their parents worried if they got sick, what were they going to do, with the alternative being the emergency room: the most expensive, and in some cases least efficient, intervener in the health care system in our country.

It does what President Bush promised to do when he ran for re-election in 2004 accepting the Republican nomination. As I've said before, President Bush said this, “In a new term—” that meant the 2005 to the 2009 term that just expired—“In a new term, we will bring in our country. As I've said before, President Bush said this, “In a new term”—that meant the 2005 to the 2009 term that just expired—“In a new term, we will bring in our country.

President Bush failed to mention.

Backed by overwhelming majorities of Americans, we can pass this bill and help raise a healthier generation of Americans. That's good for our country, it's good for our economy, and it's good for the international community.

And in this recession, we can lend some vital assistance to the millions of family budgets that are stretched, literally stretched, to the breaking point and the point of letting the health care of our children be further at risk.

Madam Speaker, renewing American health care, bringing the best care in the world, which we have right here—as Dr. GINGREY knows, we have right here—bringing it to all of our people is a hugely complex job. That work, of course, does not end today, as Chairman WAXMAN would emphasize. But this important inclusion of more than four million of our children and the guarantee of access to health care is a victory for America's values and its health care future.

I urge my colleagues, each and every one of us, to vote for this legislation, vote for our children, vote for our families, vote for a healthier America.

Mr. BARTON of Texas. Madam Speaker, can I inquire of the time remaining on each side?

The SPEAKER pro tempore. The gentleman from Texas has 7 minutes remaining and the gentleman from California has 9½ minutes remaining.

Mr. BARTON of Texas. Madam Speaker, I yield myself 3 minutes.

Madam Speaker, my admiration for the majority leader knows no bounds. Mr. HOYER is a great man, and he is an institutionalist, and he was personally involved in the negotiations of the last Congress. We got the bill. It was not a compromise. But sometimes he doesn't tell the entire facts of the matter. So I want to just point out a few things that our distinguished majority leader failed to mention.

Right now in America, the SCHIP law that we're operating under is a Barton-Deal bill—Mr. DEAL and myself, two Republicans—that extends the existing program. And to Mr. HOYER's credit and Ms. PELOSI's credit, they passed that extension in the last Congress when we couldn't get a political compromise.

Under current law, if you're low income, below 200 percent of poverty, your children are covered under Medicaid. If you're a working family that's under 200 percent of the Federal poverty limit, you're automatically covered. In some States, they go up to 250 percent of poverty, and in some States they have asked for waivers to go even higher than that. Madam Speaker, I think the State of New York may be at 300 percent. I think the State of New York may be at 300 percent.

Mr. HOYER is a great man, and he is an institutionalist, and he was personally involved in the negotiations of the last Congress. We got the bill. It was not a compromise. But sometimes he doesn't tell the entire facts of the matter. So I want to just point out a few things that our distinguished majority leader failed to mention.

Under current law, if you're low income, below 200 percent of poverty, your children are covered under Medicaid. If you're a working family that's under 200 percent of the Federal poverty limit, you're automatically covered. In some States, they go up to 250 percent of poverty, and in some States they have asked for waivers to go even higher than that. Madam Speaker, I think the State of New York may be at 300 percent. I think the State of New York may be at 300 percent.

So it is a misnomer to say that there are all of these children out there that don't have health insurance. There are some.

Now, the bill before us today really doesn't have an income test. It only looks at how far you are from the Federal poverty line, but allows the States to ask for waivers and do what are called income disregard, which basically means you could have families at 400 or 500 percent of poverty and if that State disregards their income, they can be covered. That was admitted on the House floor in last year's debate, and that provision is unchanged in the bill before us.

Now, President Obama has already scheduled a signing ceremony so there is no real suspense about whether this bill is going to pass with a Democrat majority of 258 votes and a Republican minority of 178 votes, we're pretty sure that this bill is going to prevail.

But the record should show that low-income children are covered, that children up to 200 percent of poverty are covered, and in some states it goes to 250 percent. This debate is about raising the level.

This debate is about do we want a children's health insurance program that covers every child in America with State and Federal dollars regardless of their ability to pay; do we want to freeze out the private sector for health insurance. That's what this debate is about.

Republicans are for children's health insurance. Republicans do believe, though, that we should target the help to those families that have less ability to help themselves.

And on the question of citizen verification, since we didn't have a legislative hearing, I'm not sure what the verification measurement is, but I think it's personal affirmation.

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

Mr. BARTON of Texas. Madam Speaker, I yield myself 15 seconds.

It is personal affirmation. When you sign up for SCHIP they say, “Are you U.S. citizen?” And if your parent says you are, you are. That's what personal affirmation is.

So I hope we could somehow pull out a miracle and defeat this bill and then do the bipartisan compromise that we almost pulled off in the last Congress.

With that, I reserve the balance of my time.

Mr. WAXMAN. Madam Speaker, I yield to the chairman of the Health Subcommittee and the author of the SCHIP bill in the House, Mr. PALLONE from the State of New Jersey, 1 minute with an option for more.

Mr. PALLONE. Thank you, the gentleman from California.

Madam Speaker, on this historic day I'm reminded of a quote from the Pulitzer Prize winning American author, Pearl Buck, who said, "If our American way of life fails the child, it fails us all."

Well, this is a day worthy of celebration. It comes nearly 2 years after
Deamonte Driver, a young boy from suburban Maryland, lost his life because his family lost its health insurance. And this simply should not happen in America. And if Congress does not act today, I can’t help but think of the thousands of other children whose lives will be put at risk simply because they do not have access to health coverage.

There can be no greater cause or worthwhile goal than protecting the wellbeing of our Nation’s children. I emphasize that it is not just our Nation’s children. It is not just in the SCHIP program. It is now a matter of the families of all of us. It’s not just a matter of the families of our children. It is a matter of the families of all of us. It is a matter of every single family in the United States. It is a matter of our Nation’s future.

Let’s support them today by voting “yes.”

Mr. BARTON of Texas. Madam Speaker, I yield 1 minute to the gentleman from California, Congressman McClintock.

Mr. McClintock. I thank the gentleman for yielding, and I think it’s a prime example of the unintended consequences. Since its inception, we’ve watched as SCHIP has been slowly replacing employer health plans with government-paid plans—with spiraling costs to taxpayers. Employers discovered that they could avoid their own plans, knowing that their employees would be covered by SCHIP.

This was supposed to provide health insurance for poor and working-class families but, like all things bureaucratic, it’s now morphed into one in which simples earning as much as six-figure incomes and who would have good employer-paid health insurance are being pushed into the government program. And that is the fine point of it.

"This is no longer a program for the children of poor people. It’s being used to insinuate government into the medical care of every American. Frankly, we don’t need the same people who run the TSA to run our health insurance."

Mr. WAXMAN. Madam Speaker, I yield 1 minute to a member of the Energy and Commerce Committee and a member as well of the Health Subcommittee, the gentlewoman from Illinois (Ms. Schakowsky).

Ms. Schakowsky. I am delighted to rise today in support of the Children’s Health Insurance Program Reauthorization Act. I thank Mr. Waxman and Mr. Pallone for their hard work on bringing it to us today.

As a mother and proud grandmother of four, I can think of no higher priority than ensuring that our children get the health care they need. Unfortunately, 7 million children nationally and 350,000 children in Illinois are at risk of losing their coverage if we don’t reauthorize this program.

But this bill will not only prevent SCHIP from expiring on March 31, it will also extend coverage to another million uninsured children nationally and 360,000 children in Illinois. It makes many needed improvements, including dental coverage and providing mental health parity. I am particularly pleased that it gives States the discretion to cover more women and children by lifting the 5-year ban for legal immigrants.

I am also pleased that after many thwarted efforts, we finally have a President that will sign this bill into law. It represents a renewed commitment to health care. This is the first step in making sure that every child, woman, and man in the United States has health care that is affordable, accessible, and of high quality.

Mr. DEAL of Georgia. I yield 2 minutes to the gentleman from Georgia (Mr. Deal).

Mr. Deal. Of Georgia, I thank the gentleman for yielding.

Let me clear up a couple of things. First of all, the majority leader has said that this is an effort to provide universal coverage for citizens of this country to health care. It obviously is a major step in that direction of government health care.

The problem with this bill is that it also include expanding and extending health care to citizens of other countries. In 2005, the Inspector General of HHS told us that some 46 States and the District of Columbia were using self-attestation of citizenship to enroll people in their Medicaid programs. Part of the reason was when they had asked for identification, they were accused of profiling or threatened with civil rights lawsuits. So most States backed off and said, Well, if you tell us you’re a citizen, we’ll take your word for it.

In the Deficit Reduction Act, we changed that. And we require that you now prove you’re a citizen and prove who you are. This bill changes that. And we go back.

For those of us who think, Well, just tell us a name and a Social Security number—that means that if you believe that there are not people who are out there with fraudulent Social Security numbers, then I have some stories back home I’d like to tell you.

We take a huge step backwards—and it’s not just in the SCHIP program. It applies to the Medicaid program as well. Now, that means then at a time when we are hearing people saying that we want you to secure our borders, we want you to protect us, we are saying we are going to open it up to anybody who just wants to tell you they are a citizen and, by the way, even if they tell you they are a citizen, there is no sanctions for them telling you they are a citizen, when they are not, and this bill requires you to provide them with medical care during the time period when they have defrauded.

At a time when citizens are concerned about the economy of this country, we should not be taking a step in the direction of loosening up and encouraging fraud and abuse of this program.

Mr. WAXMAN. Madam Speaker, I yield 1 minute to the gentlelady from California (Ms. Eshoo).

Ms. Eshoo. Madam Speaker, I think today is really a great day in America because the legislation that is before us is one of the most important bills that we will pass in the 111th Congress, the Children’s Health Insurance Program Reauthorization Act, or SCHIP.

As we know, the same legislation was vetoed not once but twice by President Bush, forcing the Congress to pass short-term extensions and no improvements to the program. But, today, a promise is being kept to America’s children. They will be insured with health insurance coverage. The total will be 11 million. We are adding 4 million children to be covered. I think that is a victory.

The legislation invests more than $32 billion over 5 years, and it is fully paid for. So it is good fiscal policy. It is good health policy, and it is good social policy.

Forty years ago today, I gave birth to my daughter, Karen. Today, more children are being born, and the little ones can look forward to what the Congress is providing. Bravo, bravo, bravo.

Mr. BARTON of Texas. May I inquire on the time remaining?

The SPEAKER pro tempore. The gentleman has 45 seconds remaining.

Mr. BARTON of Texas. I reserve the balance of my time.

Mr. WAXMAN. Madam Speaker, I yield 1 minute to the Speaker of the House, without whom we would not have this legislation before us today, who has been tireless in pushing forward the agenda to make sure that no child in this country goes without health insurance, the gentlewoman from California (Ms. Pelosi).

Ms. Pelosi. This is a very happy day for me, for the Congress, and for the country, for the children. I thank my colleagues for their extraordinary leadership in working on this very, very important legislation, which is strongly bipartisan, very carefully crafted, and again, a giant step forward for our children.

Almost 2 years ago, when we first talked about this legislation—we have been talking about it for years. Of course, it has been the law, and now we are expanding it. But when we first brought it into the previous Congress, it was defeated. Today, it was defeated in the afternoon when I came to the floor, and while the sun was setting in the sky—coincidentally, I came at a time when
it was, in poetry, described as the “children’s hour.”

I quoted then Henry Wadsworth Longfellow’s poem: Between the dark and the daylight, when the night is beginning to lower, comes a pause in the day’s occupations that is known as the Children’s Hour.

Today, the children’s hour has come to pass. With the bipartisan vote of this House, and the signature of the new President of the United States, we will provide health care to 11 million children in America.

We owe a great deal of thanks to our chairman, Mr. WAXMAN, to the chairman emeritus, Mr. DINGELL, and Chairwoman FRANK PALLONE, of the Energy and Commerce Committee; Chairwoman RANGEL and PETE STARK of the Ways and Means Committee. So many women on the committees have worked for this. Congresswomen SCHAKOWSKY, SHOO, and many others. This has been a product of many women working on this important issue that involves our children.

But our success really springs also from the outside mobilization that went with this. A compilation of more than 500 organizations—everyone from AARP to the DNC, March of Dimes, Easter Seals, and every organization in between—supported providing quality, affordable health care to America’s children.

More than 80 percent of Americans support our bipartisan children’s health insurance bill because they understand that with the 2.6 million jobs lost last year, even more children do not have health insurance. For every 1 percent increase in unemployment—for every 1 percent increase in unemployment—it is estimated as many as 1.5 million Americans will lose their health care coverage.

The American people know that preventive care is more cost effective than relying on our Nation’s emergency rooms. That phrase was used in the debate over the past 2 years. Everyone in America has access to health care. All they have to do is go to the emergency room. What a ridiculous statement. What a disservice to the debate.

They know also that reducing smoking, which the Campaign for Tobacco-Free Kids says this legislation will do, means healthier children leading longer lives.

The bipartisan, fully paid for children’s health insurance bill represents the new direction that Democrats have fought for that now, today, we join with our Republican colleagues to bring to the floor. This is the beginning of the change that the American people voted for in the last election and that we will achieve with President Barack Obama. We look forward to this afternoon when the President of the United States will sign this legislation.

I speak on behalf of our new Members of Congress on this floor. I see Congresswoman BETSY MARKEY and Congresswoman D’HALKEMPER on the floor. I don’t know if others are here. But they have taken a major interest. Tom PERRIELLO of Virginia has taken a major interest in this legislation too. I commend them because their coming to Congress has already, only a few short weeks in the Congress, has already made a difference in the lives of the American children.

It’s a very happy day for me because, as you know, each time I have been sworn in as Speaker, I have gavelled this House to order in honor and on behalf of all of America’s children. Right after the children’s hour begins, it signifies that we are a Congress for those children.

I urge all of my colleagues to support our effort to pass this with a tremendous, tremendous margin, and then also to celebrate the signing of the legislation this afternoon.

Mr. BARTON of Texas. I continue to reserve the balance of my time until they are ready to close. We have one speaker remaining.

Mr. WAXMAN. I yield 1 minute to a member of the Health Subcommittee and the full Energy and Commerce Committee who played a role in this legislation, the gentlelady from Wisconsin (Ms. BALDWIN).

Ms. BALDWIN. Thank you, Mr. Chairman.

I rise in strong support today of the Senate amendment to H.R. 2, the Children’s Health Insurance Program Reauthorization Act. Achieving health care for all in this time is the reason why I got into politics. It is my goal, it is my passion, it is my motivation. And for the first time during my tenure in Congress, I see real promise that the Obama administration and this Congress will work together to achieve that goal.

SCHIP takes an important first step in moving towards achieving this goal. I am proud to support this particular bill because it contains some key provisions that have been visionary and proactive in trying to get health insurance for their kids. Eleven States have moved forward ahead of the country in providing health insurance for their kids up to 300 percent of poverty, and this bill finally, due to the great efforts of Mr. WAXMAN, Mr. DINGELL, and many others, who have been working for years, Mr. PALLONE, to fashion a provision that will allow the children in those States to in fact enjoy health insurance.

In my State of Washington, over 5,000 kids are going to have health insurance as a result of this; the State will have $94 million to help those families. This is long overdue.

And to my friends across the aisle who somehow do not understand that parents who become unemployed in the downturn we are now experiencing, they are at over 20 percent of poverty or 200 percent or 300 percent, I don’t know why they don’t understand the pain of parents who can’t provide health insurance for their kids. This does it today. Let’s pass this bill.

Mr. WAXMAN. Madam Speaker. I yield 1 minute to the vice chairman of the Energy and Commerce Committee and a longtime member of the Health Subcommittee, the gentlelady from Colorado (Ms. DEGETTE).

Ms. DEGETTE. We will pass this bill today. And we will pass this bill for millions of women, like Susan Molina, who are trying to work and support their children and do the right thing for them. Susan is a single mother in my district. Her abusive husband left her, and she has struggled to work and pay for health insurance for her two children as she worked tirelessly to move from a janitor to an apartment manager position.

In 2006, Susan’s two children lost their health insurance under SCHIP because her new job paid just slightly more than 200 percent of poverty level. Susan has tried to work her way up to be a responsible member of society. Eventually, she got her children in SCHIP, and they have health care, and she could work. But then after she lost her SCHIP coverage, as she testified to Congress, to our committee, she felt like a failure as a mom.

She was working, she was in school trying to get her GED, but she still had to take her kids to the emergency room when they got an ear infection. Frankly, Madam Speaker, it is about time that the most civilized country in the world give health care coverage to all of its children.

Mr. WAXMAN. Madam Speaker. I am pleased to yield to the gentleman from Washington State, a member of the Energy and Commerce Committee, Mr. INSLEE, for 1 minute.

Mr. INSLEE. Madam Speaker, I want to particularly commend this bill, because it honors the States that have been visionary and proactive in trying to get health insurance for their kids. And to my friends across the aisle who somehow do not understand that parents who become unemployed in the downturn we are now experiencing, they are at over 20 percent of poverty or 200 percent or 300 percent, I don’t know why they don’t understand the pain of parents who can’t provide health insurance for their kids. This does it today. Let’s pass this bill.

Mr. WAXMAN. Madam Speaker. I yield 1 minute to the gentleman from North Carolina (Mr. BUTTERFIELD), a very important and distinguished member of the Energy and Commerce Committee, 1 minute.

Mr. BUTTERFIELD. Madam Speaker, I am pleased to yield to the gentleman from North Carolina (Mr. BUTTERFIELD), a very important and distinguished member of the Energy and Commerce Committee, 1 minute.

Mr. BUTTERFIELD. Madam Speaker, I am pleased to yield to the chairman of the Ways and Means Committee for yielding this time. This is a very important subject in all of our States.
Madam Speaker, without question, the people of my State in North Carolina are hurting very badly. Unemployment figures show that the number of counties with double digit unemployment actually doubled to 34 during the month of December. That is more than one-third the counties that are suffering from double digit unemployment.

When people lose their jobs, they lose access to affordable health care, and it is the children, just as the gentleman from Washington just said, it is the children who suffer most in these circumstances. Today, we have an opportunity to take another step toward ensuring that every American child has access to affordable health care regardless of family circumstances.

With the passage of this bill, my State of North Carolina will reduce the number of children who lack health insurance by 46 percent. That is 136,000 children. There will be similar impacts across the country. I urge my colleagues to join me in approving this important bill.

The SPEAKER pro tempore. The gentleman from Texas has 45 seconds remaining; the gentleman from California 1½ minutes remaining.

Mr. WAXMAN. Madam Speaker, at this time it is my great honor to yield to speak on this legislation to the gentleman from Michigan (Mr. DINGELL), who has been the author of this bill for child health insurance in the last Congress. Unfortunately, the bill was vetoed by President Bush. But we all have to recognize his strong commitment and leadership on this issue, and so I want to yield to him 1 minute to be able to speak in favor of the legislation.

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

Mr. DINGELL. I thank my friend, the chairman of the committee, I rise to voice my support for the extension of the Children's Health Insurance Program. As a long-term supporter of the program, I am delighted that we are sending a bill to the President that will be signed into law. This time there will be no veto pen to stand in the way of providing health coverage for 11 million of our kids.

High health care costs are straining already strapped families nationwide. Nowhere is this truer than in my home State of Michigan, where unemployment now tops 10 percent. With families struggling to save for retirement, to save for college, to pay mortgages and bills, this legislation will help State governments provide health care to children who otherwise would be left out.

Recently, there has been much talk about investments, good and bad. The bad kind has pushed our financial system into the brink of insolvency and has caused economic crisis on a scale that is unseen since the depression. But good investments, such as SCHIP, invest in our children and our future.

This expansion is a bipartisan effort, a collaboration of my colleagues on both sides of the aisle. Of this, I am properly grateful, and I urge my colleagues to vote for this legislation. It will be signed into law, and I look forward to working with the administration on a program of national health reform.

As someone who has spent 50 years on this effort, I know that this is just the beginning of what needs to be done. The SPEAKER pro tempore. The gentleman from Texas has 45 seconds remaining.

Mr. BARTON of Texas. I am going to yield my last pot 45 seconds to a distinguished member of the committee, MARSHA BLACKBURN of Tennessee, to close.

Mrs. BLACKBURN. Madam Speaker, I think that, I would hope, that not only my colleagues but the American people realize that this bill today contains a $72 billion tax increase on the American people. By Congressional Research Service calls the most regressive of taxes, because it is tobacco taxes. But this is a tax increase that is coming full steam ahead at us. And, Madam Speaker, it is not there to go. We—to quote of the 900,000 children that are expected to be added already have access to health insurance.

I would encourage all of my colleagues to vote against the tax increase and vote “no.”

Mr. WAXMAN. Madam Speaker, I wish to yield the balance of our time to the gentlelady from Colorado (Ms. MARKEY).

(Ms. MARKEY of Colorado asked and was given permission to revise and extend her remarks.)

Ms. MARKEY of Colorado. As working class families struggle to make ends meet in these tough economic times, we have the opportunity to ease their burden by providing health care for 11 million children. Currently, more than 1 out of 8 children in Colorado lack health insurance because they can’t afford it. As the mother of three, I understand the burden of caring for sick children and the relief of being able to take my children to the doctor without worrying about costs.

We need to expand access to children’s health care, and make sure that every child has the ability to go to the doctor and receive treatment. This is not just the right thing to do; it makes fiscal sense to give children preventive health care.

As working class families struggle to make ends meet in these tough economic times, we have the opportunity to ease their burden by providing health care for 11 million children. In my state of Colorado, we had 84,649 children enrolled in SCHIP in 2007. This legislation will preserve coverage for them, and extend it to thousands more children in the state. (Currently, more than one out of every eight children in Colorado lacks health insurance.)

As a mother of three, I understand the burden of caring for sick children and the relief of being able to take my children to the doctor without worrying about costs.

For example, we need to expand access to children’s health care and make sure that every child has the ability to go to the doctor and receive treatment. Today’s children are the next generation of leaders, and we need to insure our future. This is not only the right thing to do, it makes fiscal sense to give children preventive healthcare. I ask all of my colleagues on both sides of the aisle to pledge their support for our children and vote for this bill.

The SPEAKER pro tempore. The gentleman from New York (Mr. RANGEL) is recognized.

Mr. RANGEL. Madam Speaker, what a great opportunity for us in this August body, whether we are Republican or Democrat, to think in terms of the comfort that we are giving parents and children by providing them access to health care, in the instance that, if anything happened to these very special people, that they would have health insurance.

There is hardly a weekend that goes by that I don’t thank God for my three grandchildren, and I worry that if anything, God forbid, should happen to them, that at least we would know that they have access to health care. It reminded me when I was a young father and how precious my son and daughter would be. And then you think of course, of the so many millions of people who go to work every day not being able to concentrate on their jobs and being productive and competitive, but thinking what would happen if their child became ill.

And it is not just the compassionate and right thing to do, to know that all of us would be able to go to sleep at night and to know that we made our contribution to provide health care to 11 million kids, but even from a national security or fiscal point of view, as doctors and researchers indicate, the great burden of fiscal costs for diseases and ailments that could have been detected if the children had access to health care. So many kids drop out of school with people not even knowing that they couldn’t hear, that they couldn’t understand properly, that they couldn’t see minor things that could have been detected if the child had the availability of health care. And, of course, in other words, we can dramatically improve the quality of care and cut down the ever increasing costs of care by preventing these things from happening.

I sat here trying to listen to some arguments about why anyone would be against this bill. Sure, no one likes taxes. I am opposed to excise taxes. But, my God, cigarettes? You almost
feel like you are doing the right thing by making it difficult for kids and others to smoke cigarettes. Indeed, from a Ways and Means point of view, it is a question of whether or not the bill could be adequately funded because last year we collected more taxes because there was more consumption. So something is really working in terms of curtailing of people from destroying the quality of their own lives.

And so I do hope that we continue to have this as a bipartisan bill, that we can work past and go home and say that we worked together on one initiative that was good for our children, good for our community, and good for our country.

I now ask unanimous consent to yield the balance of my time to the chairman of our Health Subcommittee, and to have Dr. MCDERMOTT determine which Members he would like to yield to.

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

There was no objection.

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

Mr. LINDER. Madam Speaker, I yield myself my time as I may consume.

The State Children’s Health Insurance Program, which started in 1997, was for children, for children who lived in families who did not qualify for Medicaid but still needed health insurance. Today, four States have more adults in the program than children. It is being abused.

The health insurance program for children also required, originally, those in this country legally, to show that they lived in this country legally, to have documentation. This program removes that proof. You now need only to say, “Yes, I am here legally.” It also removes the 5-year requirement. When you are here legally and you are sponsored by someone, you have to be responsible for taking care of your needs for 5 years. This is removed. What will happen if we follow on with an amnesty bill for the 20 million illegals who would be immediately eligible for the SCHIP program? Would it then be fully funded?

The funding, by the way, mostly by tobacco, falls on low-income people. The burden on the lowest 20 percent with the tobacco program is 37 times more than when it was funded by an income tax. It also requires 22 million new smokers just to pay the price. I want to see the majorities go recrute them.

It is estimated that 2.4 million people will drop private insurance; families will drop because they qualify. Employers paying employees less than $80,000 a year will drop it. This isn’t mean-spirited; it is in their interest. We saw this happen before.

In 1965, every physician and dentist in America’s drawer full of patients that they treated for free. It was their community responsibility. When Medicare and Medicaid came along, they said, “Well, my taxes are going up to pay for that. The government will now do it.” And they dropped that responsibility, and the burden fell on the taxpayer.

With the upper limit disregards in this program of the essential means that 75 percent of all Americans eligible for the program. Again, I repeat. I have heard it said many times it is fully funded. And Lyndon Johnson said that about Medicare and Medicaid. I was in dental school and watched his greatest legislative achievement. “We know, using easily quantifiable user statistics that, by 1990, Medicare will only cost $9 billion and Medicaid will only cost $1 billion.” He was wrong. Medicare costs over $100 billion; Medicaid costs over $75 billion, and those entitlements are breaking this country.

The same is going to happen when the ceilings are taken off incomes and other people are put into this program. It will not be fully funded by tobacco.

This program will pay less than one-half the reimbursement to providers through Medicaid that currently Blue Cross pays. And those providers are going to disappear from the program. We are already seeing it in Medicare and Medicaid. Who is going to be left to treat these people?

There was a real bipartisan effort to reauthorize this program last year, to expand its income protections and to increase the money to pay for it. It wasn’t enough for the majority. They wanted to make it for everybody all of the time. This will not work.

I will vote against it.

I reserve the balance of my time.

Mr. MCDERMOTT. Madam Speaker, I yield 1 minute to the gentleman from North Dakota (Mr. POMEROY).

Mr. POMEROY. I thank the gentleman for yielding.

A great country holds the interests of its children first and foremost. A great country responds to tough times and steep challenges by placing the interests of its children at the head of the line when it comes to advancing measures to help. Today we have a chance to reflect this dimension of America’s greatness by passing this bill to extend vital health insurance to 11 million of our kids. We must take this action.

Like last year, we will have bipartisan support when it comes to moving this bill forward. But unlike last year, this time our efforts will receive a different reception at the White House. Our prior was a real bipartisan bill. But now we have a new President. And this bill will be received with a resounding “yes.” And the effort to get coverage to our children will at last succeed.

Mr. LINDER. Madam Speaker, at this time I yield 3 minutes to my friend from Texas (Mr. CULBERSON).

Mr. CULBERSON. I thank the gentleman from Georgia.

Each one of us as representatives of our districts has a fiduciary duty, the highest obligation of the law, to protect the Treasury of the United States to ensure that our children and grandchildren are not inheriting an unaffordable debt burden. Today the national debt exceeds $10 trillion. Today the national deficit, for the first time in history, exceeds $1 trillion. It is approaching $1.5 trillion. Today the unfunded liabilities of the United States exceed $60 trillion.

And in that set of circumstances, it is essential that this Congress, on every bill, on every issue, on every vote and in every debate think first and foremost about that debt burden that we are passing on to our children and analyze every bill before us from that perspective. Is it physically responsible? Is it financially prudent to pass the legislation before us?

Obviously the Federal Government has a longstanding obligation to provide health insurance for the very poorest of our citizens. But the key is, we fiscal conservatives want to see poor American children provided health insurance first and foremost. We fiscal conservatives want to limit the overflow of health insurance coverage to those poor American children in circumstances where they can show that they are truly citizens, they are here legally—in our current law, they have to become a citizen of the United States, you're not going to become a citizen of the United States legally, I have got to appeal the requirement that if you are here legally you wait 5 years—and that they are truly poor.

Yet with the legislation this unleashed liberal leadership of the new Congress has put before us, you are hiding behind campaign slogans. Step back and let’s forget the next election. Think about the next generation. Let’s legislate for the next generation, not the next election. And when you look at the next generation, the legislation that this unleashed liberal leadership of Congress asked us to support would allow Arnold Schwarzenegger in California to implement his plan of providing health insurance, quoting from the Washington Post, Schwarzenegger’s health insurance plan would require everyone living in California, even illegal immigrants, to have health insurance at an estimated cost of $12 billion. You’re changing existing law which requires the applicant to confirm, to verify and to prove that I am a citizen of the United States, you’re not going to become a burden on American taxpayers. Today it is required that you live here legally that you’re not going to become a burden on American taxpayers. Today it is required that you are citizen, you are a citizen of the United States legally, I have got to have a sponsor who will sign an oath confirming that I as the sponsor will make sure this person I am sponsoring does not become a burden on American taxpayers.

The SPEAKER pro tempore. The time of the gentleman from Texas has expired.
Mr. LINDER. I yield the gentleman 1 additional minute.

Mr. CULBERSON. Under current law, if I enter the United States legally, I must have a sponsor who signs an oath “I confirm and I will pay for this new, this unforeseen burden of U.S. citizenship.” I will make sure they don’t become a burden on taxpayers.” That requirement is repealed. When you look at the cost of this legislation to future generations, it’s a staggering bill to pass on to our kids. It’s an unaffordable burden to add to our children, grandchildren and great-grandchildren’s obligation. For the sake of a sound bite, for the sake of a cheap election slogan, you’re passing on an unaffordable burden to add to our children when we as fiduciaries, as trustees of the public Treasury, of the public dollar at a time of all these bailouts, the repeated bailouts of Wall Street, of rewarding bad behavior, something that the fiscal conservatives in the Congress have repeatedly said is adding to the problem by repealing the citizenship verification requirement. You’re repealing the 5-year waiting period. You’re allowing States to provide health care coverage to people up to 400 percent of poverty. It’s unaffordable. It’s unacceptable. It’s a dangerous trend. And I hope all of us vote against it.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

Mr. McDERMOTT. Madam Speaker, I yield 1 minute to the gentleman from Pennsylvania (Mrs. DAHLKEMPER). Mrs. DAHLKEMPER. Madam Speaker, I rise in support of SCHIP legislation before us today.

As I have said before, perhaps the most important reason that I ran for Congress was to help ensure that all children in this Nation have access to quality health care. A healthy start in life is something that all children deserve. And I’m particularly pleased that this bill will offer coverage to pregnant women, because I often tell the story of how I was covered throughout my pregnancy, one of the most critical times in my life, the pregnancy of my second child, when it was deemed a pre-existing condition by my private insurer.

This legislation, which will be signed by President Obama later today, will expand the SCHIP program to cover an additional 4 million children. This is an accomplishment that our Nation can be proud of.

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

To summarize very quickly, 4 minutes goes so quickly, Madam Speaker, I want to make sure that every opportunity I have to speak on this floor and that we as fiscal conservatives remind the American people that this new liberal leadership in Congress has been spending money at the rate of $100 million per minute. Let me let that sink in, $100 million per minute. We’ve only
been here the first 17 days of this Congress, and this new leadership managed to spend about $1.3 trillion more than the entire annual budget of the United States. And our primary concern about this legislation is that we want to see health insurance for poor American kids. But the bill that dropped in front of us is going to open the door for fraud, for illegal aliens to apply, and for people who are here legally to walk in and get coverage. The minute they enter the United States, they become a burden on American taxpayers.

This legislation is going to allow people up to age 21 who earn $80,000 a year to apply for health insurance as if they were poor. It’s fiscally irresponsible, particularly at a time of record debt and record deficit. Let us remember particularly at a time of record debt and record deficit. Let us remember particularly at a time of record debt and record deficit.

Mr. McDERMOTT. Madam Speaker, I yield to the gentleman from California (Mr. BECERRA) ½ minutes.

Mr. BECERRA. Madam Speaker. 200 years ago in America and we know now what it was like 200 years ago in America. We understand that no one should die of a preventable disease or illness. We have 11 million children in this country who are still uninsured. Today’s legislation will make sure that about half of those kids, about 4 million of those kids will be insured, along with seven other million who today benefit on an ongoing basis from this SCHIP legislation.

Today we say this is the 21st century and America understands that no one should die of a preventable disease or illness. We have 11 million children in this country who are still uninsured. Today’s legislation will make sure that about half of those kids, about 4 million of those kids will be insured, along with seven other million who today benefit on an ongoing basis from this SCHIP legislation.

We know what it was like 200 years ago in America and we know now what it was like 2 years ago in America. We know that today we must do better for our kids and that is why we pass this legislation today.

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

Mr. McDERMOTT. Madam Speaker, I yield 1 minute to the gentleman from Virginia (Mr. PERRIELLO).

Mr. PERRIELLO. Madam Speaker, today I rise in support of H.R. 2, the State Children’s Health Insurance Program Reauthorization Act of 2009.

At a time of high unemployment, and when more Americans are losing employer-sponsored health care for their children, this bill is needed urgently for the 150,000 Virginia children currently insured by the program, and the 55,000 more who will be covered.

This approach makes good public health policy. It’s morally the right thing to do by our children, and it’s good economic policy because it rewards the very families and parents who are working their way out of poverty. At a time when the cost of health care is crushing America’s families and America’s businesses, this is an important lifeline to extend to children in Virginia and children throughout the country.

While I am in full support of the underlying legislation, I am disappointed to learn that the Senate bill includes a disproportionate increase in the excise tax rate on tobacco products. The proposed tobacco tax could impact jobs and State revenues in already tight times.

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

Mr. PERRIELLO. In these very difficult times, we are in this together as a matter of public health and as a matter of economic sense.

As the son of a pediatrician, I am pleased to have the opportunity to vote in favor of this critical legislation and in favor of children in the Fifth District.

I urge my colleagues on both sides of the aisle to join me in putting America’s children first and cast a vote in favor of this important bipartisan legislation.

Mr. LINDER. Madam Speaker, I reserve the balance of the time.

Mr. McDERMOTT. Madam Speaker, I yield 1 minute to the gentlewoman from Texas (Ms. JACKSON-LEE).

Ms. JACKSON-LEE of Texas asked and was given permission to revise and extend her remarks.

Ms. JACKSON-LEE of Texas. Let me thank the chairman of the full Energy and Commerce Committee, Mr. WAXMAN. Let me thank the manager, Mr. McDERMOTT, and the chairman of the Full Committee on Ways and Means.

This is a miraculous accomplishment. The children of America are shouting today. It’s important to know that there are 8.9 million uninsured children in America. Overall, 11.3 percent of children in the United States are uninsured. That is unacceptable, and it is not befitting of this great Nation.

In Texas we have close to 1.5 million children that are uninsured. Today we say to them that they are a priority, and that their health care and their preventative health care is crucial; that it is not a waste of money. When 74 percent of uninsured children eligible for CHIP, for Medicaid are not enrolled, this is not a waste of money.

The Children’s Health Insurance Program SCHIP health insurance program will have access. I am gratified that they will also have access for certain adults that meet certain criteria; and I am gratified that we still have an opportunity to protect certain hospitals owned by physicians that will continue to serve children that are uninsured as well.

This is a great bill. We should vote on it enthusiastically and continue to work again to enroll more children for this great medical service.

Madam Speaker, I rise today in strong support for the Senate Amendment to H.R. 2—"the Children’s Health Insurance Program Reauthorization Act". We stand today, closer to helping 4 million children without health insurance. No longer will these children be forced to live with fear of getting sick. Today is a great day. Today we are able to bring 4 million children to the fold. Finally, we can enroll those 4 million children that are begging for help that Yes We Can!

NATIONALLY AND IN TEXAS

There are an estimated 8.9 million uninsured children in America. Overall, about 11.3 percent of children in the United States are uninsured, but the percentage of uninsured children in each state varies widely. Based on a 3-year average, there were an estimated 20.9% of uninsured children (under 19 years of age) in the State of Texas representing 1,454,000 of the State’s children.

According to the Institute of Medicine, uninsured people are less likely to use preventive services and receive regular care. They are also more likely to delay care resulting in poorer health and outcomes. Texas has the highest uninsured rates of all 50 States and the District of Columbia (2005–2007). Almost one-quarter (24.4%) of Texans are uninsured compared to 15.3% of the general U.S. population.

Recent studies estimate that for every 1 percent increase in U.S. unemployment, 1.1 million Americans lose health insurance and more than a million enroll in Medicaid and CHIP. While Texas’ 6 percent December unemployment rate remains better than the national average of 7.7 percent, the States are uninsured, but the percentage of uninsured children in each state varies widely. Based on a 3-year average, there were an estimated 20.9% of uninsured children (under 19 years of age) in the State of Texas representing 1,454,000 of the State’s children.

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HOW DOES CHIP HELP TEXAS FAMILIES?

According to 2004 U.S. Census data, Texas has the highest rate of uninsured children in the country with 21.6% of children in Texas lacking health insurance coverage. Nearly 90% of uninsured children in Texas have at least one working parent. The high children health insurance means that it is unaffordable for many Texas families. According to the Milliman Medical Index, the annual cost of health insurance for a family of four is $13,385.

Although many Texans have employer-sponsored health care insurance, many cannot get affordable coverage for dependents through an employer.

National data shows that virtually all the net reduction in SCHIP enrollment has been among children in families with incomes below 150% FPL. I want to share with you just some of the scary health statistics that are affecting children:
74% of uninsured children eligible for SCHIP or Medicaid but not enrolled.
11% of uninsured children in families not eligible for Medicaid or SCHIP with incomes below.
15% of uninsured children in families with incomes at or below the poverty-level who are ineligible for Medicaid and SCHIP.
90% of uninsured children that come from families where at least one parent works.
50% of two-parent families of uninsured children in which both parents work.
3.4 million uninsured children who are white, non-Hispanic.
1.6 million uninsured children who are African American.
3.3 million uninsured children who are Hispanic.
670,000 uninsured children of other racial and ethnic backgrounds.

I am very pleased to see that this new version does not include the restrictions on physician-owned hospitals. Along with many of my colleagues, I have been very concerned that we had with the prohibition on physician-owned hospitals. Which is why I worked with my colleagues to ensure that this language was not included.

In my district of Houston, Texas the population has grown close to 4.5 million people and there are only approximately 16,000 beds available in the city. Physician-owned hospitals like St. Joseph Medical Center in my district provide 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 the Houston's first and only teaching hospital. They delivered over 6,000 babies in 2008, of which 3,700 were insured by Medicaid. They currently provide $14M in uninsured care in the Houston Market. A Houston Institution for the Houston's first and only teaching hospital. They delivered over 6,000 babies in 2008, of which 3,700 were insured by Medicaid. They currently provide $14M in uninsured care in the Houston Market.

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 they were going to shut down this hospital and turn it into high-end condominiums, I personally worked with the hospital board, community leaders, and local government to ensure this did not take place.

Eventually, after I was assured that it would be responsibly managed and it's doors would remain open, I was able to help a hospital corporation, which, in partnership with physicians, purchased the hospital and has made it the premier hospital in the region to keep open St. Joseph's doors including its qualified emergency room responsive to a heavily populated downtown. This formerly troubled medical center is now in the process of re-opening Houston Heights Hospital, the fourth oldest acute care hospital in Houston.

ROBIN FROM TEXAS—HER STORY

Her daughter has a developmental disorder, known as autism. She was not certain of the extent of the program diagnosis of her disorder due to her lack of funds being a single mother, and lack of quality health insurance. She is one of the many uninsured in Texas.

She scraped together money to take her daughter to the doctor when she gets sick and does not have the ability to secure health care for 30 minutes of private speech therapy a week to complement what the school system provides.

She cannot qualify for SSI or Medicaid, they say she makes just over the maximum allowable income. She had trouble qualifying for CHIP in the past as well. Sadly once this mother has paid for daycare, speech therapy, clothing, car insurance, food, shelter, transportation, the rising cost of gasoline etc., she can barely keep the bills let alone quality insurance on her salary.

Robin wants the American dream for her and her daughter, but she is unable to obtain it. She is stuck in an old apartment building, with an even older car, and inadequate health coverage for her daughter. Her daughter's condition is known as autism. She was not certain of the extent or the prognosis diagnosis of her disorder. She is one of the many uninsured in Texas.

THE ECONOMIC AFFECT ON HEALTHCARE

The economy has now lost 1.2 million jobs since the beginning of the year, with nearly half of those losses occurring in the last three months alone, pointing to acceleration in the pace of erosion in labor markets. It is more important than ever in this economy that children's healthcare is not sacrificed.

Madam Speaker, my faith is renewed in the process that is being designed in the media. Thoughtful and deliberate negotiations were taken to advance this legislation—and through your leadership we have succeeding in bringing this to the floor for passage.

I look forward to a day when every child is covered and can play on football fields and jungle gyms without their parents fearing a bankruptcy injury to their child. This legislation is a piece of mind to 4 million families and I will joyfully cast my vote for passage of this important legislation.

Mr. LINDER. Madam Speaker, can I inquire as to the time remaining on each side?

The SPEAKER pro tempore. The gentleman from Georgia (Mr. LINDER) has 2 minutes remaining. The gentleman from Washington (Mr. McDERMOTT) has 4½ minutes remaining.

Mr. LINDER. Madam Speaker, I reserve.

Mr. McDERMOTT. Madam Speaker, I listened to my colleague, I listened to the gentleman on the other side, and I read an article I read in this morning’s Washington Post. Over in Arlington, which is just across the river, they have a clinic where people go who don’t have health insurance and hope that their number is drawn from a lottery so that they can get to see a doctor. Our health care system is in serious problems, from the seniors all the way down to the young people in this country.

Now, this bill says to the States, here’s some additional money for you to expand coverage to your youngsters. Through no fault of their own, they’re born into a home where there is no way to pay for health care. And we are giving the States, in this time of economic collapse brought on by the fiscal conservatives in this body, who said that we could spend and spend and spend, and never have to meet the day of reckoning, the people who are now going to suffer from that will be women and children.

Children have nobody to speak for them but us. And for us to put that money out there and give them the opportunity to have health care is humane in the very strong sense of that word.

How anybody could vote against this, I have no idea, after you’ve wasted a trillion dollars on a war in Iraq, and have the real estate industry totally out of control, and then you say to the children, you can’t see a doctor. What kind of body is this if we don’t take care of children?

I yield the remaining 3 minutes of my time to Mr. Waxman.

Mr. WAXMAN. Madam Speaker, we wish to reserve our time to close the debate.

Mr. LINDER. Madam Speaker, I would like to point out that nobody on this side opposes children. The SCHIP program was started under the Republican majority in 1997, principal sponsor being Republican Senator Orrin Hatch.

We believe the program was a good step in allowing for the health coverage of children whose parents did not qualify for Medicaid. What will destroy this program is a lack of restraint and irresponsible expansion of it.

It is true we are in the midst of a global economic collapse. And that has caused that? Abuse, lack of restraint, corporate leaders spending other people’s money, shareholders, ignored limitations, ignored risks, ignored warning signs, and gave us the problem we have today.

What makes us different? We are spending other people’s money and we’re spending more and more of it. We have a GAO study that says that if we continue to spend in our discretionary spending at the current percentage of the overall economy, if we continue to tax at 19 percent of GDP, which is about the average since 1945, that in just 31 years from today, the entire Federal revenue stream will be insufficient to pay the interest on the debt because of entitlements, Social Security, Medicare, which is much worse than the interest Social Security, Medicare.

And to solve those programs in the face of President Obama’s desire to get a handle on entitlements, we stand here today proposed to add a new one. It is true that this is designed as a block grant program. But there are no limitations on it. This will go out of control just like all of the other programs have, and our children will pay. Madam Speaker, I hope we all oppose this.

Mr. WAXMAN. Madam Speaker, Members of the House of Representatives, this bill is going to pass by an overwhelming bipartisan majority, as it passed in the last Congress as well, at least twice. But the difference is, this bill will be signed tonight by the President of the United States.

President Bush vetoed this children’s health bill twice. And it is interesting to review the arguments he gave for re-jecting the legislation. First of all, he said, there’s no problem for children getting health care when they need it. They can always go to an emergency
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room of a hospital. Of course, the care in an emergency room of a hospital is the most expensive care, and it often means that the child has gotten sicker than otherwise would be the case and is forced to go to that emergency room as the only option.

And the second reason he gave for vetoing the bill is, to me, one of the most astounding. He said, why should taxpayers subsidize parents for their children’s health insurance if the parents could afford to buy a private health plan for their own children? Well, many parents just can’t afford it or will not have that as an opportunity because of a pre-existing medical condition. But think of that argument.

Suppose the President of the United States said, we ought not to have public schools for children whose parents could afford to send them to private schools. I find that a remarkable argument for him to have made.

We in this country, should value the opportunity for every child to succeed to the fullest extent of her or her ability, and that means education for all children and health care when those children need it. We do not see the President of the United States sign this bill tonight because election results make a difference. And we will have a President who will sign this bill into law, along with a bipartisan majority in the House and the Senate. And that will be a happy day for America’s children.

Mr. ENGEL. Madam Speaker, today is another great day for American families. Later this afternoon, President Obama will sign the State Children’s Health Insurance program Reauthorization into law.

Just one week ago, President Obama signed the Lilly Ledbetter Fair Pay Act into law—a bill which restores basic protection against pay discrimination. When women do better, families do better, and the Lilly Ledbetter act will make it easier for families to pay for day-to-day expenses like groceries, child care and doctor’s visits.

We build on the enactment of family security legislation today by providing health care coverage for 11 million children. In this commonsense legislation, we will preserve coverage for the roughly 7 million children currently covered by SCHIP and extend coverage to 4.1 million uninsured children who are currently eligible for, but not enrolled in, SCHIP and Medicaid.

As the third largest S-CHIP program in the nation, New York reduced the number of uninsured children in the State by 46%; reducing the number from 400,000 to approximately 267,000. I don’t know about you, but that’s the type of change I can believe in.

The State Children’s Health Insurance Program catches the most overlooked segment of our population—those families and children that earn too much to qualify for Medicaid but too little for health insurance.

This land-breaking and much needed piece of legislation will provide coverage to those families that are eligible for but not yet enrolled in SCHIP and Medicaid.

The legislation is truly bipartisan in nature, and is supported by numerous organizations including the American Hospital Association, AARP, and families USA.

My Democratic friends and Republican comrades, I urge you to take a stand against health injustices and take a stand for our children. I urge you to vote in support of the Children’s Health Insurance Program Reauthorization Act.

Ms. HIRONO. Madam Speaker, I rise today in strong support of H.R. 2, the Children’s Health Insurance Program (CHIP) Reauthorization Act. Our nation should have compassion for the most vulnerable among us, and CHIP helps millions of low-income children receive healthcare.

The last time we had a floor debate on H.R. 2, there were references made by those in opposition to the bill to a program in my state called Keiki Care. It was suggested by those individuals that the Keiki Care program was cancelled due to perceived crowding-out, where parents drop their children’s private insurance in order to enroll into a free government program.

That claim was entirely false, and I join Congressman ABSCOMBE in correcting the misstatements made by the opposition. The Keiki Care program did not have an issue with crowding-out. It was intentionally designed so that those who wish to enroll in the program must be continuously uninsured for six months. There was also no spike in program enrollment that even suggests that parents were indeed dropping their private insurance to join. I would like to insert into the RECORD a fact sheet on Keiki Care published by the group Hawaii Covering Kids.

In Hawaiian, “keiki” means “child” or taken literally “little one.” H.R. 2 is a bill that provides for the health and well-being of the keiki most in need of our help. I urge my colleagues to join me in voting in support of H.R. 2 today.

KEIKI CARE

GOAL

All children and youths living in Hawai‘i are enrolled in health insurance.

CHILDREN’S HEALTH

Compelling national health care statistics drive Hawai‘i Covering Kids’ goal:

Children who are uninsured are twice as likely not to receive any medical care;

Only 45% of uninsured children had one or more well-child visits in the past year compared with more than 70% of insured children;

More than one in three uninsured children do not have a personal physician; and

Uninsured children are less likely to receive proper medical care for common childhood illnesses such as sore throats, earaches, and asthma.

BACKGROUND INFORMATION

Approximately five percent of Hawai‘i’s children and youths are uninsured statewide which means over 16,000 kids do not have health insurance. Hawai‘i Covering Kids sponsored meetings in October 2006 and January 2007 to determine the “gap groups” and possible solutions. We concluded these children and youths are most likely to be uninsured.

Eligible for QUEST or Medicaid Fee-for-Service in households between 251–300% FPL but parents cannot afford monthly premium plus other out-of-pocket expenses.

In families with incomes above 300% FPL and parents cannot afford private health insurance.

Have temporary visas (V, H, K, etc.);

Undocumented immigrants; and

Student dependents (F visa) whose parents cannot afford university health insurance plans.

2007 INITIATIVE

The Hawai‘i State Legislature introduced HB1008, now Act 236, to help uninsured children and youths in the gap groups. It included paying QUEST and Medicaid Fee-for-Service monthly premiums for children between 251–300% FPL and establishing a free Keiki Care plan for children ages 31 days to 19 years old who do not have public health insurance. The Keiki Care plan is modeled after the low-cost HMSA Children’s Plan with limited benefits and some out-of-pocket expenses. It requires the child live in Hawai‘i and be continuously uninsured for six months. Exceptions to the six-month uninsured provision include: (1) children who “income out” of QUEST or Medicaid Fee-for-Service, (2) children enrolled in a managed care children’s plan on the effective date (one-time only exemption), (3) newborns uninsured since birth, and (4) children in families affected by Aloha Airline’s bankruptcy.

TIMELINE

3 May 2007—HB1008 HD2 SD2 CD1 Passed by the Legislature;

30 June 2007—Signed by the Governor as Act 236;

1 March 2008—Enrollment Commenced;

1 April 2008—Keiki Care Effective Date.

ENROLLMENT

1 April 2008—1,827;

1 November 2008—2,021.

CROWD-OUT

Hawai‘i has never experienced problems with parents dropping their children’s private health insurance to enroll them in public-financed programs. Keiki Care specifically discourages this tactic (called “crowd-out”) through an eligibility requirement that each child must be uninsured continuously for six months, limited benefit package, and some out-of-pocket expenses. The
Parents with uninsured children often face hard choices: (1) pay the electric bill or pay the doctor; (2) fill the refrigerator or fill a prescription. That is why uninsured children often go to school with sore throats and may not participate in co-curricular activities—not only because their parents fear an injury, but also because they fear the impact medical bills could have on their family budget.

Overall, Keiki Care supports healthier children, confident parents, and reliable payments to health care providers while preserving precious charity care and limited uninsured funds for those who are uninsured. Keiki Care empowers parents by connecting their children to a pediatrician and regular preventive health care. Should a sudden illness or injury occur, the children are also insured for emergency care which averts personal and institutional financial crises. In fact, as the number of insured kids has increased in Hawai‘i, hospital emergency department data for 2000–2006 show that visits by uninsured children and youths have declined from 5.25% to 3.79%.

Keiki Care helps Hawai‘i’s economy

Imagine your child awakens in the night with an asthma attack and needs health care. The coughing and breathing worsen, however your child has no health insurance. You struggle to pay for food, rent, and other basic living expenses and are fearful of the hospital emergency room because of potentially ruinous medical bills. What do you do?

This dilemma is familiar for thousands of parents and guardians of uninsured children and youths throughout Hawai‘i. As state budgets face monetary shortfalls, taxpayers should know it is cheaper to cover kids with health insurance than cover expensive hospital costs for uninsured kids. That is why federal, state, and community organizations collaborated to create Keiki Care for uninsured children and youths in the “gap group”—those who do not qualify for public health insurance and their costs cannot provide private health insurance. It should be clarified that specific provisions discourage parents from dropping their children’s private health insurance to enroll in Keiki Care: (1) child must be continuously uninsured for six months, (2) limited health care benefits, and (3) out-of-pocket expenses.

A modest investment in Keiki Care helps Hawai‘i’s economy because should a sudden illness or injury occur, children are insured for emergency care which averts personal and institutional financial crises. In fact, as the number of insured kids has increased in Hawai‘i, hospital emergency department data for 2000–2006 show that visits by uninsured children and youths have declined from 5.25% to 3.79%.

Keiki Care also empowers parents by connecting them to a pediatrician and regular preventive health care. Compelling national health care statistics published in a recent Covering Kids & Families “State of Coverage” report reflect this: (1) more than 50% of uninsured children and youths have one or more well-child visits a year compared with more than 70% of insured children, (3) more than one in three uninsured children do not have a personal physician, and (4) uninsured children are more prone to pediatric care for childhood illnesses such as sore throats, earaches, and asthma.
finance their everyday needs—including healthcare. In 2008, one million additional children enrolled in Medicaid or SCHIP as a result of lost employment issued insurance.

In a country where a large portion of people receive healthcare insurance through their employer, it is not surprising that when the economy and job market plunge, the number of uninsured Americans soars. And children frequently pay the highest price.

This issue hits close to home. My state of Florida is the second highest state in the nation in terms of overall health. Like other low ranking states, Florida has a large uninsured population and a high rate of child poverty. In fact, Florida has the second largest number of uninsured children in the country. What's more, a disproportionate number of Florida's uninsured children are black, Hispanic and reside in rural areas.

However, the targeted provisions in the 2009 SCHIP Reauthorization bill give us reason to be hopeful. Make no mistake. SCHIP and other emergency and supplemental programs are the only lasting answers to the problems that are intrinsic in America's healthcare system. State, local and federal entities must execute a coordinated effort to lessen the burden of uninsured people in this country as we embark on the road to long-term economic and health/business development.

President Obama signing the 2009 SCHIP bill into law is a noble beginning to achieving health care reform, and sends a strong message to our nation's children.

In the absence of the Select Panel for the Promotion of Child Health said, “Children are one third of our population and all of our future.”

SCHIP is as much of an investment in addressing the issues of today as it is to ensure the well-being of our nation's economy and competitiveness tomorrow. I am pleased to see that we are giving millions of children the basic health benefits they rightly deserve.

Mr. BACA. Madam Speaker, I rise today in support of this important legislation. I commend the willingness of those who are paying for this legislation, particularly the small businesses, local cigar importers, who showed a great willingness to do their part to see the SCHIP legislation passed despite the sacrifices they will have to make.

This is a proud day in the House of Representatives. I urge my colleagues to join me in voting for this important legislation.

Mr. GENE GREEN of Texas. Madam Speaker, I rise today in support of final passage of H.R. 2, the Children's Health Insurance Program Reauthorization Act of 2009.

This bill should have been passed last year, but after working on this bill for an entire Congress, I am pleased with the final version before us today.

This bill will extend the SCHIP program for four and a half years and provide SCHIP coverage for the 7 million children already enrolled in the SCHIP and will insure nearly 4 million additional children.

The bill also includes a provision that will give 400,000 to 600,000 legal immigrant children access to health care. These children are currently barred from SCHIP coverage because of a five year waiting period for Medicaid for legal immigrants.

This provision, which was originally in H.R. 485, the Immigrant Children's Health Improvement Act, will give states the option to cover children and pregnant women lawfully residing in the United States.

Current law requires these legal immigrants to endure a five year waiting period before they have access to Medicaid coverage when they would otherwise be eligible.

The waiting period costs more than covering these children because they often have no health insurance and end up in emergency rooms for primary care treatment.

The SCHIP reauthorization bill also includes language from a bill I originally introduced and will give one year of emergency Medicaid coverage for children born in the U.S. and their mothers, which is crucial in protecting the health and wellness of newborns born in this country.

I hope my colleagues will join me in supporting this legislation and reauthorize the SCHIP program to extend coverage to nearly 11 million low-income children.

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

In 1996, Congress required that legal immigrants wait five years after coming to the United States before receiving welfare benefits.

It's only fair that American taxpayers not foot the medical bills of foreign nationals who arrive with a sponsor's pledge not to let them become a "public charge." This bill, H.R. 2, changes current law and allows immigrants to get medical benefits at the expense of U.S. taxpayers.

The five-year waiting period for immigrants to receive government benefits is the last line of defense for the U.S. taxpayer. It should not be expanded.

Prior to 1996, the cost of welfare for immigrants had jumped to $8 billion a year. The number of noncitizens on Supplemental Security Income increased more than 600 percent between 1982 and 1995. Both of these numbers have been cut in half since H.R. 2 was 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 defeated.

Mrs. CAPPS. Madam Speaker, I rise today in support of this bill and in support of America's children.

As someone who spent over 20 years of my life as a school nurse dedicated to the betterment of children's healthcare, I can think of nothing greater than fulfilling the promise of quality healthcare for all deserving children. It was with great frustration I watched as President Bush repeatedly vetoed our proposals to improve the Children's Health Insurance Program.

And I could not be prouder to know that the bill we pass today will be signed into law thanks to the commitment of President Obama to our nation's children. Signing this bill into law will mean 4 million more children get the care they need.

Four million more children won't have to unnecessarily miss days of school because of preventable illness. Four million more children's parents won't have to wait in the emergency room for their daughters and sons to receive routine care.

Earlier today I met with a school nurse who relayed to me that a child in her school district was injured on the playground and they can't find a doctor to perform a necessary MRI because the child is uninsured.

I wish this was an isolated incident and that no other parent had to take their son from doctor to doctor and pray that someone will perform the procedure for free. But it is all too common.

Passage of this legislation today may not help this one child's family in time, but we can be sure that four million more children's parents can take comfort that they will not ever face this situation in the future.

I urge my colleagues to vote for this legislation and in favor of our children's future.

Mr. MARKEY. Madam Speaker, I rise today in strong support of the Senate-amended version of the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009.

I am proud to be an original cosponsor of this important legislation to expand the highly
successful State Children’s Health Insurance Program (SCHIP). This bill will provide health insurance to an additional 4 million low-income children on top of the nearly 7 million who already benefit from the program. SCHIP also improves access to dental care and mental health services and includes provisions to improve and utilize health information technology for children.

In my home state, SCHIP enrollment is part of the reason why Massachusetts has the lowest rate of uninsured children in the country. More than 180,000 Massachusetts children receive care through SCHIP. For this reauthorization will allow the state to cover about 56,000 more Massachusetts children who currently do not have health insurance.

It is unfortunate that the previous two attempts to reauthorize SCHIP were vetoed by President Bush, who chose to side with big corporations over children. With the current economic crisis causing significant job losses, millions of Americans also are losing their health coverage, making today’s vote even more important.

While President Bush twice dashed the hopes of millions of low-income families in need of health care for their children, the Obama administration recognizes the value of ensuring that all low-income children get the health care they need.

Three weeks ago this chamber approved CHIPRA by a larger margin than the two votes on SCHIP bills in the 110th Congress. I urge my colleagues to once again stand with the hard working families who want to provide their children with the health care they need. Vote yes on this critical legislation.

Mr. ETHERIDGE. Madam Speaker, I am a strong supporter of the Children’s Health Insurance Program, and I rise in support of this legislation. With one out of eight children in North Carolina lacking health insurance, and with the economic downturn making it even more difficult for families to afford health care, this legislation is more important than ever.

At the same time, I feel it is important to say a few words about fairness. Time and time again, Congress has singled out tobacco to pay for care spread across the country’s economy. North Carolina’s tobacco farmers grow a legal crop. These hard working farm families who work hard to be able to pay their bills and provide a better life for their children have suffered greatly from transformations in the global economy. Because my district is the second largest tobacco producing district in the country, H.R. 2 disproportionately affects my constituents. It is unfair for North Carolina’s farm families to pay the entire cost of this bill, which has benefits that accrue to the nation and must find more equitable ways to pay for worthy initiatives like the Children’s Health Insurance Program, and I urge my colleagues to work together to be fiscally responsible without placing the burden on one region of the country or one segment of the economy.

In these difficult economic times, North Carolina will need additional help to bear the economic effects of reduced farming and manufacturing. According to researchers at North Carolina will need additional help to bear the economic downturn making it even more important.

Mr. REYES. Madam Speaker, as we work together to provide health care to America’s children, we should all remember the family farmers who grow tobacco. I ask that we take steps in future legislation to help all of those who are negatively impacted by this bill, especially including families in the Second District of North Carolina. However, today, for our children’s health, I urge my colleagues to join me in supporting this bill.

Mr. REYES. Madam Speaker, I rise in strong support of H.R. 2, the State Children’s Health Insurance Program (SCHIP) Reauthorization Act of 2009, as amended by the Senate.

At this time, the reauthorization of SCHIP is critically important for the nation and particularly my district of El Paso, Texas, where over 20,000 children in El Paso County are enrolled in the program. My district has one of the highest rates of uninsured children in the country, and the current economic recession is making it even harder for many more families to afford health insurance.

I am deeply troubled that Texas has the highest number of uninsured children in the United States. It is simply unacceptable to have one in five children in my state without health insurance, and this legislation will expand coverage for millions who are uninsured. This is a program that gives children a second chance at success and is affecting many families across our nation. Recent studies estimate that for every one percent increase in our national unemployment rate, 1.1 million Americans lose health insurance and more than a million enroll in Medicaid and SCHIP.

Having a large number of uninsured children in our communities places a tremendous financial burden on parents and local hospitals, as families are forced to send their children to the emergency room, often at a cost of more than $1 billion. Other analysis shows that North Carolina’s citizens pay over four percent of the costs of this legislation while receiving only two percent of the benefit. This will mean lost jobs in a region that is already one of the top ten in the nation in unemployment, and is one of the top five fastest areas in unemployment growth. I am hopeful that we can work together to get my home State the economic support it needs to weather both the national economic downturn and the prove ready to provide health care.

At the same time, it is vital that we expand and extend CHIP to provide much-needed health care to our most vulnerable citizens. North Carolina has 296,000 uninsured children, the sixth-largest number in the country, and nearly half of these children would be able to get insurance under the provisions of this bill. Together with the 240,000 children currently served by NC Health Choice for Children, the new enrollees would be able to get the health care they need. Preventative care and timely treatment of disease ensures that children are healthy and productive, able to fulfill their potential. Access to health care also saves money for our health system in the long term, because it is more cost-effective to get primary care at a doctor’s office than to go to the emergency room.

The bill improves the benefits available under CHIP, including by ensuring dental coverage and mental health parity. It improves the quality of care, and prioritizes coverage for the lowest-income children. Together these provisions will enhance children’s lives and keep children from suffering from preventable disease.

As North Carolina’s former Superintendent of Public Instruction, I have seen firsthand that healthy children are better prepared for learning and success. My life’s work has been to help children make the most of their God-given abilities, and CHIP plays a key role in giving children the environment they need to grow. Therefore, despite my misgivings about the funding mechanism, I will cast my vote in favor of H.R. 2.

Madam Speaker, as we work together to provide health care to America’s children, we should all remember the family farmers who grow tobacco. I ask that we take steps in future legislation to help all of those who are negatively impacted by this bill, especially including families in the Second District of North Carolina. However, today, for our children’s health, I urge my colleagues to join me in supporting this bill.

Mr. ABERCROMBIE. Madam Speaker, it is my understanding that Section 214 of the Children’s Health Insurance Program Reauthorization Act of 2009, H.R. 2, would apply to the citizens of the Republic of Palau, the Republic of the Marshall Islands, and the Federated States of Micronesia.

According to the Compact of Free Association negotiated and agreed to by the United States, the citizens of these countries are here legally. However, the federal government currently does not provide assistance to states for the care of these individuals through such programs as Medicaid or SCHIP. Since Section 214 of this bill applies to those legally residing in the United States, I believe this clearly includes the citizens of the Republic of Palau, the Republic of the Marshall Islands, and the Federated States of Micronesia.

Today’s bill provides sufficient federal funds to help states maintain their current programs and extend coverage to four million additional uninsured low-income children. Many states may experience much higher enrollment in SCHIP than projected due to job loss and lower incomes, and many would be unable to support the higher demand without this relief.

I am proud to support this legislation. I applaud President Obama and my colleagues in Congress for this a top priority.

Mr. ABERCROMBIE. Madam Speaker, I rise in support of the Children’s Health Insurance Program Reauthorization Act of 2009, H.R. 2, which would apply to the citizens of the Republic of Palau, the Republic of the Marshall Islands, and the Federated States of Micronesia.

According to the Compact of Free Association negotiated and agreed to by the United States, the citizens of these countries are here legally. However, the federal government currently does not provide assistance to states for the care of these individuals through such programs as Medicaid or SCHIP. Since Section 214 of this bill applies to those legally residing in the United States, I believe this clearly includes the citizens of the Republic of Palau, the Republic of the Marshall Islands, and the Federated States of Micronesia.

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I am proud to support this legislation. I applaud President Obama and my colleagues in Congress for this a top priority.

Mr. WAXMAN. Madam Speaker, I bring to the attention of the House that a quorum is not present.

Pursuant to House Resolution 107, the previous question is ordered.

The question is on the motion by the gentleman from California (Mr. Wax- man) to table the motion to reconsider the question.

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

Mr. LINDER. Madam Speaker, I object to the vote on the ground that a quorum is not present and make the motion in order that a quorum is not present.

The Speaker pro tempore. Evidently a quorum is not present.
Mr. HUNTER, Mrs. LUMMIS and Mr. BACHUS changed their vote from 'yea' to 'nay.'

So the motion was agreed to. The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.


COMMUNICATION FROM CHAIRMAN OF COMMITTEE ON WAYS AND MEANS

The SPEAKER pro tempore laid before the House the following communication from the Chairman of the Committee on Ways and Means:

HOUSE OF REPRESENTATIVES, WASHINGTON, DC, January 12, 2009.

H. RES. 118

Resolved, That the following members are, and are hereby, elected to the following standing committees:

COMMITTEE ON AGRICULTURE—Ms. Lummis, Chairman, Committee on Education and Labor—Mr. Thompson of Pennsylvania.

COMMITTEE ON SMALL BUSINESS—Mr. Coffman of Colorado.

Mr. PENCE (during the reading).

Madam Speaker, I ask unanimous consent that the resolution be considered as read and printed in the RECORD.

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

There was no objection.

The resolution agreed to.

A motion to reconsider was laid on the table.

REMOVAL OF NAME OF MEMBER AS COSPONSOR OF H.R. 135

Mrs. NAPOLITANO. Madam Speaker, I ask unanimous consent that the name of Mr. Solomon be removed as a cosponsor of H.R. 135.

The SPEAKER pro tempore. Is there objection to the request of the gentlewoman from California?

There was no objection.

COMMUNICATION FROM CHAIRMAN OF COMMITTEE ON WAYS AND MEANS

The SPEAKER pro tempore laid before the House the following communication from the Chairman of the Committee on Ways and Means:

H. RESOLUTIONS 115

Resolved, That the following members are, and are hereby, elected to the following standing committees:

COMMITTEE ON AGRICULTURE—Ms. Lummis, Chairman, Committee on Education and Labor—Mr. Thompson of Pennsylvania.

COMMITTEE ON SMALL BUSINESS—Mr. Coffman of Colorado.

Mr. PENCE (during the reading).

Madam Speaker, I ask unanimous consent that the resolution be considered as read and printed in the RECORD.

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

There was no objection.

The resolution agreed to.

A motion to reconsider was laid on the table.